An Investigation into the Prevalence of Mental Health Disorder and Patterns of Health Service Access in a Probation Population

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Executive Summary

The over-arching aim of this study was to pilot a methodology for assessing the prevalence of mental health disorder and substance misuse amongst offenders under probation supervision in Lincolnshire. This is an area in which existing literature and policy papers suggest there is a paucity of research. The study was divided into three stages.

1.0 Stage One

The first stage investigated the prevalence of mental health disorder and substance misuse amongst offenders under probation supervision in Lincolnshire. It also examined offenders' self-reported needs, and the extent to which offenders felt that their needs were being met by existing service provision.

1.1 Study Design

When conducting this stage of the study, the researchers utilised a number of established screening tools with a random sample of offenders that was stratified by probation office and tier of risk. Demographic information was collected about each participant. The Alcohol Use Disorders Identification Test (AUDIT) was used to investigate drinking levels; the Drug Abuse Screening Test (DAST) was used to investigate drug use; and an amended version of the Prison Screening Questionnaire (PriSnQuest) was used to determine 'likely cases' of mental illness. Participants who screened positive on the PriSnQuest tool also completed the Mini International Neuropsychiatric Interview (MINI) — a diagnostic tool to screen for current and past/lifetime mental health disorders, the CANFOR-S — which investigates health heeds, and an amended version of the Client Socio-demographic and Service Receipt Inventory (European Version) which examines patterns of service use. In addition, a sub-sample of participants who screened negative on the PriSnQuest also completed the full range of measures for this stage of the study as a false-negative check.

Analysis showed that the 173 participants interviewed during this stage of the study were broadly representative of the wider caseload in Lincolnshire Probation Trust in terms of gender and ethnicity.

SAPAS versus SCID-II in a probation sample

Stage 1 also involved using SAPAS as a brief screen for 'likely cases' of personality disorder. This screening tool had not been used with a probation population before. Consequently, findings of this tool were compared with those of the 'gold-standard' screen for personality disorder, the

SCID-II for a sub-sample of 40 participants. The results of this sub-study are presented here as 'Stage 4'.

1.2 Findings

1.2.1 Prevalence
Offenders were found to be a deprived group, with a relatively high prevalence of mental illness when compared to the general population. Overall, 27.2% of offenders had a current mental illness (weighted figures that consider PriSnQuest false-negatives revise this figure up to 38.7%). 39.9% of participants had a past/lifetime disorder (weighted prevalence is 48.6%). Key results in terms of particular categories were as follows (weighted estimates are given in brackets):

- 15% of participants had a current mood disorder (17.9%)
- 21.4% of participants had a current anxiety disorder (27.2%)
- 8.1% of participants had a current psychotic disorder (11%)
- 2.3% of participants had a current eating disorder (5.2%)
- 47.4% of participants were 'likely cases' of personality disorder according to the SAPAS
- 38.2% of participants had a past/lifetime mood disorder (43.9%)
- 15.6% of participants had a past/lifetime psychotic disorder (18.5%)

When looking at levels of substance misuse amongst offenders on probation, results show that 55.5% of participants scored 8+ on AUDIT – indicating a strong likelihood of hazardous/harmful alcohol consumption, and 12.1% of participants scored 11+ on DAST – indicating 'substantial' or 'severe' levels of drug use.

A weighted logistic regression analysis suggested that the following were associated with an increased risk of a current mental illness at a statistically significant level: receiving benefits, suicidality and personality disorder. In addition, the following were associated with a reduced risk of a current mental illness at a statistically significant level: increasing age and paid employment. However, only 'age' retained a statistically significant association in the presence of other variables in the final model. The lack of other significant associations is likely to be due to the sample size in the study.

1.2.2 Comorbidity and Dual Diagnosis
Levels of co-morbidity and dual diagnosis are known to be high in prison populations, but very little research has examined this in a probation population. Results of this study suggest that there is also a very high degree of comorbidity and dual diagnosis in a probation population.

72.3% of those who were positive on the PriSnQuest screen had both a substance misuse problem and a current mental illness. Levels of dual diagnosis were higher for use of alcohol than for use of drugs. Furthermore, 89.4% of participants with a current mental illness also had a personality disorder.

1.2.3 Self-Assessed Needs

The results of the CANFOR-S screening tool indicated that participants *with* a current mental illness had a higher mean level of need than those *without* (mean scores were 10.53 and 4.59 respectively). Results of a Mann-Whitney 'U' test also showed that there was a statistically significant difference between these two groups in terms of their mean 'met' and 'unmet' needs scores at the p=<0.05 level.

1.2.4 Access to Services

The CSSRI-EU screening tool was used to investigate access to mental health services. Service use was examined for different diagnostic groups; and overall results indicate relatively low levels of service access, given the high levels of health needs in the population. 60% of participants with a current mood disorder did not report accessing any mental health service. This compares with 59% of those with a current anxiety disorder, 50% of those with a current psychotic disorder, 75% of those with a current eating disorder, and 55% of 'likely cases' of personality disorder. Of those scoring 8+ on the alcohol screening tool (AUDIT), 40% reported accessing a substance misuse service. Finally, of those scoring 11+ on the drug abuse screening tool (DAST), 88% reported accessing a substance misuse service.

2.0 Stage Two

The second stage of the project compared the findings from the clinical interviews conducted in Stage 1 to information in probation case files. It aimed to examine the extent to which probation staff were aware of and recording offenders' mental health and substance misuse problems, and to examine the information that probation staff record about offenders' access to health services.

2.1 Study Design

A researcher examined the probation case files for a purposive sample of participants in Stage 1 – namely those who screened positive for a current mental health disorder.

As very little research of this nature has been conducted to date, a data-collection tool was designed from scratch for this stage of the study. One researcher used this to collect quantitative data for every file and qualitative data for every fifth file. Qualitative data were manually coded

into themes using the constant comparative method. The methodological learning produced from this section of the study is given in brief in section 5.0 below.

2.2 Findings

2.2.1 Recording of Mental Illness and Substance Misuse

Analysis of the quantitative data showed considerable variation across disorder types in the extent to which a mental illness identified by the researchers in Stage 1 was recorded by probation staff in case files. Some of the files examined during this stage of the study were incomplete, as data from them had been destroyed prior to the file being archived. Thus two sets of figures are provided in the report — those for 'all files', and those for 'complete files' only. Findings for complete files only were as follows:

- **Any current mood disorder** — 73% of cases identified by researchers in Stage 1 were also recorded in the probation files
- **Any current anxiety disorder** — 47% of cases identified by researchers in Stage 1 were also recorded in the probation files
- **Any current psychotic disorder** — 33% of cases identified by researchers in Stage 1 were also recorded in the probation files
- **Any current eating disorder** — none of cases identified by researchers in Stage 1 were also recorded in the probation files
- **Any likely personality disorder** — 21% of cases identified by researchers in Stage 1 were also recorded in the probation files
- 83% of those scoring 11+ on DAST in stage one had a **drug problem** recorded in their probation files
- 79% of those scoring 8+ on AUDIT in Stage 1 had an **alcohol problem** recorded in their probation files

Thus probation staff were more likely to identify and record substance misuse than mental illness.

2.2.2 Access to Services

The researcher compared Stage 1 interview data on which services individuals were accessing with what was recorded in probation case files. Results showed that in a third of cases offenders told a researcher that they were accessing a mental health service, but this was not recorded in their probation case file. However, 70% of the files examined also contained information about access to services which had not been recorded by a researcher during the interviews for Stage 1 of the study.

A more positive picture of service access is painted when 'interview' and 'file' data are combined than when one considers the interview data in isolation. The percentage of participants with a current mental illness who were not accessing any kind of mental health service is 23% when the two data sources are combined.

2.2.3 Barriers to Service Access: Qualitative Data
The following barriers to service access were apparent in the qualitative file data:

- Motivation: an offender's lack of motivation to address an issue means that they do not engage with services
- Dual diagnosis: services would not accept individuals with both a substance misuse and a mental health problem
- Referral criteria: in some cases offenders simply didn't meet the referral criteria for existing service provision — indicating a potential need to widen provision

3.0 Stage Three
Many of the above themes were further explored in the third stage of the study. This consisted of a series (n=20) of semi-structured interviews with a purposive sample of offenders under probation supervision and probation staff. The interviews investigated what currently works well in linking offenders with mental health and substance misuse services, what act as barriers to access, and where improvements could be made to facilitate access to services for this group. This is an area in which there is currently a paucity of literature.

3.1 Study Design
Purposive sampling was employed to ensure participation from individuals with relevant knowledge/experience from a range of probation offices across the county. Interviews were conducted by both research staff and service user representatives working as pairs. Interviews were recorded and transcribed verbatim, then analysed in NVivo8 using the constant comparative method. Findings from offenders and staff are presented separately in the report. However, for brevity, they are combined in the summary below, although attention is drawn to where different ideas were expressed by the two groups.

3.2 Findings
Staff discussed a range of potential routes into services for offenders, such as direct referral from probation/access via a GP or access via the Health Support Service at Lincolnshire Probation Trust. They identified numerous **enablers** for access to services for offenders – factors which either made it easier for offenders to access services, or which encouraged them to access services:

- Joint meetings between themselves, an offender and health service staff
- Services guaranteeing confidentiality
- Co-location of services
- Clear communication within and between agencies
- A good relationship between an offender and probation staff
- Probation staff knowing a worker within the service which they wish to refer to (so they have an identified point of contact)
- Probation staff having sufficient mental health awareness training to identify the signs and symptoms of mental illness and to make referrals to appropriate services

Offenders echoed staff in discussing the importance of a good relationship between probation and themselves to aid access to services. In addition, many of them highlighted how much they valued the support that the probation service had given them, and underlined the importance of being honest with probation about their needs.

Staff identified the following as **barriers** to service access for offenders:
- Referral systems
- Lack of flexibility in provision, particularly in relation to people with complex needs
- Poor/one-way communication between services
- Silo working
- Stigma
- The need to travel long distances to access services
- A lack of resources for the treatment of particular issues, such as alcohol misuse
- Mental health professionals appearing to be reluctant to treat complex cases or to accept responsibility for mental health treatment requirements
- Probation staff having insufficient mental health awareness training
- Offenders' inability to engage with services for a variety of reasons

Offenders echoed the points about the regimented nature of some current service provision, problems with referral systems resulting in long waiting lists, lack of resources, travel distances, difficulties with communication between agencies and stigma. They also stated that having a poor relationship with probation staff could form a barrier to service access, and in some cases pointed to their own unwillingness to ask for/accept help with health problems.

When asked to discuss **positive experiences** of facilitating access to services for offenders, staff stated that they valued services with straightforward referral procedures, and services which were able to work flexibly with offenders and take the time to listen to the full range

of their needs. Likewise, when asked to discuss positive experiences of accessing services, offenders stated that they valued services which were quick and easy to access, and which worked flexibly taking the time to listen to their needs. Many offenders also discussed the benefit of having ongoing support from the Probation Service and the benefit of the flexible approach taken by probation. In addition, they stated that they had valued staff who appeared to have a genuine desire to help them, who explained their health problem to them rather than simply giving them a diagnosis, and who provided a professional voice to speak on their behalf about their health problems.

When staff were discussing **negative experiences**, perhaps the most frequently noted shortcoming was inadequate provision of alcohol services. Staff also raised issues around ensuring that appointments were offered frequently enough for offenders and around continuity of care. Staff also discussed cases where they felt that offenders had been 'fobbed off' with medication and cases where they had questioned the willingness/ability of services to work with problematic/chaotic individuals who may struggle to attend appointments. Offenders also discussed perceived inadequacies in the current level of service provision in some areas.

Finally, in terms of **improvements**, as one might expect, many of the suggestions that staff gave built on their earlier discussions on barriers to service access and negative experiences. The main issues that they raised centred around improving communication between agencies, which they felt could be achieved through methods such as co-working of cases or the provision of specialist workers in probation with mental health expertise. Staff also discussed the need to expand service provision, particularly in relation to alcohol services and also in terms of improving the range of provision available locally. Offenders stated that improving both internal information sharing and communication between services was key to improving access to services and offenders' experience of accessing health services. They also outlined the need to improve the organisation of services in order to reduce waiting lists and improve the flexibility of service provision to meet their needs.

4.0 Stage Four

As stated above, nested within Stage 1 there was also a sub-study of the use of SAPAS as a short screen for PD with offenders on probation. Results of this screening tool were compared with those of SCID-II for a sub-sample of 40 participants. This section of the study concluded that SAPAS would be a suitable screen to use to identify likely cases of PD in this population in the future, and that 3+ was an appropriate cut-off score for this tool when used with a probation population.

5.0 Methodological Learning

As this was a pilot study, it also resulted in valuable learning around methodological decisions involved in this type of research. Thus the researchers involved in the study are now better informed in terms of being able to give a more accurate estimate of the likely prevalence of mental illness in a probation population for sample size calculation in future studies. In addition, they developed a number of strategies for improving recruitment in a probation setting. Moreover, they have refined a data collection tool for collecting health information from probation case files together with methods of tackling some of the challenges involved in this type of data collection.

6.0 Conclusion

Although Lincolnshire Probation Trust may not be representative of all probation areas across the country, this study has shown that the prevalence of mental health disorder in the probation population in this area is high. In addition, it has shown that many of offenders' health needs are unmet and that there are a number of ongoing barriers to access to health services for offenders, particularly for those with complex needs. In addition, offenders may feel ambivalent about engaging with health interventions. Overall, one can only conclude that there is a need for the mental health and substance misuse needs of offenders to be given a higher priority in terms of service delivery, education and research. Information from this report can be used to provide an evidence base from which commissioners can work to ensure that appropriate services are provided to meet the needs of this hard-to-reach group and that steps are taken to address some of the ongoing barriers to service access for offenders in the community.

Introduction

Summary of the Study

This study was funded by an East Midlands Research for Patient Benefit grant. The research is divided into three stages, each of which is presented separately below. Stage 1 aimed to investigate the prevalence of mental health disorders, substance misuse, needs and patterns of service access amongst offenders under probation supervision in Lincolnshire, through one-to-one clinical interviews with a stratified random sample of offenders. A sub-study was included in this stage which investigated the use of a brief screen for 'likely caseness' of Personality Disorder (PD) (SAPAS) with a probation population. This is reported here as 'Stage 4'. Stage 2 investigated the extent to which probation staff were aware of, and recording, offenders' mental health and substance misuse problems, and the nature of any action taken by the probation service to address these issues. In Stage 3, qualitative interviews were undertaken in order to investigate the experiences of probation staff when trying to facilitate access to health services for offenders, and the experiences of offenders trying to access health services. This stage of the study aimed to highlight models of good practice in service provision for offenders, and barriers to service access for this hard-to-reach group. This stage also includes recommendations on how access to services could be improved for offenders under probation supervision.

The over-arching aim of the research is to pilot a methodology for assessing the prevalence of mental health disorder and substance misuse amongst offenders under probation supervision. In addition, the study aims to gather data which will be shared with a multi-agency steering group and used to inform both probation practice and health service provision for this hard-to-reach group.

Study Setting

The National Probation Service Lincolnshire has recently gained Probation Trust status and will henceforth be referred to as 'Lincolnshire Probation Trust'. During the study period, staff working in this service were supervising between 1,500 and 1,800 offenders. When considering the findings of this pilot study, it is important to note that Lincolnshire Probation Trust varies from other probation areas in three important ways. Firstly, Lincolnshire is a large rural county, which may have implications for the profile of its caseload and the range of service provision available when compared to more urban probation areas — something which is explored in more detail later in this report. In addition, in 2008-2009 staff of all grades from Lincolnshire Probation Trust

were offered the opportunity to participate in Mental Health Awareness Training provided by the University of Lincoln. Nationally, participation in such training is unusual for probation staff (Brooker and Sirdifield, 2009; Sirdifield *et al.*, 2010). Furthermore, Lincolnshire Probation Trust has a Health Support Service which employs nurses to work with offenders under supervision to address their health problems, and to encourage offenders to access mainstream health services. Thus, one might argue that staff working in this Trust are more aware of and focused on offenders' health issues than those working in other probation areas; and may also possess a different range of knowledge, skills and resources to those found in other probation areas.

Background

The background literature could have been presented in one of two ways: one large combined research and policy review in the background section, or (as we have attempted here) a review of recent policy and a separate presentation of the background research literature relevant to each of the separate stages. Members of the steering group felt that the literature lent itself to the latter approach rather than the former, although the literature as a whole is examined coherently in the final discussion section.

Recent Policy

In April 2009 Lord Bradley published his review of the mental health problems or learning disabilities faced by people in the criminal justice system. In the context of an increasing UK prison population, this review examined the issue of diverting offenders with mental health problems or learning disabilities away from the criminal justice system at various points in the offender pathway and into health and social care services. The diversion of offenders with mental health disorders away from the criminal justice system has been the focus of numerous government policy papers prior to Lord Bradley's review, but still happens in a piecemeal manner in England. The review drew attention to the numerous barriers to diversion from the criminal justice system. It highlighted a lack of service provision — in particular pointing to a dearth of mental health and alcohol service provision in some areas — which makes it difficult for sentencers to effectively utilise mental health treatment and alcohol treatment requirements. Moreover, it stated that "services are currently organised in such a way as to positively disadvantage those needing to access services for both mental health and substance misuse/alcohol problems" (Lord Bradley, 2009: 21) — a fact that echoed the findings of an earlier report by the Social Exclusion Unit in 2002. Thus one potential barrier to diversion is a lack of service provision and/or that services are not provided in a way that meets the needs of complex cases.

Two other potential barriers to diversion highlighted in the review were ongoing problems with information sharing and understanding between agencies, and a lack of training (including mental health awareness training). These issues may result in 'silo' working and in staff failing to identify offenders with mental health needs who may be appropriate for diversion into treatment services.

In addition, the review emphasised the paucity of information on the health needs (including the mental health needs) of offenders at various stages of the pathway through the criminal justice system; stating:

> "currently data is not routinely collected in relation to offenders' health needs at every stage of the criminal justice system, and therefore it is difficult to estimate the full scale of need. This in turn makes it difficult to inform the commissioning and planning of appropriate services" (Lord Bradley, 2009: 138).

Thus the report highlighted the need for studies such as this which pilot methods for investigating the health needs of offenders and the extent to which they are being met by current service provision.

Much of the little existing data on the health needs of offenders under supervision draws on Offender Assessment System (OASys) data, as demonstrated by the evidence report for the Green Paper *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders* (2010a). This report outlines the intention of the Ministry of Justice to work with the Department of Health to ensure that less serious offenders who have mental health problems and/ or are drug dependent are diverted away from prison (MoJ, 2010b: 2). It states that, according to OASys, 37% of offenders under supervision have a drug misuse need, 32% have an alcohol need, and "female offenders report higher levels of drug and alcohol problems compared to male offenders" (MoJ, 2010: 51). However, OASys assessments are not conducted on all offenders and thus these data may not be wholly representative. Neither is an individual's mental health expertly assessed. Thus there is a need for research which draws on a wider range of data sources.

This is also reflected in *Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board* (2009), which states that "despite some recent improvements, limited health research has been undertaken in prison or probation settings" (Department of Health, 2009: 10). Similarly, the NOMS East Midlands Strategic Commissioning Plan 2010-2013 sets conducting and refining analysis of offender needs to inform the commissioning of services as a priority (MoJ, undated).

Although funded prior to the Bradley Review, this report addresses many of Lord Bradley's recommendations; primarily in piloting a method of collecting much-needed information on the health of offenders under supervision to ensure that service provision is needs-based. However, it also touches on Bradley's recommendations on the need to improve partnership working between criminal justice, health and social care agencies and to co-ordinate staff training to improve knowledge and skills in relation to areas such as mental health awareness, personality disorder, dual diagnosis and information sharing.

Stage 1

Aims

The first stage of this study employs a number of structured clinical interview tools, in order to:

- pilot a methodology to establish the prevalence of mental health disorder — including personality disorders and substance misuse — amongst a random sample of offenders under probation supervision in Lincolnshire;
- and establish the self-reported health needs of these offenders and the extent to which offenders feel that their needs are being met by existing service provision.

Thus, findings from Stage 1 will include an estimate of the proportion of offenders under supervision who are likely to be experiencing a mental health problem or substance misuse problem. In addition, as co-morbidity and diagnostic complexity are significant features of the *prison* population, Stage 1 also aims to provide an estimate of the extent of comorbidity and dual diagnosis in this population.

A sub-study within Stage 1 involves comparing the results of a short screening tool for personality disorder (SAPAS) with those of the 'gold standard' assessment tool (SCID-II) to assess the performance of SAPAS with a probation population. This is reported here as 'Stage 4'.

Finally, findings from Stage 1 will illustrate offenders' self-assessed health needs and patterns of access to health services, demonstrating the extent to which their needs are met by current service provision.

Background

Mental Health Disorders

A systematic review of research on prison mental health by Brooker *et al.* (2007) demonstrated that a wealth of studies have been conducted on this topic world-wide, including national studies of the prevalence of mental health disorders amongst prisoners in England and Wales (see for example, Singleton *et al*., 1998). However, comparatively little research has focused on the prevalence of mental health disorders amongst offenders in the community.

Some studies have been conducted on the mental health of offenders in Probation Approved Premises. For example, Geelan *et al.*, (1998) used existing records and offender self-report to build a picture of the mental health of 83 residents of an Approved Premises specifically for men with mental health disorders. Here, 30% of residents had schizophrenia, 18% had a personality disorder, 6% had depressive episodes, 4% mania, 1% anxiety, 1% OCD and 11% 'other psychotic disorder'. Interestingly, 11% of residents were found to have no disorder. In a study by Hatfield *et al.* (2004), probation staff completed a questionnaire and the General Health Questionnaire with residents of seven Approved Premises in the Greater Manchester area. Not all of these premises specifically housed offenders with mental health disorders. This study concluded that 29.5% of residents were likely to have mental health needs. However, the residents of Approved Premises are unlikely to be representative of wider probation populations, as they are likely to be individuals convicted of relatively serious offences.

In addition to these studies, several papers have been published describing the caseloads of probation psychiatric services established in some areas of the UK. However, these studies are again limited to the clients of these services and thus only provide a proxy measure of the prevalence of mental health disorders across all offenders in a given probation area (see for example, Collins *et al.*, 1993; Huckle *et al.*, 1996; Cohen *et al.*, 1999).

Pritchard *et al.* (1990, 1991) investigated the mental health of young people under probation supervision in Bournemouth and Southampton (aged 18-35); i.e. across the whole caseload rather than a sub-section of the caseload. Here, probation staff were asked to complete a questionnaire about individuals on their caseload. In the 1990 study, 25% of the offenders were recorded as having a mental health disorder, and in the 1991 study this decreased to 21%.

Brooker *et al.*, (2008) conducted a health needs assessment of 183 offenders under probation supervision in Nottinghamshire and Derbyshire which concluded that, overall, 17% of the sample had been diagnosed with a mental health disorder. Here, the most prevalent disorder was depression, affecting 7% of offenders.

Perhaps one of the most comprehensive studies of the mental health of people under supervision was conducted in the USA by Lurigio *et al.* (2003). The study was based on a stratified random sample of 627 adults under supervision in Illinois, with the sample being stratified by county. Trained interviewers used the MINI International Neuropsychiatric Interview version 2.2 to examine mental health disorder in this group. This study showed that the most prevalent *current* mental health disorder was depression (major depressive episode), affecting 13.2% of the population. 11.2% of the sample had a current psychotic disorder.

All of these studies employ different approaches to measure the prevalence of mental health disorders. Some studies approximate the proportion of individuals who are likely to have a mental health disorder through measures such as previous use of mental health services or staff opinions, whilst others attempt to measure it directly using structured screening tools.

Thus, as stated in many recent policy papers, there is a paucity of high quality research into the prevalence of mental health disorders amongst offenders under probation supervision (DH/ NOMS, 2011; Lord Bradley, 2009; and DH, 2009). Examination of the few studies which do exist shows that cultural differences and methodological variation between studies makes it difficult to reach firm conclusions about the prevalence of mental health disorders in probation populations. Stage 1 of this study aims to build on the strengths of the existing literature and address some of the weaknesses to produce a template for assessing the level of psychiatric morbidity in a probation population.

Substance Misuse

In addition, the study aims to investigate the level of drug and alcohol misuse amongst offenders under probation supervision. A number of the existing studies outlined above provide estimates of the proportion of offenders under supervision involved in substance misuse and thus shed some light on the extent of dual diagnosis in this population. For example, in the Geelan *et al.* (1998) study, 29% of the residents were cited as having alcohol abuse/dependence, and 10% as having drug abuse/dependence. Pritchard *et al.* (1990) found that staff recorded 49% of probation clients as having a problem with alcohol, 21% as having a problem with soft drugs, and 11% as having a problem with hard drugs. Lurigio *et al.* (2003) report that 25% of their participants stated that they had used illicit drugs during the month prior to interview. Overall, "14% of respondents had alcohol use problems only, 16% had drug use problems only, and 13% had both alcohol and drug use problems" (Lurigio *et al.*, 2003: 639). In addition, they found that there were higher rates of mental illness amongst participants who were misusing substances than among those who were not.

Similarly, in a study of community-based offenders in Canada, Wormith and McKeague (1996) found that 27.1% of offenders classified as having a mental health disorder also had an alcohol or drugs problem, compared to just 5.1% of the overall sample. Furthermore, results of an American survey using personal interviews with adults under probation supervision (Ditton, 1999) show that 41.4% of mentally ill offenders under supervision had been using alcohol at the time of their offence, compared to 39.7% of 'other probationers'. 18.1% of individuals under

supervision with a mental illness were using drugs at the time of their offence, and 39.5% had used drugs in the month prior to their offence. Using the CAGE screening tool, this study showed that 34.8% of 'mentally ill probationers' and 22.1% of 'other probationers' had a history of alcohol dependence.

Brooker *et al.* (2008) also used the CAGE screening tool, and found that "49% of offenders in Derbyshire and 40% of offenders in Nottinghamshire were assessed as being at risk of abuse or dependence on alcohol" (2008: 24); whilst UNCOPE scores suggested that 39% of the sample were at risk of drug misuse.

Finally, in a survey of prisoners and offenders in the community, Budd *et al.* (2005) found that around three in ten offenders in the community stated that they had used heroin, crack or cocaine in the twelve months prior to interview (2005: vi); whilst Mair and May's (1997) survey of offenders on probation suggested that 42% of offenders had used cannabis in the last 12 months, 8% had used heroin, 8% cocaine, 8% methadone and 24% amphetamines. At least 10% of the sample was thought to have an alcohol problem (Mair and May, 1997: 23). The figures in both of these studies may well be an underestimate, as offenders who did not participate in the interviews may have higher rates of substance misuse than those who did participate and/ or offenders in the community may be unwilling to disclose the full extent of their substance misuse.

Again, these studies use different methods of assessing levels of substance misuse, making comparison of findings problematic.

Health Needs and Access to Services
As outlined above, a relatively small number of studies have investigated the extent of mental health disorder and the extent of substance misuse in probation populations. However, to the authors' knowledge, even fewer studies to date have examined the self-defined health needs of offenders under probation supervision in any way. Those that do are based on the results of Offender Assessment System (OASys) screening assessments. For example, Moore (2007) examined data from 101,240 OASys Self-Assessment Questionnaires (SAQ) from 42 probation areas and 126 prisons in the UK. The SAQ consists of twenty-seven potential problem areas against which offenders are asked to indicate, a) whether or not the area is a problem for them, and b) whether or not the area is linked to their offending. Findings from the areas relating to the health of offenders show that 'feeling depressed' was indicated as a problem on 35% of the questionnaires; and in 12% of cases this was recorded as linked to offending. 'Drinking too much alcohol' was recorded as a problem on a quarter of the questionnaires, and linked to offending

on 19% of them. Finally, 'taking drugs' was recorded as a problem on 24% of the questionnaires, and linked to offending on 16% of them. The study notes that, overall, "seventeen per cent of offenders in the SAQ sample believed they had no social or individual problems, and 47 per cent thought they had no problems which were linked to offending" (Moore, 2007: 1).

Similarly, in their review of the Probation Service's work with alcohol misusing offenders, McSweeney *et al.* (2009) studied OASys data and probation case files in six purposively selected case study sites and stated that alcohol was recorded as criminogenic need in OAsys in 49% of the assessments studied; whilst drug misuse was recorded as an influence on offending behaviour in a quarter of cases. Offender self-assessment data indicated that 31% of offenders indicated that they drank too much alcohol, with 23% recording this as an influence on their offending. This study pointed to a high level of unmet need in relation to alcohol misuse, and states that the provision of Alcohol Treatment Requirements is often hampered by issues such as a lack of dedicated funding, a lack of service provision and a lack of guidance on probation's role in this area.

The SAQ also includes numerous problem areas which are similar to those investigated in this study using the CANFOR-S.

As Moore states, the limitation of his study is that the sample is not necessarily representative of a probation population because OASys assessments are not conducted on all cases (something which is discussed further in Stage 2 of the study), and there is no national standard for the completion of the SAQ. As detailed below, this study will use the CANFOR-S to collect data on the self-assessed needs of all offenders who screen positive on the PriSnQuest, detailing in which areas offenders believe they have both 'met' and 'unmet' needs.

In terms of offenders' access to services, a study by Howerton *et al.* (2007) using in-depth interviews with 35 male offenders — both before and after release from a Category B prison in England — suggests that offenders' access to services may be limited by distrust (both as a result of chaotic upbringings, and of previous negative experiences with healthcare professionals) and by a fear of receiving a diagnosis of mental illness.

Various studies have examined patterns of service access amongst offenders under probation supervision in the UK. For example, the Brooker *et al.* (2008) health needs assessment reported that 15% of offenders in their sample had accessed a mental health service in the twelve months prior to data collection. Several studies have been conducted in probation Approved Premises. For example, in their study of an Approved Premises for male offenders with mental health

disorders, Geelan *et al.* (1998) state that 54% of residents had previously accessed a mental health service as an outpatient, and 63% had previously been a mental health service in-patient. The Hatfield *et al.* (2004) study detailed above investigated the extent of psychiatric service use by 533 residents of seven Approved Premises in Greater Manchester. One of these was for offenders with mental health needs, and one was for women. Residents with mental health needs at these two premises were "significantly more likely to receive mental health services than residents with mental health needs at the other men's premises (p <0.01)" (Hatfield *et al.*, 2004: 108). This study is largely based on questionnaires completed by staff and reports that, overall, 5.8% of residents had accessed a Psychiatric Nurse/CPN, 2.6% had accessed a Mental Health Social Worker, 1.7% had accessed a Forensic Psychiatrist, 4.9% a Psychiatrist, 0.8% an OT, 1.9% a Psychologist, and 21% a drug/alcohol worker.

Finally, two linked papers (Keene *et al.*, 2003; Rodriguez *et al.*, 2006) used case record linkage to compare patterns of service access amongst various sub-populations within one English county. Individuals aged 55+ were excluded from the analysis in these papers. Results showed that 8.2% of offenders (defined as individuals charged with at least one offence) contacted community health services, 31.7% contacted A&E, 5.4% contacted Social Services, 5.3% contacted drugs services, and 3.8% contacted alcohol services within the study period. Overall, this group contacted a mean of 0.66 agencies (Rodriguez *et al.*, 2006: 415). This compared with a higher mean of 0.81 agencies amongst the 'mental health' group – those "registered (in contact) with the Community Mental Health Trust during the three-year period" (2006: 413). Individuals who were *both* offenders and had a mental health problem (n=1752 – 11.6% of the offenders) contacted a mean of 1.48 agencies — 17.6% contacted community health services, 53.9% contacted A&E, 25.8% contacted social services, 12.7% contacted a drugs service, and 14% contacted an alcohol service. The amount of service use was even higher for those who were frequent offenders (charged with an offence on three or more occasions during the study period) with mental health disorders, who contacted a mean of 1.87 agencies.

Stage one of this study aims to add to this picture through a detailed examination of offenders' access to a wide range of health services using a modified version of the CSSRI-EU screening tool (see below for further details).

Methods

Ethics
The initial project proposal was discussed with members of Lincolnshire Probation Trust's Senior Management Team, and presented to the Leadership Forum for Case Management staff.

Following this discussion the project protocol was finalised and ethical approval was sought and granted for all stages of the study from the Clinical and Academic Workforce Innovation (CCAWI) Ethics Committee at the University of Lincoln, and from the Nottingham Research Ethics Committee (see letter of approval Appendix A). In addition to this, the project lead signed an information sharing agreement with the probation service, and all research staff underwent enhanced Criminal Records Bureau checks.

Sample Selection

We anticipated a prevalence of mental health problems of 50% in the Lincolnshire probation population. In order to estimate this with a precision of +/- 6% (95% Confidence Interval) and assuming that the population size is 1,500, then 228 individuals are required to be recruited. We planned to recruit a stratified random sample of 1 in 7 offenders under probation supervision in Lincolnshire. The stratification variables are level of dangerousness (tiers 1-4) and geographic location (seven probation offices in Lincolnshire).

Initially a random sample of 228 individuals was selected from a list of all active cases on Lincolnshire Probation Trust's caseload as of 10th March 2009, excluding those held on pre-release — constituting a one in seven random sample of offenders under supervision across this area. However, the rate of attrition of this sample was very high, so another random selection of a further 188 cases was made from this same initial sample list in August 2009. Following this, a completely new overall caseload list was acquired in November 2009 and a new sample of 333 cases was selected from this, which constituted a one in five random sample of offenders under supervision in Lincolnshire at this time. Finally, in February 2010 an additional list of 294 cases was selected. Overall a total of 957 probation clients were selected from which 173 were interviewed — a random sample of 1 in 5.5.that was stratified for probation office and tier of risk.

Inclusion/Exclusion Criteria

Pre-release cases were excluded from the sample as the research aims to focus on offenders being supervised in the community rather than those awaiting release from custody.

In cases where there was doubt about the capacity of an individual to provide informed consent due to a learning disability or dementia individuals would be automatically excluded from the study (n=0). Individuals unable to give informed consent due to recent substance misuse were approached on two further occasions in case they had the capacity to consent at a later stage (n=1).

Individuals were given a literacy screened information sheet and consent form and asked to consent to participating in Stage 1 of the project, and to allowing a researcher to study their probation case file for Stage 2 of the research. Just one individual stated that they were willing to participate in Stage 1 of the study but not Stage 2 and was thus excluded from participation in the study.

Finally, anyone without an understanding of English sufficient to give informed consent and participate in the study was excluded from the sample. This amounted to 24 people overall.

Sample Structure

Risk assessments are conducted on all new probation cases, and following this they are allocated to one of four tiers. There is then an expectation that the amount of resources that the probation service allocates to a case will increase with the tier as shown below:

*Table 1: Probation tiers**

Tier 4	Very high and high risk of harm cases. These should have a primary focus on public protection with enhanced supervision. These cases require the highest level of skill and resources. High local and national priority cases, usually prolific offenders.
Tier 3	Medium to high risk of harm cases. The emphasis is on the need for rehabilitation and personal change for offenders.
Tier 2	Medium to low risk of harm cases which focus more on re-integration into the community and on practical help.
Tier 1	Low risk of harm cases. A low likelihood of re-offending and low risk of serious harm. Focused on punishment, with the majority of cases being single requirement.

* Adapted from NOMS Offender Management A Brief Guide For Probation Staff, National Probation Service/NOMS

Consequently, we have stratified our sample by tier as theoretically there may be a link between the likelihood of having a mental health disorder and risk. Therefore, our sample needed to be representative of the proportion of cases allocated to each tier in the wider Lincolnshire caseload. In addition, our sample was stratified by which probation office an individual reports

into as the geographical area in which they lived would affect access to services.

Overall response rates are shown in Figure 1 overleaf.

Figure 1: Overall Stage 1 recruitment

Overall Lincolnshire Caseload

3288[1] cases

↓

Initial Sample Selection

1022 cases

↓

65 duplicates with list 1 removed

957 cases

↓ (left branch) ↓ (right branch)

Number of Exclusions

784 (82%)

Number of Interviews

173 (18%)

↓

Number Excluded by Reason

Refusal	164
Order Ended[2]	396
In Prison	64
Not Asked	18
Warrant Out	17
Did Not Attend[3]	8
In Breach	18
Suspended	2
Not Compliant	10
In Court	3
Interpreter	24
Transfer Out	35
Not Suitable[4]	20
Withdrawals[5]	5

Number Interviewed by Office

		Positive to *Current* Disorder	
		N	% by Office
Boston	35	8	23
Gains	19	3	16
Grantham	17	4	24
Louth	4	1	25
Lincoln	57	21	37
Skegness	29	10	34
Spalding	12	4	33
TOTAL	**173**	**51**	

↓

47 PriSnQuest positive cases screen positive to a current disorder and continue onto **stage two** (examination of files)

1. Two sample selections were made from one overall caseload list – in April 2009 and August 2009; and two sample selections were made from another overall caseload list – in November 2009 and February 2010. We had interviewed our total target sample at Louth by the second stage, so the November and February selections did not contain any potential participants from Louth.

2. Term Expired + Order Revoked combined

3. Appointment with researcher arranged, but participant failed to attend

4. Probation staff excluded due to current illness/heavy substance misuse/lack of contact with the probation service preventing participation

5. One case withdrawn as only willing to participate in Stage 1, not Stage 2. Four cases withdrawn due to incomplete paperwork.

Interview process

The research team presented the project proposal to all case management teams across the county, and gave them copies of the information sheets and consent forms used in the study. Following this, each case management team received a list of individuals on their caseload who were selected as potential participants in the study. Case management staff were then asked to introduce the project to potential participants at their next appointment with probation (if appropriate) and notify the research team of whether they would like to participate in the research. Staff were also asked to provide a reason for non-participation.

As far as possible, appointments with the research team were co-ordinated to coincide with an individual's next appointment at probation in order to reduce the impact on probation resources such as interview rooms.

The majority (n=144) of interviews were conducted at probation premises, but in some cases interviews were conducted at an offender's home (n=8), or by telephone (n=21). In the case of home interviews, the researchers attended in pairs, and followed guidance from probation lone-working procedures. Telephone interview data has only been included where signed consent forms were received by the research team in the post. Researchers asked for the individual's date of birth to check their identity when initiating the interview, and checked that the participant was fully aware of the purpose of the research, the risks and benefits of participation and the fact that they were free to withdraw from the study at any stage.

Participants received a £10 Tesco voucher for each hour or part-hour of their time.

As many offenders under probation supervision have low levels of literacy (McMahon *et al.*, 2004), participants were given a literacy screened information sheet and consent form, and invited to ask questions if there was anything they didn't understand about the project. If a potential participant was unable to read the information sheet alone, researchers read the information sheet to them to ensure that they were giving informed consent. The forms made it clear that individuals were free to decline to participate in any or all of the research, and that any information that they provided would remain confidential except in cases where someone revealed plans to commit a further offence, or the researcher had concerns about their mental health. In these cases, the participant would be encouraged to see their GP as appropriate and relevant information would be shared with probation staff.

Interviewees then completed a series of structured interview tools with the researcher as outlined in Figure 2 below.

Figure 2: Interview structure
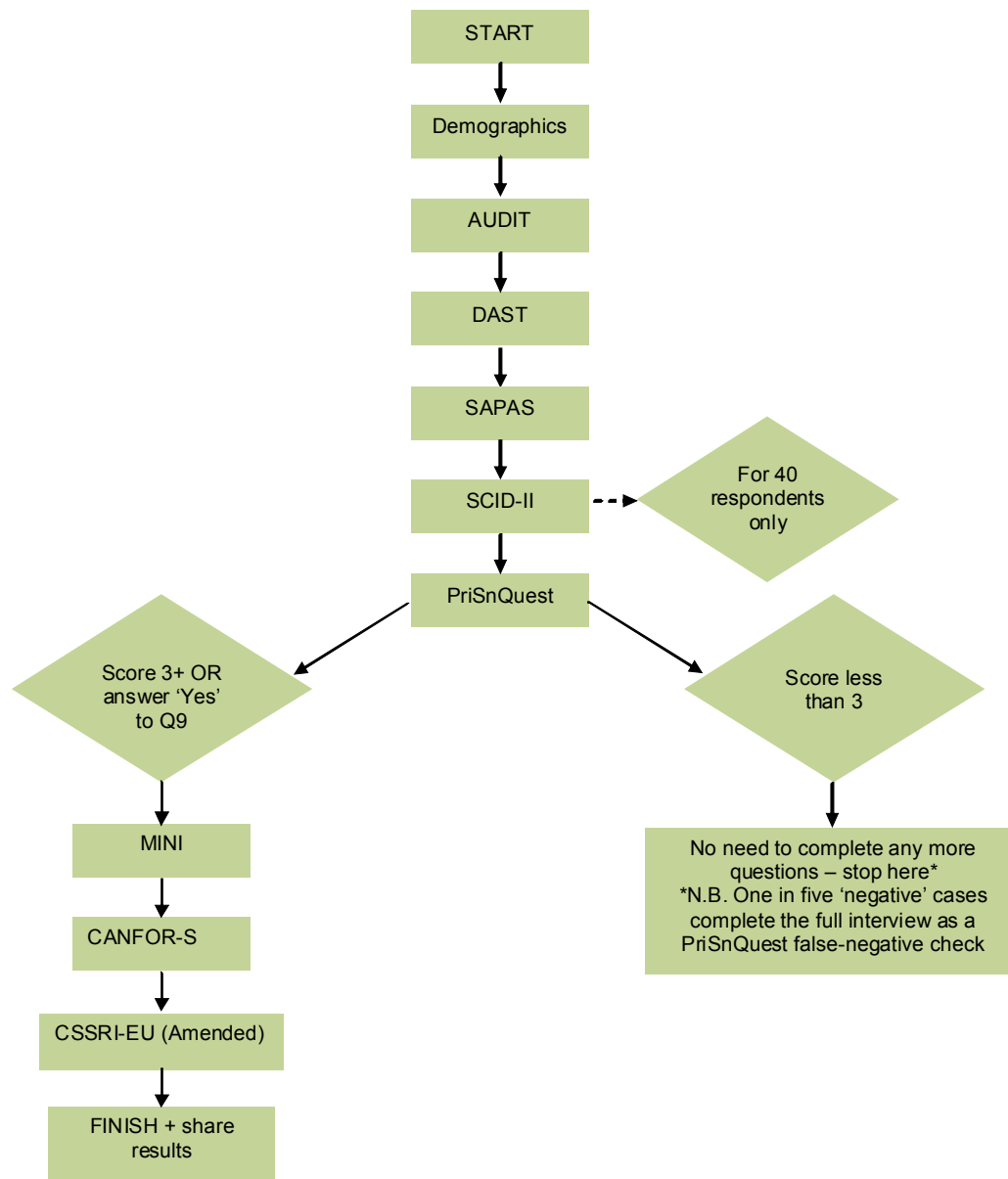
Following this, interviewees who screened positive to a *current* mental health disorder on the MINI entered Stage 2 of the study.

Initially, participants were asked a series of **demographic** questions. These were included to enable the researchers to describe the characteristics of their sample, and to compare factors such as rates and types of disorder between sub-groups, e.g. to examine possible differences between male and female participants (list in Appendix B).

Following this, two measures of substance misuse were included in the Stage 1 interviews to provide information on the extent of dual diagnosis in the sample. The **Alcohol Use Disorders Identification Test (AUDIT)** (Babor *et al.*, 1992) contains ten items which are scored from 0-4 giving a total score ranging from 0-40. A score of 8+ indicates that it is very likely that the participant is drinking harmful levels of alcohol. This tool is cited as a 'gold standard' measure of levels of alcohol consumption (Newbury-Birch, 2009), and was selected for use in this study for a number of additional reasons. Firstly, this tool has previously been used in prison and court environments (McMurran, 2005; Farrell *et al.*, 2002), and is currently used by the National Probation Service to investigate levels of alcohol consumption. Secondly, this tool is quick to use. Thirdly, unlike some similar tools, it allows a researcher to screen for less severe but still potentially hazardous levels of drinking rather than simply screening for dependence (Saunders *et al.*, 1993). Fourthly, it corresponds with ICD-10 definitions of dependent drinking. Finally, several studies have tested the specificity, sensitivity and predictive validity of AUDIT and found it to be "a valuable tool in screening for hazardous and harmful alcohol consumption so that intervention can be provided to those at particular risk of adverse consequences" (Conigrave *et al.*, 1995: 1; Reinert and Allen, 2002). AUDIT scores are shown to correlate strongly with other instruments such as MAST (Bohn *et al.*, 1995: 1). Furthermore, Bohn *et al.* (1995) report that it is superior to other tools in discriminating between hazardous and non-hazardous drinkers.

The **Drug Abuse Screening Test** short version **(DAST)** (Skinner, 1982) is a twenty item screen for drug abuse (including both use of illegal drugs and misuse of prescription drugs). A score of six or more indicates a substance misuse problem (abuse or dependence). Again, this tool was selected for inclusion in the study as it is quick and easy to administer and has been shown to be reliable and to have good levels of sensitivity and specificity when used with criminal justice populations. Skinner (1982) showed that the scale has high internal consistency reliability, and Maly (1993) showed that DAST has a sensitivity of 96% and a specificity of 79-81% (McPherson and Hersch, 2000).

The **Standardised Assessment of Personality – Abbreviated Scale (SAPAS)** is a brief eight-

item screening for likely caseness of personality disorder, which was validated by Moran *et al.* (2003). This tool was selected for use in the study for a number of reasons. Firstly, it is brief to administer and does not require specialist training to use, meaning that it may be suitable for use by probation staff as part of their everyday practice. Secondly, Moran *et al.* (2003) state that this tool performs well in settings where you would expect the prevalence of personality disorder to be high, suggesting that it is likely to be appropriate for use in probation settings. A sub-study of this project was designed to compare results of screening using SAPAS with a sub-sample of 40 cases who completed the 'gold-standard' for personality disorder screening (the SCID-II) and is reported here as 'Stage 4'.

PriSnQuest is an eight-item questionnaire which was designed specifically for use as a brief screening instrument in prisons to determine whether someone is likely to have a serious mental illness. Individuals who score 3+ are said to have symptoms of mental illness requiring investigation by a suitably qualified professional. Two additional questions were added to this tool – "*Have you ever seen anyone formally in any kind of mental health service?*" and "*Have you ever previously been diagnosed with a mental health disorder?*" In order to be over-inclusive, participants who scored 3+ on the PriSnQuest or answered 'yes' to the first of the two additional questions were asked to continue onto the later stages of the questionnaire. Those who did not meet these criteria were not asked any additional questions.

The **Mini International Neuropsychiatric Interview (MINI)** is a short diagnostic interview which screens for a combination of current and lifetime DSM-IV and ICD-10 mental health disorders. This tool was selected for inclusion in the study as it has a relatively short administration time (meaning that it is suitable for use with individuals with short attention spans and/or appointments with multiple agencies, and making it more likely that it could be used by probation staff as part of their everyday activities). In addition, it has been used in a number of studies in criminal justice settings (see for example Marzano *et al.*, 2010; Black *et al.*, 2004; Lurigio *et al.*, 2003).

CANFOR-S – The CANFOR was developed by PriSM at the Institute of Psychiatry to assess the needs of individuals with severe mental illness (Phelan *et al.*, 1995). The short version of this tool was included in the study and investigates a range of twenty-five areas in which people may have difficulties, whether people are receiving help in these areas, and whether they are satisfied with any help that they are receiving or perceive the area to still be a problem for them. The focus of this tool is on the month prior to the interview. This tool was included in the study as a means of investigating self-reported 'needs'. In addition, it was used to investigate the extent to which participants were receiving what they perceived to be 'adequate support' in areas in which they identified that they had a need.

Finally, an amended version of the **Client Socio-demographic and Service Receipt Inventory – European Version (CSSRI-EU)** (Beecham and Knapp, 1992) was used to investigate patterns of service access. This tool was amended to avoid repetition of questions covered elsewhere in the interview; we focused in particular on the 'service receipt' and 'medication profile' sections of this tool.

Data Storage

The study was adopted by the UK Mental Health Research Network and consequently information from all sections of the Stage 1 interview except the MINI was entered anonymously into the Open Source Clinical Data Management System (OpenCDMS). Monthly accrual figures were submitted to the Mental Health Research Network. The data were later exported into SPSS version 14. MINI data were collected on paper questionnaires and then entered into SPSS. Consent forms, and hard-copies of paperwork from the remainder of the interview were all stored in locked metal filing cabinets in line with University data storage procedures. In addition, computer files were password protected.

Recruitment Challenges

This was a pilot study, and as may be expected the research team encountered a number of challenges in recruiting participants to the study. As stated above, having gained permission from the appropriate gatekeepers to conduct the study in Lincolnshire Probation Trust, the research team initially presented details of the proposed study to all offender management teams across the county, outlining the aims and stages of the research and what would be required of probation staff. Each team then received a list of offenders who had been selected as potential participants in the study. Staff were asked to introduce the study to potential participants at their next probation appointment and contact the research team to notify them of whether each individual would like to participate or not. Initially, as shown in Figure 3 overleaf, this worked well. However, the number of appointments booked soon began to fall below desired monthly accrual targets.

Figure 3: Monthly recruitment trends
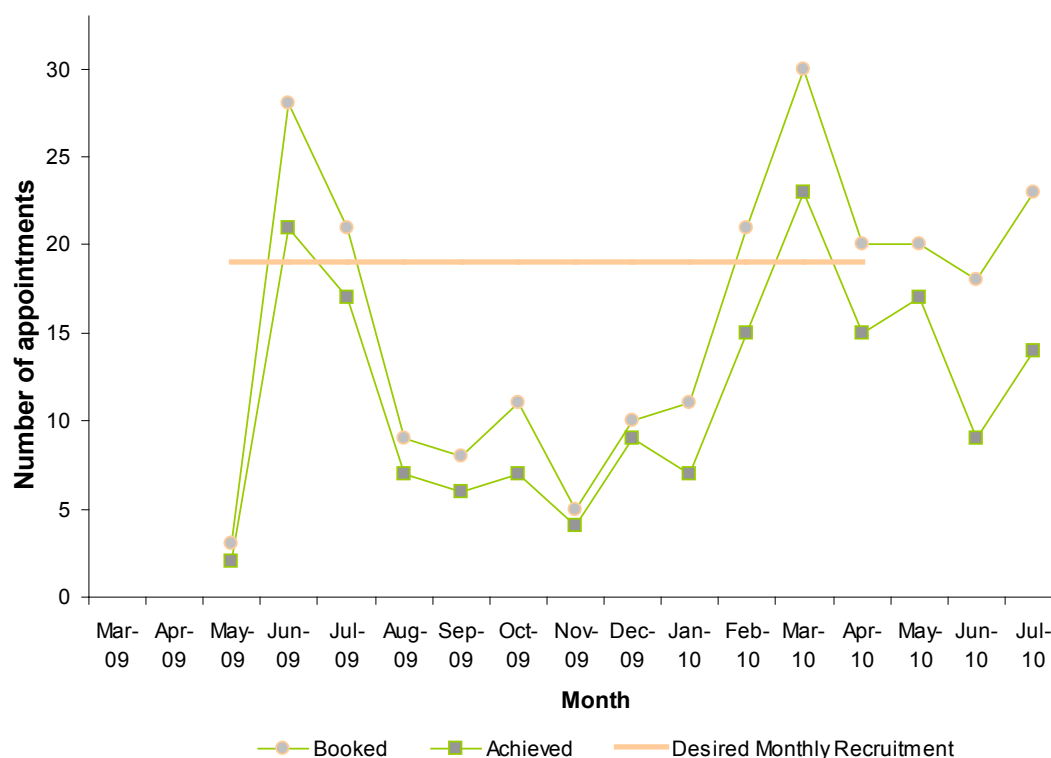
Consequently, the research team needed to investigate why this was the case. A number of issues were encountered which might explain the difficulties in recruiting to the study:

- Lincolnshire Probation Trust began to go through a restructure which led to a number of changes in team structures. This also made it difficult for the research team to keep track of who was leading each team and to book into team meetings to present an update on project progress and discuss any problems and how these could be resolved. Likewise the team were unable to secure a slot at the offender management leadership forum to update probation managers on project progress in early 2010.
- Staff often stated that they had forgotten to ask offenders if they would like to participate in the study as they were very busy and/or did not see it as a priority. This resulted in a number of orders being terminated before offenders were asked if they would like to participate. To attempt to resolve this issue, the research team worked with probation administrators to periodically update information on when offenders were due into probation. This allowed them to remind staff that a particular individual had been selected as a potential study participant shortly before their appointment.

In addition, it allowed research staff to make themselves available in the reception of probation offices on days where several offenders on the recruitment list were due to attend.

- Some staff reported that they felt that offenders were too ill to participate in the study, or had too many other issues to deal with at a given time, and so delayed asking them until a later date.
- Conversely, some staff appeared to think that the research team only needed to see individuals who were mentally ill, and so did not approach cases on the list that they considered to be well.

Clearly some factors were circumstantial and 'out of the hands' of the study team. There were, nonetheless, steps that could be taken to improve recruitment if the study were to be repeated elsewhere. For example, it would be beneficial to book into team meetings on a quarterly basis, and to book into a leadership forum meeting about half-way through the data collection period. Securing slots at these meetings in advance would allow the research team to provide regular project updates face-to-face, and to discuss any barriers to recruitment in person.

In addition, researchers should identify at each office admin staff who can give them regular updates on offenders' appointment times from the start of the data-collection period to allow them to remind staff about potential participants in a timely manner.

Analysis Procedures

Data were entered into SPSS version 14 and summarised using descriptive statistics. Percentages were rounded up to one decimal place. Further weighted analysis required that the data be transferred to STATA version 10. This allowed the analysis to take account of the false negative (i.e. hidden) cases by using weights for the cases detected among the original PriSnQuest screened negatives (Dunn *et al.*, 1999). The revised estimates and associated confidence intervals are estimated using the STATA logit procedure with probability weights. In order to assess the association between potential risk factors and current disorder, weighted logistic regression was used. In the first place, each variable was assessed separately; any association with a significance level of less than 10% was then entered into a further multivariate analysis restricted by Domain (i.e. Demographic, Crime Related and Clinical). Finally, using the same criteria ($p<0.10$) from the previous analysis, the remaining variables were entered into a final model.

Findings

Sample Characteristics

Table 2 below shows that comparison of the individuals within the study sample to those on the overall caseload for Lincolnshire Probation Trust reveals very little difference between the two groups in terms of gender and ethnicity. 87% of both groups are male, 13% female, and approximately 2% of both samples are black and ethnic minority, whilst the remainder are white.

In terms of tier of risk, those in tier one are slightly under-represented in the study sample, and those in tier three are slightly over-represented.

Further examination of the sample characteristics shows that the study participants had a mean age of 36 years, and a median age of 33 years.

In 2009 the overall employment rate in Lincolnshire was 73.1%, and 11% of the working age population in Lincolnshire had no qualifications (LRO, 2011). However, 60.7% of the study sample were unemployed, with just 26.6% classing themselves as in paid employment or self employed, and 32.9% had no qualifications – demonstrating that offenders have a higher level of deprivation than the that of the general population.

Table 2: Overall caseload vs. sample characteristics

Variable		Overall Caseload		Study Sample	
		N	%	N	%
Gender	Male	2876	87.3	150	86.7
	Female	420	12.7	23	13.3
Ethnicity	Asian	16	0.5	1	0.6
	Black	34	1.0	2	1.2
	Mixed	21	0.6	0	0
	White	3206	97.3	170	98.3
	Other	5	0.2	0	0
	Not stated	14	0.4	0	0
Tier of Risk	One	607	18.4	16	9.3
	Two	1126	34.2	62	35.8
	Three	1383	42.0	87	50.3
	Four	170	5.2	8	4.6
	Unknown	10	0.3	0	0

The Prevalence of Mental Health Disorder

Table 3 overleaf shows the prevalence of current mental illness amongst offenders under supervision in Lincolnshire. Overall, just over a quarter (27.2%) of offenders interviewed in the study had a current mental illness. As shown in Figure 2 above, one in five participants who screened negative on the PriSnQuest completed the full interview as a false-negative check. Weighted prevalence figures were calculated for all major diagnostic categories to account for any false-negatives on the PriSnQuest screen. Thus, taking into account the weighting formula, the proportion of offenders under supervision in Lincolnshire with a current mental illness is 38.7 percent.

The most prevalent type of current mental disorder is personality disorder which SAPAS scores indicate affects 47.4% of the sample. The least common were anorexia nervosa (affecting no interviewees) and current panic disorder which was experienced by 1.16% of participants. 14.5% of the sample had experienced a major depressive episode, and 2.3% had experienced either a current manic or hypomanic episode.

Overall, 21.4% of the sample had a current anxiety disorder (with a weighted prevalence figure of 27.2%). 9.8% of the sample had current agoraphobia. 6.4% had current social anxiety disorder (social phobia) and 3.5% had current generalised anxiety disorder. Current post-traumatic stress disorder affected 4.6% of the sample.

The overall prevalence of current psychotic disorders was 8.1% (with a weighted prevalence of 11%). 2.89% had a current psychotic disorder with a mood disorder, and 5.2% had a current psychotic disorder without a mood disorder.

Overall, just 2.3% of the sample had a current eating disorder (with a weighted prevalence of 5.2%), and all of these were cases of bulimia nervosa.

Table 3: Current mental illness

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

* With the exception of personality disorder, N's are shown for the 88 participants who completed the full interview. For the major diagnostic categories, weighted prevalence figures are shown in brackets to account for false-negatives on PriSnQuest. The prevalence of personality disorder was based on SAPAS scores, which were available for all 173 participants.

Table 4 below shows the prevalence of past/lifetime mental illness amongst offenders under supervision in Lincolnshire. Overall, 39.9% of participants had a past/lifetime disorder (this increases to almost half of the sample – 48.6% when using the weighted prevalence figures). The most common category of disorders was mood disorders, which affected 38.2% of the sample (increasing to 43.9% when using the weighted estimates). Over a third (35.8%) of the sample had experienced a major depressive episode in the past, and 21.39% had recurrent depression. 11.0% had experienced either a manic or hypomanic episode in the past, and 15.6% had a lifetime psychotic disorder. 9.8% of the sample had a lifetime diagnosis of panic disorder.

Table 4: Past/lifetime mental illness

Disorder	N	%	CI (95%) (%)
Mood Disorders			
Major depressive episode past	62	35.8	28.7-43.0
Recurrent depressive episode	37	21.4	15.3-27.5
Mania (manic episode past/hypomanic episode past)	19	11.00	6.3-15.6
Any mood disorder	66	38.2	30.9-45.4
	(76)	(43.9)	(32.4-56.1)
Anxiety Disorders			
Panic disorder lifetime	17	9.8	5.4-14.3
Psychotic Disorders			
With mood disorder lifetime	16	9.3	4.9-13.6
Without mood disorder lifetime	11	6.7	2.7-10.0
Any psychotic disorder	27	15.6	10.2-21.0
	(32)	(18.5)	(11.7-28.0)
Any past/lifetime mental illness	69	39.9	32.6-47.2
	(84)	(48.6)	(36.2-61.1)

* N's are shown for the 88 participants who completed the full interview. For the major diagnostic categories, weighted prevalence figures are shown in brackets to account for false-negatives on PriSnQuest

Differences in the prevalence of current and past/lifetime disorders were looked at in terms of various socio-demographic factors. Although largely this showed that there were no significant differences between groups. Full tables for subgroups are shown in Appendix B.

The analysis was extended to examine the association between current disorder and potential risk factors. Table 5 overleaf summarises the results for each variable of interest. The results are summarised into three domains: demography, crime and clinical associated factors. Due to the limitations imposed by the size of the dataset, each variable was reduced to a binary form (with the exception of age (years) and suicidality which has three levels: low, medium and high risk). Column 2 provides the odds Ratio associated with each variable. These are generally consistent with anticipated differences. For example, male sex, education, in receipt of benefit, previous imprisonment, violence against the person, alcohol problems, drug problems, suicidality, and personality disorder are all associated with increased risk; whereas increasing age, being married, owner occupier, paid employment, urban living, are associated with reduced risk. However, only age, employment, benefit claim, suicidality and personality disorder reached statistical significance. The multivariate analysis within each domain revealed that claiming benefit, when considered at the same time as paid employment, ceased to be an influence. In the final model, only age retained a statistically significant association in the presence of the other variables. The lack of more striking associations is likely to be due to the small sample size.

Table 5: Results of covariate analyses using weighted logistic regression. Main outcome, any current disorder

Variable (Domain)	Univariate Odds ratio (95%CI)*	Domain Specific Multivariate Odds ratio (95%CI)**	Full Multivariate Odds Ratio (95%CI)***
Demographic			
Male Sex	2.01 (0.47, 8.61)		
Age (years)	0.94 (0.91, 0.98)	0.95 (0.91, 0.99)	0.95 (0.91, 0.99)
Married	0.34 (0.09, 1.34)		
Education (GCSE+)	1.40 (0.47, 4.14)		
Owner Occupier	0.37 (0.10, 1.37)		
Employment	0.20 (0.06, 0.62)	0.26 (0.06, 1.04)	0.32 (0.09, 1.20)
Claim Benefit	3.54 (1.09, 11.55)	0.93 (0.21, 4.10)	
Urban	0.85 (0.29, 2.46)		
Crime Related			
Previous Prison	1.09 (0.38, 3.18)		
Violence to Person	1.61 (0.57, 4.56)		
Clinical			
Alcohol Problem	2.05 (0.74, 5.74)		
Drug Problem	2.77 (0.66, 11.67)		
Suicidality (3 levels)	3.22 (1.60, 6.53)	2.60 (1.20, 5.66)	2.24 (0.91, 5.48)
Personality Disorder	3.88 (1.17, 12.84)	3.09 (0.91, 10.51)	2.59 (0.73, 9.16)

*Entered singularly. **Selected if P<0.10 within Domain. ***Selected if p<0.10 from Domain Analysis.

The Prevalence of Substance Misuse

Overall, 55.5% of the sample scored 8+ on the AUDIT screening tool, indicating a strong likelihood of hazardous/harmful alcohol consumption. The mean score on this instrument was 11.6. The cut-off score for referral into alcohol services used by Lincolnshire Partnership NHS foundation Trust is 10 (LPFT, 2006) – 44.5% of the sample met this criteria.

12.1% of the sample scored 11+ on the DAST screening tool — indicating either a 'substantial' or 'severe' level of drug abuse. The mean score on this instrument was 3.13.

The Extent of Co-Morbidity and Dual Diagnosis

Table 6 overleaf shows that, overall, 72.3% of the sample who screened positive on the PriSnQuest had both a substance misuse problem (defined as scoring 8+ on AUDIT or 11+ on DAST) and a current mental illness — thus dual diagnosis is a major feature of this population. Just 17.1% of those without a current mental illness had a substance misuse problem. It is important to note that co-morbidity with likely alcohol misuse is much higher than co-morbidity for likely drug misuse for those identified with a mental illness (66% versus 21%). If the group with any substance misuse are considered (n=104) then such misuse and the presence of a mental illness are strongly correlated (from 71% for anxiety-based disorders to 80% for depression).

Table 6: Prevalence of current major disorders with substance misuse

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

* This table is only based on those (n=88) who were PriSnQuest positive

Table 7 below shows the extent of co-morbidity between personality disorder and the major diagnostic groups for current disorders for those who were PriSnQuest positive. This shows that, overall, 89.4% of those with a current mental illness also had a personality disorder, as compared to 36.6% of those who did not have a current mental illness.

Table 7: Prevalence of current major disorders and likely personality disorder

Disorder	Likely Personality Disorder (SAPAS Score of 3+)	%	CI (95%) (%)
Any current mood disorder (n=26)	23	88.5	76.2-100.0
Any current anxiety disorder (n=37)	34	91.9	83.1-100.0
Any current psychotic disorder (n=14)	11	78.6	57.1-100.0
Any current eating disorder (n=4)	4	100.0	100.0-100.0
Any current mental illness (n=47)	42	89.4	80.6-98.2
No current mental illness (n=41)	15	36.6	21.8-51.3

* This table is only based on those (n=88) who were PriSnQuest positive

Thus in summary, this section of the study shows that there are high rates of mental illness amongst offenders under supervision in Lincolnshire, and that dual diagnosis and co-morbidity are a common feature of this population. This will be unpicked further in the discussion at the end of this section.

Self-Reported Health Needs and the Extent to Which They Are Being Met By Current Service Provision

Table 8 below compares the CANFOR-S scores for individuals *with* and *without* a current mental illness. It shows that, overall, the mean score for those with a current mental illness was 10.53, compared to just 4.59 for those without a current mental illness. The CANFOR-S total score was positively skewed (more than 50% of the sample scored zero). For this reason the sub-group analysis was carried out using a non-parametric analysis (Mann-Whitney 'U' test). This showed that there was a statistically significant difference between groups on their 'total need' scores. Mean scores for 'met' and 'unmet' needs are also higher amongst those with a current mental illness than amongst those without a current mental illness and these differences also reached statistical significance on the Mann-Whitney 'U' test at the 0.05 level.

Table 8: Differences in CANFOR-S Scores comparing major mental health disorders with no disorder

Disorder	Type of Need	Mean CANFOR Score	Standard Deviation	Inter-Quartile Range	Mann-Whitney U Test*
Any current disorder	Met need	2.83	2.37	1.13-3.88	z= -2.161 p=0.031
	Unmet need	7.70	6.13	2.45-11.70	z= -4.155 p=<0.001
	Total need	10.53	6.31	5.50-15.10	z= -4.517 p=<0.001
No current mental illness	Met need	1.83	1.83	0.50-2.74	N/A
	Unmet need	2.68	3.42	0.39-4.78	N/A
	Total need	4.59	3.72	1.50-7.38	N/A

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

Mean scores were also compared for those *with* and *without* a current mental illness on each individual item on the CANFOR-S (e.g. 'accommodation need' or 'self-care need'). There were no statistically significant differences between groups on 14 of the 25 items. However, as one would expect, there were significant differences on the 'psychotic symptoms', 'psychological distress', 'treatment' and 'information about condition and treatment' items. Here, those with a current mental illness had a mean score of 0.57 for 'psychotic symptoms' compared to a score of 0.08 for those without a current mental illness (z= -3.671, p=<0.001). When looking at 'psychological distress', those with a current mental illness had a mean score of 1.28 and those without a current mental illness had a mean score of 0.70 (z= -3.410, p=0.001). The mean score for 'treatment' ('do you agree with the treatment, medical and/or psychological, prescribed?') for those with a current mental illness was 0.63, whilst the mean score for those without a current mental illness was 0.20 (z= -2.604, p=0.009). 'Information about condition and treatment' showed a mean score of 0.43 for those with a current mental illness, and of 0.05 for those without a current mental illness (z= -2.898, p=0.004).

Statistically significant differences were also apparent on the 'alcohol' and 'drugs' items. Those with a current mental illness had a mean score of 0.59 on the alcohol item, whilst those without had a mean score of 0.23 (z= -2.025, p=0.043). Those with a current mental illness had a mean score of 0.46 on the drugs item, whilst those without a current mental illness had a mean score of 0.18 (z= -2.324, p=0.020). This may be a reflection of the extent of dual diagnosis in the probation population.

The 'physical health' and 'safety to self' items also showed statistically significant results. The mean score on the physical health item for those with a current mental illness was 0.63, whilst that for those without a current mental illness is 0.25 (z= -2.562, p=0.010). On 'safety to self' the mean score for those with a current mental illness was 0.52, whilst for those without it was 0.10 (z= -3.049, p=0.002).

Finally, the 'daytime activities', 'company' and 'money' items also showed statistically significant results. The mean scores on 'daytime activities' for those with and without a current mental illness were 0.59 and 0.23 respectively (z= -2.304, p=0.021). For company, the mean score for those with a current mental illness was 0.67; for those without, it was 0.30 (z= 2.049, p=0.040). For the 'money' item, the mean score for those with a current mental illness was 0.74; for those without, it was 0.28 (z= -2.692, p=0.007).

Access to Services

As well as investigating offenders' self-reported needs, stage one also explored offenders' patterns of access to services. A total of 44 cases screened positive for *both* current and past/ lifetime disorders and thus may be expected to have had some contact with mental health services during the timescales investigated on the amended version of the CSSRI-EU. However, the CSSRI-EU was not completed on one of these cases, thus the data presented below are based on 43 cases. Throughout this section, it should be noted that it is possible for a participant to access more than one type of service.

Generally, data indicate low levels of mental health service access. For example, just 2% of this group stated that they had accessed an inpatient hospital service[1]. Figures were higher for access to primary care/community care services,[2] which were accessed by 40% of cases. 14% of cases had accessed an outpatient hospital service[3], and 12% had accessed a community-based day service[4].

Table 9: Overall service access

	Inpatient Mental Health Hospital Service (Previous 12 months)		Outpatient Mental Health Hospital Service (Previous 3 months)		Community-Based Mental Health Day Service (Previous 3 months)		Primary/ Community Care Mental Health Service (Previous 3 months)	
	N	%	N	%	N	%	N	%
Accessed	1	2	6	14	5	12	17	40
Not Accessed	42	98	37	86	38	88	26	60

* Table is based on the cases screening positive for both current and past/lifetime disorders. Percentages are rounded to the nearest whole number

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1 Defined as having been an inpatient in either an acute psychiatric ward/psychiatric rehabilitation ward/long-stay ward within the 12 months prior to interview
2 Defined as accessing either a Psychiatrist/Psychologist/CPN/Case Manager/Social Worker/OT for mental health reasons within the 3 months prior to interview
3 Defined as either a psychiatric outpatient visit/other hospital visit (including A&E)/day hospital visit for mental health reasons during the 3 months prior to interview
4 Defined as accessing either a community mental health centre/day care centre/group therapy/ sheltered workshop/other community-based day service for mental health reasons during the 3 months prior to interview

In addition, 15 (35%) of the participants included in this stage of the analysis (i.e. those screening positive for both a current and past/lifetime disorder) attended substance misuse services; 28 did not.

Analysing these data by diagnostic categories (see Table 10 below) shows that of 25 participants with a current mood disorder, none had accessed an inpatient mental health hospital service, three had accessed a mental health hospital service as an outpatient, four had accessed a community-based mental health day service, and eight had accessed a primary/community care mental health service[5]. A total of 15 (60%) of participants with a current mood disorder were not accessing any kind of mental health service (as defined above).

Of the 34 participants with a current anxiety disorder, one had been an inpatient in a mental health hospital, four had accessed a mental health hospital as an outpatient, three had accessed a community-based mental health day service, and twelve had accessed a primary/community care mental health service. 20 (59%) of individuals with a current anxiety disorder had not accessed any kind of mental health service during the timeframes examined in Stage 1.

Of the 14 participants with a current psychotic disorder, none had been mental health hospital inpatients, two had accessed a mental health hospital as an outpatient, three had accessed a community-based mental health day service, and five had accessed a primary/community care mental health service. Seven (50%) of cases with a current psychotic disorder did not report that they had accessed a mental health service.

Just four participants had an eating disorder, one of whom accessed both a community-based mental health day service, and a primary/community care mental health service. Three (75%) of these cases did not report accessing any mental health service at this stage of the study.

Of the 38 cases who screened positive as 'likely' cases of personality disorder, one had been an inpatient in a mental health hospital, four had accessed a mental health hospital as an outpatient, five had accessed a community-based mental health day service, and 14 had accessed a primary/community care mental health service. A total of 21 (55%) of these cases did not report accessing any mental health services in Stage 1.

Finally, when looking at those with any kind of current mental illness and using the definitions above, 22 participants (51%) did not report accessing any mental health services at Stage 1.

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5 Defined as accessing either a primary/community care mental health service during the 3 months prior to interview

Table 10: Service access by diagnostic categories

Disorder	Inpatient Mental Health Hospital Service (Previous 12 months)		Outpatient Mental Health Hospital Service (Previous 3 months)		Community-Based Mental Health Day Service (Previous 3 months)		Primary/ Community Care Mental Health Service (Previous 3 months)	
	Yes N (%)	No N (%)	Yes N (%)	No N (%)	Yes N (%)	No N (%)	Yes N (%)	No N (%)
Any current mood disorder (n=25)	0 (0%)	25 (100%)	3 (12%)	22 (88%)	4 (16%)	21 (84%)	8 (32%)	17 (68%)
Any current anxiety disorder (n=34)	1 (3%)	33 (97%)	4 (12%)	30 (88%)	3 (9%)	31 (91%)	12 (35%)	22 (65%)
Any current psychotic disorder (n=14)	0 (0%)	14 (100%)	2 (14%)	12 (86%)	3 (21%)	11 (79%)	5 (36%)	9 (64%)
Any current eating disorder (n=4)	0 (0%)	4 (100%)	0 (0%)	4 (100%)	1 (25%)	3 (75%)	1 (25%)	3 (75%)
Any likely personality disorder (n=38)	1 (3%)	37 (97%)	4 (11%)	34 (89%)	5 (13%)	33 (87%)	14 (37%)	24 (63%)

*Table is based on the cases (n=44) who screened positive for both current and past/lifetime disorders at Stage 1. The percentages have been rounded to the nearest whole number.

Of those with both a current and past/lifetime disorder who scored 8+ on AUDIT (i.e. were likely to be drinking harmful/hazardous levels of alcohol), 12 (40%) stated that they were accessing a substance misuse service.

Of those with both a current and pas/lifetime disorder who scored 11+ on DAST (i.e. reported a substantial/severe level of drug abuse), seven (88%) reported that they were accessing a substance misuse service.

The above findings on access to services will be triangulated with information from probation case files in Stage 2 of the study.

Stage 2

Aims

Stage 2 of the research aims to compare the findings of Stage 1 of the project to information contained in probation case files in order to investigate:

- the extent to which probation staff were aware of and recording the mental health and substance misuse issues identified in Stage 1 of the research;
- and the action being taken and recorded on addressing these issues (i.e. which if any health services are offenders in touch with)?

Background

Very few studies within the existing literature appear to have investigated the extent of mental illness and substance misuse in a probation population by using data in probation case files. However, as detailed earlier, Moore (2007) reported findings from analysis of 101,240 Self Assessment Questionnaire (SAQ) assessments in both probation and prison settings, and the answers to some of the questions on this tool may be used as proxy measures of mental health/ substance misuse problems. For example, this study reports the proportions of offenders stating that 'taking drugs', 'drinking too much alcohol' or 'feeling depressed' is a problem for them.

However, not all offenders under probation supervision complete this assessment. Indeed, as Fitzgibbon and Green (2006) report, not all offenders under supervision are subject to any form of OASys assessment. Moreover, their small-scale study suggested that when OASys is completed on individuals who are known to have, or appear likely to have mental health problems, it is often only a tick-box exercise. This may be due to workload pressures, and Fitzgibbon and Green (2006) suggest that the completion of assessments is likely to be poorer when cases are frequently assigned to different members of staff. Data quality is improved when offenders are consistently managed by one individual. In comparing the information contained in OASys assessments for ten offenders with wider "naturally occurring documentary evidence, in the form of case records, reports and completed forms contained in the case files" (Fitzgibbon and Green, 2006: 38) they concluded that many assessments

> "failed to incorporate or expand on significant issues contained within the case file. For example, issues such as previous suicide attempts, psychiatric treatment, and domestic violence were often highly significant to risk levels but not mentioned or only procedurally included" (ibid, 2006: 39).

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Thus, using OASys alone is unlikely to provide a representative or complete picture of the extent to which probation staff are aware of and recording offenders mental health and substance misuse needs and any interventions being offered to meet these needs. Consequently, this study examines a broad range of information contained in probation case files as outlined below.

Methods

Sample Selection
A purposive sample of participants who screened positive for a *current* mental health disorder in Stage 1 of the research study were selected for inclusion in this stage of the research as these constitute the cases where we might expect probation staff to be identifying mental health issues and monitoring/facilitating contact with services.

Data Collection Process
As stated in the introduction to this report, this is a pilot study, and given that so little research has been conducted using probation case files to examine the health of offenders under probation supervision, a data collection tool had to be designed from scratch for this stage of the study. This aimed to log quantitative data from probation case files to show which mental health disorders were recorded in the file (information which will be compared with Stage 1 findings), and qualitative data to set the recording of disorders in context and to highlight any barriers to service access. The draft tool was piloted with a total of four probation case files and refined in consultation with members of the project steering group.

Following the pilot, project researchers concluded that any of the following information could be disregarded during data collection for this stage of the study:

- Information dated after the Stage 1 interview occurred
- Previous convictions data (pre-cons)
- Police reports
- Witness statements

In addition, it became evident that the answers to some specific questions on 'standard forms' contained within the case files were relevant to the research. Consequently, fields were added to the data collection sheet as appropriate.

Four other issues became apparent during the pilot phase. Firstly, as one might expect, disorders were unlikely to be recorded in probation case files using exactly the same terminology as that

employed by the screening tools used in Stage 1 of the study. Thus it was decided that 'catch all' categories would be added to the data collection tool to include things like a 'broad mention of depression' rather than specifically a 'major depressive episode', and 'personality disorder' of an unspecified type. Secondly, the size and volume of information contained in probation case files varied enormously, and recording qualitative data relevant to the study verbatim was likely to be extremely time-consuming. Consequently, the decision was taken to record qualitative data on every fifth file examined, and to give an indication of the 'richness' of data contained in each file, indicating how representative this subgroup of files were of the larger sample. Thirdly, OASys data were not present on all files. As some sections of OASys relate directly to the health of offenders, in cases where relevant OASys data were not contained in the paper files, probation staff were asked to provide researchers with the 'drugs', 'alcohol' and 'health and other considerations' section of the assessment. Finally, some of the selected files had been 'stripped' for archiving prior to commencement of Stage 2 of the study. A new field was added to the data collection form to record when this was the case as clearly those that had been stripped would no longer contain the full volume of information which may have been recorded previously about an offender's health.

The final data collection tool can be seen in Appendix C.

One researcher (CS) entered both qualitative and quantitative information anonymously into the data collection sheet in Microsoft Word. As there was potential to collect person-identifiable qualitative data here, the researcher replaced key words as appropriate to disguise participants' identities e.g. [Name] or [Place]. Data were then transferred into SPSS version 14.

As far as possible, files were examined in batches (organised by team leaders) to minimise the impact of the research on probation resources.

Data Storage
Computer files were password protected and hard copies of data collection sheets were stored in a locked metal filing cabinet in accordance with University data storage policy.

Recruitment Challenges
As participants had already consented to their files being examined if required in this stage of the research, the only recruitment challenges encountered were in ensuring that files were 'ready' for the researcher when she arrived at a probation office. This was addressed through close liaison with Team Leaders and Senior Administrators across the county.

Analysis Procedures

Quantitative data were entered into SPSS version 14 and analysed using descriptive statistics to show the proportion of cases in which disorders identified in Stage 1 of the research were recorded in probation case files. Due to the differences in timescales apparent between the Stage 1 and Stage 2 data sources, analysis was conducted on the 44 cases who screened positive in Stage 1 for both a current and past/lifetime disorder.

In order to begin examining barriers to service access in more detail, qualitative data were manually analysed thematically drawing on Tesch's (1990) and Coffey and Atkinson's approach to descriptive/interpretational qualitative analysis. Data from each case file were recorded verbatim in Microsoft Word. These files were then printed and initially, all data relating specifically to access to services were highlighted ensuring that sufficient context was retained for each excerpt to retain meaning when read out of context. Tesch (1990) refers to this as 'decontextualisation'. Following this, data were re-read, line by line, and divided into themes representing types of barriers to service access represented in the data. The data from each of these themes were then saved together and re-read (recontextualistion) to ensure consistency in coding.

Findings

Recording of Mental Illness

Initial examination of the quantitative data on which disorders were recorded in probation case files for the whole subgroup (n=44) of offenders screening positive for both a current and a past/lifetime disorder suggests that the most common category of disorders identified and recorded by probation staff is current mood disorders (see Figure 4 below). Here, 64% of cases identified formally by the researchers in Stage 1 of the project were also recorded in the probation files.

However, 23 of the above case files had been 'stripped' for archiving prior to data collection for this stage of the study and were thus incomplete. Consequently, much of the data that would previously have been held in them was not accessible to the researcher, which means that in some cases we may be underestimating the amount that probation had recorded about an individual's mental health. Thus, Figure 4 below also separately displays data for files that had not been archived. This indicates that when examining the 'complete' files, the proportion of cases in which a mood disorder identified by a researcher in Stage 1 had been recorded increased from 64% to 73%.

Overall, current anxiety disorders formally identified by a researcher in Stage 1 of the research were recorded in case files in 37% of cases. However, examination of just the 'complete' case files shows that 47% of current anxiety disorder cases identified in Stage 1 were recorded (an increase of 10%).

Overall, probation case files recorded 36% of the psychotic disorders which were identified in Stage 1. Interestingly the proportion of psychotic disorders identified in Stage 1 and recorded in the files decreased from 36% to 33% when examining the non-stripped files.

None of the current cases of bulimia nervosa were recorded in the probation case files.

Finally, just 10% of the likely personality disorder cases identified using SAPAS in Stage 1 were recorded in the probation case files overall. When examining the 'complete' files, the proportion of likely personality disorder cases identified in Stage 1 and recorded in the case files increased from just 10% up to 21%. However, this still means that individuals who are likely cases of personality disorder do not have this recorded in nearly four fifths of cases.

It should be noted that in addition there were also cases where probation files made reference to disorders which were not identified by a researcher in Stage 1 of the study. This is likely to be the result of the 'catch all' categories which were used in this stage of the study to account for differences in terminology between the screening tools used in Stage 1; and the file data examined here and was particularly common in the case of mood disorders. Thus, a probation file may contain a broad reference such as 'feels depressed' which does not actually relate to a formal diagnosis of depression.

Figure 4: Percentage of disorders recorded by both a researcher and probation
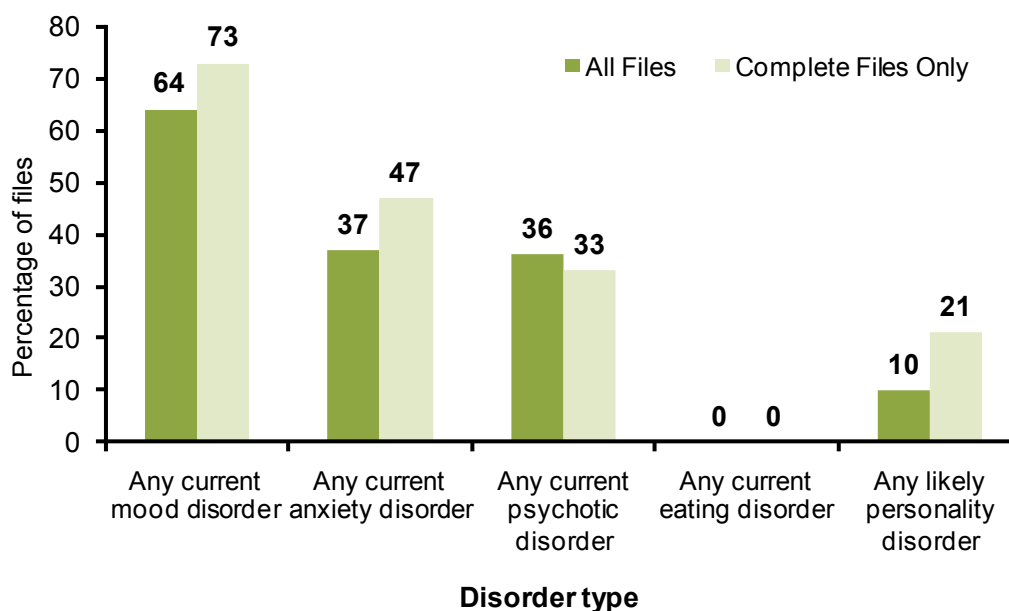
One could create numerous hypotheses regarding why the recording of mental illness appears to be so low (for some disorders in particular) in probation case files. For example, this could be as a result of the method of data collection – the researcher examined offenders' paper case files, but perhaps information on their mental health is recorded elsewhere electronically, or only recorded by the Health Support Service working within this Probation Trust (whose records the researcher did not have access to). It may also be to do with either a) probation staff's ability to recognise the signs and symptoms of mental health issues or b) offenders' willingness to disclose mental health diagnoses – issues which will be further examined in Stage 3 of the study. In addition, it may be to do with the extent to which probation staff feel that it is their responsibility (as opposed to that of another agency) to monitor offenders' mental health and/or how staff make the decision whether or not to record information about offenders' health.

Recording of Substance Misuse Problems for Those with a Current Mental Illness

The extent to which substance misuse issues were recorded in probation case files for participants screening positive for both current and past/lifetime mental health disorders was also investigated in this stage of the research; i.e. we recorded the extent to which dual diagnosis was recorded in probation case files.

Only eight cases in this subgroup scored eleven or more on the Drug Abuse Screening Test in Stage 1, and drug misuse was recorded in the case files for seven out of eight (88%) of these cases in Stage 2 (see Figure 5 below). There were also an additional 19 case files for individuals who scored less than 11 on DAST in which drug misuse was recorded in their probation case file. Closer examination of these cases shows that five of them had scored 1-5 on the DAST, suggesting a low level of drug abuse; and six had scored 6-10, suggesting a moderate level of drug abuse. The remaining eight participants had a score of zero on the DAST, indicating that no drug misuse was reported. This may either be a result of a difference in timescales (i.e. the participant was not misusing any drugs at the time that they completed the DAST with the researcher, but the case file contains information dating back to a point in time when they were), or a result of participants being less than truthful on this topic during the Stage 1 interview.

In terms of alcohol misuse, a total of 30 offenders scored eight or more on the AUDIT screening tool, indicating a potentially harmful/hazardous level of drinking. This had been recorded in the probation case files for 23 (77%) of these cases. Alcohol misuse had also been recorded in an additional five files for individuals who scored less than eight on the AUDIT during Stage 1 of the study. These cases had a mean AUDIT score of 4.8, and again this difference may be the result of differences in timescales or of participants underreporting their levels of alcohol consumption in Stage 1.

Figure 5: Percentage of Substance Misuse Recorded by both a Researcher and Probation
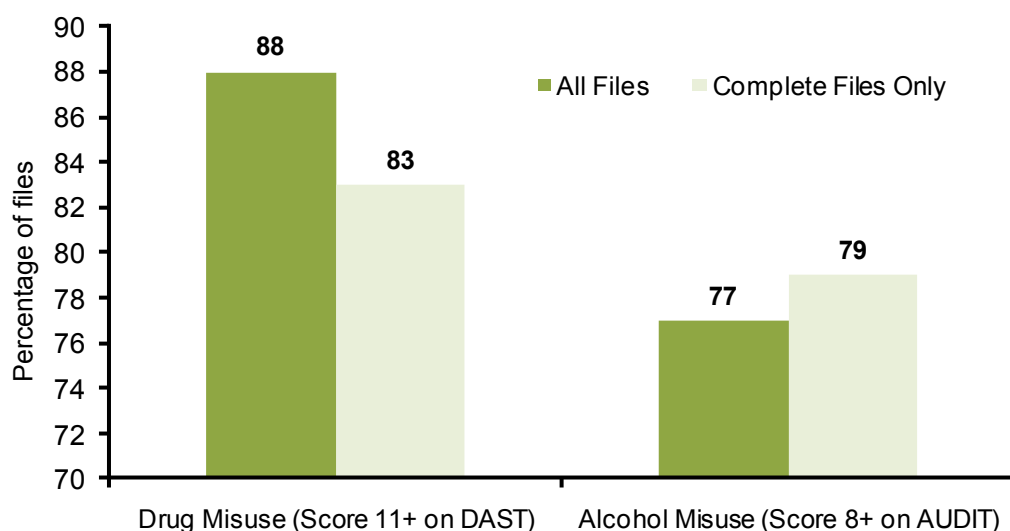
Examination of the files which had not been stripped for archiving (i.e. complete files only) shows that only six participants in this subgroup scored eleven or more on the DAST, and drug misuse was recorded in five (83%) of their files. An additional nine files on participants scoring less than eleven on the DAST also contained references to drug misuse. Four of these individuals had a score of zero on the DAST, indicating that no drug misuse was reported during the Stage 1 interview. The other five individuals had a mean score of 6.2 on the DAST.

Fourteen participants in this subgroup scored eight or more on the AUDIT, and alcohol misuse was recorded in the probation case files for 11 (79%) of these. Alcohol misuse was also noted in an additional two files for participants who scored less than eight on the AUDIT screening tool. These participants had scores of '5' and '6' on the AUDIT.

These findings indicate that for substance misuse, whether or not a file had been 'stripped' for archiving made little difference to the overall rate of recording. It appears that probation staff are more likely to record substance misuse issues than mental health issues in an offender's case file. Again, numerous hypotheses could be proposed to explain this, which may constitute topics for further research.

Access to Services

There were 43 cases that screened positive for both a current and past/lifetime disorder in Stage 1, and for whom information on access to services was collected in both Stage 1 and Stage 2 of the study.

As shown in Table 11 below, analysis of these cases shows that there were 14 cases where access to a service was recorded in Stage 1 (face-to-face interviews with a researcher) but not in Stage 2 (on the probation case file). In effect: in a third of cases an offender told a researcher that they were accessing a service in Stage 1, and this was not recorded in their probation case file. This may reflect 'gaps' in the fullness of the information contained in probation case files, or may suggest that participants overstated their contact with services in Stage 1 of the research. However, in all but three of these cases, the file did contain data on access to other types of services than those identified in Stage 1, suggesting that access to services is being monitored closely by probation.

Overall, access to the same substance misuse/mental health service was recorded in both Stages 1 and 2 in 27 (63%) of cases.

In addition, a total of 30 (70%) of probation case files examined here contained information on access to services, which was not recorded by a researcher in Stage 1. This is most likely to reflect differences in the timeframes used for data collection in the two stages of the project. In Stage 1, the CSSRI-EU tool focuses on the use of inpatient hospital services during the 12 months prior to interview, and the use of outpatient hospital services, community-based day services and primary/community care services during the three months prior to interview. Probation case files contain information dating back for as long as the individual has been in contact with the probation service, and thus may cover a much longer period of time. This difference may also be a reflection of inaccurate recall on the part of participants, or an unwillingness to share information about service access with a researcher.

In Stage 1, a total of 22 participants with a current mental illness did not report accessing any mental health services. In contrast, when this data is combined with that in the probation case files, this figure reduces to just six cases where offenders did not appear to be accessing any mental health services. These are highlighted in pale green in Table 11 below. Again, this suggests that, a) offenders have been in contact with services in the past, but not within the 12- or 3-month timeframes examined in Stage 1 of the research; b) they were more willing to share information on service access with probation than with a researcher; or, c) their recall was inaccurate during Stage 1 interviews.

In addition, there were four case files where it was unclear whether a participant was accessing a service (e.g. their GP) for physical or mental health reasons, and thus they may not have been in receipt of mental health services. These are highlighted in dark green (see Legend) in Table 11 below.

Table 11: Comparison of service access between Stages 1 and 2 for those with both current and past/lifetime disorders

Legend

No contact with mental health services
Unclear that there has been contact with a mental health service

Case Number	Diagnoses (Current and/or past/lifetime disorder	Only recorded by the researcher	Recorded by both probation and the researcher	Only recorded by probation
207.2	• Current, past and recurrent depression • Current hypomanic episode • Lifetime panic disorder • Social phobia • PTSD • Mood disorder with psychotic features	None	Drugs Service	None
1049.2	• Current agoraphobia without history of panic disorder • Current social phobia • Current and lifetime psychotic disorder	None	None	None
718.0	• Current, past and recurrent depression • Current agoraphobia without history of panic disorder	None	None	GP
726.0	• Past and recurrent depression • Lifetime panic disorder • Current and lifetime psychotic disorder	None	Psychiatrist GP Psychiatric outpatient visit	Psychiatric inpatient Probation HSS
306.0	• Current, past and recurrent depression • Current and lifetime psychotic disorder	CPN/Case Manager	Psychiatrist Drugs service	GP Crisis Team
278.0	• Current, past and recurrent depression	None	None	None
326.0	• Past depression • Current agoraphobia without history of panic disorder	None	GP	Probation HSS

Case Number	Diagnoses (Current and/or past/lifetime disorder	Only recorded by the researcher	Recorded by both probation and the researcher	Only recorded by probation
768.0	• Past depression • Past hypomanic symptoms • Current agoraphobia without history of panic disorder	None	Acute psychiatric ward Psychiatrist GP Drugs service	Psychologist Crisis team A&E Prison in-reach and ACCT Social Services Outpatient clinic
1071.2	• Past and recurrent depression • Lifetime panic disorder • Lifetime mood disorder with psychotic features • Current GAD	CPN/ case manager	GP	None
1528.2	• Past and recurrent depression • Current agoraphobia without history of panic disorder • lifetime mood disorder with psychotic features	None	Psychiatrist GP	Hospital CPN
326.2	• Current, past and recurrent depression • Lifetime panic disorder • Current OCD • Current mood disorder with psychotic features	Emergency or crisis centre GP Alcohol service	None	None
391.2	• Current and past depression • Current social phobia • Lifetime psychotic disorder	None	Psychiatric outpatient visit CPN/ case manager Alcohol service	Probation HSS
573.0	• Current depression • Current and past hypomanic episode • Current agoraphobia without history of panic disorder • Lifetime mood disorder with psychotic features	Emergency or crisis centre	None	None
575.0	• Current, past and recurrent depression • Current GAD	None	Alcohol service GP	CMHT

Case Number	Diagnoses (Current and/or past/lifetime disorder	Only recorded by the researcher	Recorded by both probation and the researcher	Only recorded by probation
810.0	• Current, past and recurrent depression • PTSD	CPN/ case manager	None	Bereavement counselling Drugs service Probation HSS
1068.2	• Past and recurrent depression • Past hypomanic symptoms • Lifetime panic disorder • Current and lifetime psychotic disorder	None	Drugs service	Probation HSS GP CARATS
321.0	• Current agoraphobia without history of panic disorder • Current and lifetime psychotic disorder	Psychiatrist	Psychiatric outpatient visit GP CPN/ case manager	Drugs service
513.2	• Current and past depression • Past hypomanic symptoms • Lifetime panic disorder • Panic disorder with agoraphobia • PTSD • Current bulimia nervosa	None	GP Drugs service Alcohol service	None
1009.0	• Past and recurrent depression • Past manic episode • Current agoraphobia without • history of panic disorder • OCD • Lifetime mood disorder with • psychotic features	None	Drugs service GP Psychiatrist Psychiatric outpatient visit	None
766.2	• Current and past depresssion • Current manic episode • Current social phobia • Current and lifetime mood disorder with psychiatric features	None	Alcohol service GP	Hospital Counselling
615.2	• Past and recurrent depression • Past manic episode • Current hypomanic episode	Outpatient 'other' Community based services 'other'	Psychiatrist GP	Substance misuse service Social worker Hospital

Case Number	Diagnoses (Current and/or past/lifetime disorder	Only recorded by the researcher	Recorded by both probation and the researcher	Only recorded by probation
778.2	• Current, past and recurrent depression • Past hypomanic symptoms	None	Psychiatrist Social worker	Community forensic team GP
1642.2	• Current, past and recurrent • depression • Past manic episode • Past hypomanic symptoms	None	None	Substance misuse service
717.2	• Past depression • Lifetime panic disorder • Current panic disorder with • agoraphobia • Current social phobia	GP	None	Psychiatrist
892.2	• Past and recurrent depression • Current agoraphobia without history of panic disorder	None	None	None
1032.0	• Past and recurrent depression • Current agoraphobia without history of panic disorder	GP	Psychiatrist	Crisis team
1167.0	• Past depression • Current social phobia • Lifetime mood disorder with psychotic features	None	None	Probation HSS GP Counsellor
1592.2	• Past and recurrent depression • Lifetime panic disorder • Current agoraphobia without history of panic disorder • Current GAD	Social worker	CPN/ case manager	Psychiatrist Crisis Team CMHT
659.2	• Current and past depression • Current agoraphobia without history of panic disorder • Current GAD	Sheltered workshop GP	None	Drug service CMHT CPN Psychiatrist
1011.0	• Current, past and recurrent depression • Current agoraphobia without history of panic disorder	None	None	Drug service CPN GP Psychiatrist Probation HSS

Case Number	Diagnoses (Current and/or past/lifetime disorder	Only recorded by the researcher	Recorded by both probation and the researcher	Only recorded by probation
1144.0	• Current and past depression • Lifetime panic disorder • Current panic disorder with agora-phobia • Current social phobia • Current GAD	None	Alcohol service	Substance misuse service GP Counselling
1329.0	• Current and past depression • PTSD • Lifetime mood disorder with psy-chotic features	None	None	Inpatient mental health hospital service CMHT Substance misuse service Probation HSS
764.2	• Past depression • Past manic episode • Current and lifetime psychotic disorder	None	Community mental health centre GP Drug Service	Crisis team Special-ist mental health center
1428.0	• Past depression • Current agoraphobia without his-tory of panic disorder • Current and lifetime psychotic disorder	None	GP	None
946.0	• Current and past depression • Past manic episode • Current OCD • Current and lifetime mood disorder with psychotic features	GP	None	None
1136.0	• Current and past depression • Past manic episode • Lifetime panic disorder • Current panic disorder with agora-phobia • Current social phobia • Current and lifetime mood disorder with psychotic features	None	Community mental health centre GP CPN/ case manager	Counsellor Probation HSS Social Worker Psychiatrist

Case Number	Diagnoses (Current and/or past/lifetime disorder	Only recorded by the researcher	Recorded by both probation and the researcher	Only recorded by probation
1148	• Current, past and recurrent depression • Past manic episode • Lifetime panic disorder • Current panic disorder without history of agoraphobia • PTSD • Current and lifetime psychotic disorder	Primary care 'other'	Drugs service	None
1382.0	• Current, past and recurrent depression • Past manic episode • PTSD • Current and lifetime mood disorder with psychotic features	None	Drugs service	CPN CARATS
1278.2	• Past and recurrent depression • Lifetime panic disorder • Current social phobia • Current bulimia nervosa	None	None	Alcohol service Counselling GP Crisis team
622.2	• Current and past depression • Past manic episode • Lifetime panic disorder • Current social phobia • Current and lifetime mood disorder with psychotic features • Current bulimia nervosa	Group therapy Sheltered workshop	Psychiatrist GP CPN/ case manager	Community outreach service Drugs service Crisis team
1179.0	• Current, past and recurrent depression • Lifetime panic disorder • Current agoraphobia without history of panic disorder • PTSD • Current and lifetime psychotic disorder • Current bulimia nervosa	None	None	Substance misuse service
1506.0	• Current, past and recurrent depression • Past manic episode	None	Social worker Drugs service	None

Case Number	Diagnoses (Current and/or past/lifetime disorder	Only recorded by the researcher	Recorded by both probation and the researcher	Only recorded by probation
973.2	• Past depression • Current agoraphobia without history of panic disorder	None	Psychologist	Social worker GP Substance misuse service

 * NB Information from case files was not included if it only stated that a participant had been *referred* to a service rather than accessed it.

Qualitative Data on Barriers to Service Access

As stated in the introduction to this section, one of the aims of Stage 2 of the research was to investigate the action being taken and recorded in probation case files to address offenders' mental health/substance misuse problems; i.e. to record qualitative data around what services offenders are accessing. To this end, qualitative data was collected from every fifth file of those screening positive for a current mental illness. This data was manually coded into themes to highlight potential barriers to service access for offenders.

Several potential barriers to service access could be identified in the probation case file data. Firstly, in the case of substance misuse, there could be a problem with the degree of **motivation** that the offender has to address this issue and the extent to which they perceive it to be a problem; as exemplified by the quotes below:

"Is reluctant to seek support from [substance misuse agency] or his GP"

"He tells me he does not consider himself to have a problematic use of alcohol however this is contradicted as he also acknowledged that alcohol may have disinhibited his behaviour. He tells me he drinks approximately 3 or 4 pints of lager 3 or 4 times a week and does not consider this to be excessive"

"It appears that this man has an acute fear of being without drugs that as he says 'give him a crutch, buzz, escapism and ease the pain'. In addition he is so entrenched in the social side of drug misuse and, whilst he has some appreciation of the risks associated with being within the drugs scene, there is also a protective aspect to his lifestyle"

"Although he realises that combining Amphetamines and alcohol could have a detrimental effect on his

*mental and physical health, he continues to drink alcohol when taking Amphetamines and is ambivalent
about coming off Amphetamines"*

In some cases, this resulted in requirements which had been put in place by the courts to address a substance misuse issue being unworkable:

*"Assessed as suitable for a DRR but low motivation and indeed he was unable to keep up DRR
appointments and was unmotivated to engage and reduce his intake. Therefore, DRR was deemed
unworkable and removed by the court"*

Secondly, in some cases, access to services was problematic as the participant had both a substance misuse and a mental health problem and services will not accept **dual diagnosis** cases as shown below:

*"Has been assessed by the crisis team who refuse to get too involved until [name] starts to address his
drug use seriously"*

Thus it is often necessary for the individual to address their substance misuse problem before they can access mental health services, as shown below:

*"Has been signed off by his GP for the last few months with psychotic symptoms which his GP is now
happy to refer him to psychiatrist as [name] is now free of drugs and alcohol"*

Similarly, in one case, the offender needed to address their substance misuse issue before related physical health issues could be addressed:

*"He has a number of long term drug related health problems including Hepatitis A, B and C. He is not
able to make use of medical treatment to assist this condition until he is drug free"*

In some cases, the offenders simply did not meet the **referral criteria** for a particular intervention:

*"Possible drug related psychosis. However, not assessed as meeting criteria for mental health
treatment"*

*"I can also confirm that [name] attended [substance misuse agency] for an assessment for suitability for
a Drug Rehabilitation Requirement… However, he did not met the criteria as he was due to re-engage
with [substance misuse agency] and it was felt this was a more suitable approach"*

Many of these themes are further explored in Stage 3.

Stage 3

Aims

The third stage of the study consists of a series of semi-structured interviews with probation staff and offenders under probation supervision. This aims to investigate the experiences of probation staff working to facilitate access to mental health services for offenders on their caseload, and the experiences of offenders under supervision when trying to access mental health services.

Ultimately this section of the study aims to demonstrate good practice in providing services for offenders, and to highlight any barriers to service access that are encountered in order to make recommendations on how service provision for this group could be improved. Findings will be shared with our multi-agency steering group to enable work to commence on overcoming both any 'perceived' and 'real' barriers to service access.

This stage of the project also aimed to increase service user capacity through involving service users in both the planning and conduct of this stage of the research.

Background

To the best of the authors' knowledge, very few studies have examined the views of either probation staff or offenders on health service provision for users of criminal justice services.

Semi-structured qualitative interviews can be used to provide "richly descriptive reports of individuals' perceptions, attitudes, beliefs, views, and feelings, the meanings and interpretation given to events and things" (Hakim, 1987: 22). They were selected for this stage of the study for several reasons. Firstly, to allow the wording and order of questions to be changed to suit participants' responses and to enable participants to raise issues that are important to them rather than the agenda of the interview being entirely pre-determined by the interviewer (Robson, 2002). Secondly, unlike structured interviews, semi-structured interviews allow the interviewer to examine issues in more depth, making them suitable for exploratory research where little is known about a topic. Thirdly, unlike surveys, semi-structured interviews do not discriminate against individuals with basic skills difficulties and thus were considered appropriate for use with offenders.

Methods

Sample Selection and Structure

Interviews were conducted with a purposive sample of nine offenders and eleven probation staff. Purposive sampling was employed in this stage of the research to allow the selection of participants with knowledge/experience that is relevant to the research questions detailed above.

Thus the offender sample was composed of individuals who screened positive for a current mental health disorder in Stage 1, and had indicated to a researcher that they either had experience of accessing services, or had recently made an attempt to gain access to services. The staff sample was composed of probation staff with offender management responsibilities and was structured to ensure representation from each probation office across the county as theoretically there may be cultural differences between offices and/or the range of health services available may vary between areas.

Interview Process

Offenders were approached at the end of the Stage 1 interview, or afterwards (via probation staff) and given a literacy screened information sheet and consent form which introduced Stage 3 of the research. The information sheet clearly outlined the purpose of the research, gave assurances regarding anonymity and confidentiality, and stated that participants were free to withdraw from the research at any stage with no penalty.

Staff were also sent an information sheet and consent form to ask if they would like to participate in this stage of the research.

Interviews were conducted in two intensive blocks — one in September 2010 and one in October 2010 — and were organised by probation office at relatively quiet times for probation appointments to minimise the impact on probation resources. All of the interviews were conducted in probation offices with appropriate safety procedures in place. The time in between the first and second blocks of interviews was utilised to begin transcription and to reflect on the first interviews with a view to changing the approach/investigating particular issues in more detail as appropriate.

The Service User Representatives received training in qualitative interviewing. Following this, a

draft semi-structured interview guide was drawn up by a combination of a Research Assistant (CS) and the Service User Representatives (DM-H and MT) based on the research questions above; and was refined in discussion with steering group members. (This can be seen in Appendix D.)

The interviews were conducted by two pairs of researchers: CS and AC and DM-H and MT. Interviews with offenders focused on their positive experiences of accessing services and also any barriers that they may have encountered which could be removed to improve access to services for this group. Interviews with staff focused on whether they feel competent to elicit the symptoms of mental health disorder, their awareness of local services, their confidence in making referrals, and barriers that they (or offenders on their caseload) have encountered in facilitating access to (or accessing) services.

Interviews were taped and transcribed verbatim. Both staff and offenders participating in this stage of the study received a £10 voucher for their time.

Data Storage

Interviews were transcribed verbatim into Microsoft Word and stored in password protected documents which were then imported into a password protected project in NVivo version 8. In addition, one half of the pair acted as a note-taker during each interview in case the audio recording failed or was of poor quality. Notes were stored in locked metal filing cabinets in line with the University data storage policy.

Recruitment Challenges

A total of 47 offenders screened positive on the PriSnQuest tool and also screened positive to a current mental health disorder in Stage 1 of the research. 24 of these individuals had experience of accessing healthcare services and thus met the inclusion criteria for Stage 3. However, when recruitment into Stage 3 commenced, six of these individuals were not able to be contacted as they were no longer in touch with the probation service; six did not confirm whether or not they wished to participate; and one individual declined participation in this stage of the research. Thus, eleven individuals consented to take part, but two of these did not attend their appointment with the research team; meaning that a total of nine offender interviews were completed overall.

The number of offender interviews conducted could perhaps have been increased if research staff had recruited into this stage of the study from the start of commencement of Stage 1. However, offenders are a largely transient population and so it may still be that many would have moved prior to commencement of the Stage 3 interviews and thus may not have been accessible to the researchers. Future research wishing to replicate this research could run the two stages simultaneously.

A total of 20 staff were approached to participate in Stage 3. The first eleven staff to reply that they would like to participate were interviewed, and at this point the researchers felt that they had both covered all of the probation offices and also reached data saturation point so further potential participants were not pursued for a response.

Analysis

Verbatim transcription was considered appropriate for this stage of the study, because whilst it may be extremely time consuming, ultimately it yields a much greater depth, richness and accuracy of information than note-taking or selective transcription (McLellan, Macqueen and Neidig, 2003: 67). This was felt to be particularly important as there is very little in the existing literature relating to this stage of the research. However, any information which may have identified the study participant was disguised within the transcription; for example, individual's names were replaced with [name].

As in Stage 2, the approach to analysis drew on Tesch (1990) and Coffey and Atkinson's approach to descriptive/interpretational qualitative analysis. Transcripts were created in Microsoft Word and each was checked for accuracy by at least two members of the research team. Data were then imported into NVivo version 8 for analysis.

Initially, two particularly 'rich' interviews (one with a member of probation staff, and one with an individual under probation supervision) were selected and all data relating specifically to, a) examples of positive experiences of service access (either personal or in terms of referring offenders into services), b) examples of negative experiences of service access, and c) barriers to service access, were coded under these headings with sufficient text being coded to ensure that the segments of text retained meaning when read out of context. This process of removing segments of text from their original place within the interview transcript whilst retaining sufficient text for them to still retain meaning is referred to by Tesch (1990) as 'decontextualisation'.

These data were then recontextualised and systematically coded into emergent themes using

the constant comparative method (Glaser and Strauss, 1999). Thus each new segment of data which could potentially be added to a category was compared with the existing data within that category in order to develop consistent coding. Clearly defined sub-themes were created within the above areas of investigation (as free nodes representing the concept being talked about in the text), ensuring that attention was paid to any 'negative' cases.

The codes created from these two transcripts were then structured into a conceptual 'coding tree' within NVivo and the coding framework was then applied to the remaining transcripts. The initial coding tree was subsequently re-defined in an iterative process as text was read and re-read both within and across cases. Once coding was partially complete, a series of 'propositional statements' were written to act as definitions of each coding category with which potential 'new' data could be compared prior to being added to a code (Maykut and Morehouse, 1994). Codes were merged together and structured under 'meta-concepts' as appropriate and these form the structure of the findings presented below.

Memos were created throughout the analysis process to provide an 'audit trail' of decision-making.

There were a number of ways in which the presentation of findings from this section of the study could be structured. However, as probation staff and individuals under probation supervision have different perspectives on the topic of access to services for offenders, the decision was taken to present their views separately. Thus, we start by examining the data from interviews with probation staff below.

Findings

A: Staff Interviews

Enablers for Access

Analysis of the transcripts from interviews with probation staff showed that factors which *enabled* access to services for offenders could be classified under three broad themes. Firstly, 'service organisation': namely the range of routes into services for offenders and aspects of the way in which services are organised which facilitate access to services for offenders. Secondly, 'relationships': the idea that the relationship between a member of probation staff and an offender can be key to them gaining access to services, and also that if probation staff know members

of a health service personally then this makes it easier for them to refer into the service. Thirdly, 'awareness': the extent to which both a member of probation staff is aware that an offender has a health issue, and the extent to which an offender recognises their own health issue influences the ease with which individuals are able to access services.

Service Organisation

Examination of the responses from probation staff in relation to factors that enabled access to services for offenders highlighted that staff described three main (somewhat overlapping) **routes into services***.* Firstly, in some cases, probation staff were **directly referring** offenders into a wide range of relevant services as shown by the excerpts below:

Par: we discuss on a one to one basis with them what, to find out what the problems are .h and then would refer them onto whoever, er: whatever other agencies or, or professionals would be suitable to help them in whatever way, for example .h LAT (Lincolnshire Action Trust) for help with training and employment, Healthy Living Nurse for medical problems, .h errm, (3) housing providers for well, we would, we would just basically steer them in the right direction for whatever [help]
Int: [Mm hm]
Par: additional help, they needed

Par: We ask them to go to see Addaction for alcohol or drugs it's our, basically a Probation Service Officer, or a Probation Officer is described as a broker of services really

Par: we have I've finally got him into mental health supported accommodation
Int: Mm
Par: and I've also got him a Mentor as well to help him .hh build his confidence getting out of his flat because he's quite isolated and he's
Int: Yeah
Par: stuck in his flat so .hh I think I've been able to help in terms of getting him the right acc[ommodation]
Int: [Yeah]
Par: getting him a Mentor erm linking with erm his CPA I attend CPA meetings, understand I have a better understanding of his mental health and how that's
Int: Yeah
Par: impacting on his day-to-day life as well as his offending.

Par: there's a lot of other people who, .h I think its obvious that they've got some degree of mental health problems, .h perhaps caused by their drug use, whatever, .h erm, that (2) you can pick up on as you get to know them in one to one supervision .h and obviously then encourage them, if you like to go to see their GP or some professional that would be able to help them
Int: Mm hm

However, depending on the case, in many instances staff believed that it may be more effective to encourage an offender to **self-refer** to a service rather than making the appointment for them:

Par: If they are presenting with problems, if they are disclosing that they have er drug or alcohol
         issues then we will refer them anyway or certainly encourage them to to self-refer because
         it's always better if they self-refer, they're taking responsibility again for, for what they
         are doing and it's more likely that they are going to engage if if they are motivated to go
         themselves. If they have to be referred, it's not quite the same, erm, it's something that they
         have been made to do in a sense, and they feel that they've been told to go there rather
         than they've gone there voluntarily .h to take, to take part, to try and sort out their problems

Often, probation staff described **joint meetings** with other agencies as an effective means of engaging offenders with services and/or overcoming some of the barriers that they might face by combining resources to provide a greater level of support when required:

Par: I just thought of another case .hh that I did have not too recently erm where erm [name] had
         been referred to I'd referred her to NACRO for floating support and again that was more erm
         the the Floating Support Worker then we sort of used to have .hh three you know three way
         meetings so the offender, Floating Support Worker and myself
Int: Yes
Par: and you know if we knew .hh erm she had an appointment coming up for counselling because
         she was sort of very nervous and anxious about about attending .hh you know we'd sort of see
         if one of us could you know just go along and sit with you know literally sort of make you know
         cos that is the big thing really you know they just .hhh don't know (laughs) what they do but they
         just (laughs) don't seem to get
Int: Yeah
Par: get to their appointments! (laughs)

Par: So that you know erm that's the same with a couple of my guys began with the Assertive
         Outreach they I've got a really good rapport with them and they kind of I work quite well with
         them I sound really arrogant but .h work quite well with them and but then they've got a really
         bad opinion of like the Assertive Outreach Team so why don't we get together
Int: Ah huh

Par: and work together and then
Int: Ye[ah]
Par: [that's] surely got to be best for the individual

Par: Housing services? We do liaise with housing services I've had some success with them,
        erm (2) I find that the housing service will respond well, if er, probation and the client's
        Doctor, health services combine and support the client's application for, whatever it is erm
        additional points, or or a certain types of accommodation. .h Erm they respond quite well to
        that. Er, they don't respond particularly well just to a client but they will respond well if the
        services get involved, erm health *and* probation alongside the client, supporting the client
        get good response from the housing I find
Int: So working in partnership[()]
Par: [working] in partnership, er, supporting the client works well with
        housing, yeah, yeah. They will take notice

In many cases though, either access to a particular service could only be gained
via an offender's **GP**, or probation staff thought it sensible to involve the GP:

Int: Yeah and then erm if someone has a mental health problem
Par: .hh you see then now that's not quite as easy because there isn't a referral well the a referral
        process but what *I* would do is do it via way of the GP
Int: Mm
Par: Because the GP really needs to be involved anyway I I would say the GP has to be involved .h

Int: Yeah
Par: If it's a mental health problem so that's the way in
Int: Yeah
Par: I would be encourage them to get an appointment with the GP or:: I would even have done on
        more than one occasion rung the GP to discuss
Int: Yeah
Par: my concerns
Int: Mm hm
Par: Or written to the GP to discuss my concerns

However, in some cases it was necessary to ensure that an offender was registered with a GP
to begin with:

Par: so you know a first step really would be going to see you know making sure they're registered
        with a with a [Doctor]
Int: [OK]
Par: going to their GP [you know]

From there, probation staff often encourage offenders to see their GP as a route into
other services:

Par: obviously if there's a erm there might be something wrong with someone saying I feel depressed, I can't get out of bed, I can't leave the house, then obviously I can refer to our Nurse who can further diagnose or the best way I find is just to just to ma' make them an appointment at the er GP really or or I usually say like I want to see the GP by next appointment, then obviously th' obviously it's their role really and they usually refer on to Beaconsfield for a further assessment if needed

Int: And so, speaking about referring into a mental health service

Par: Yeah

Int: OK rather than a GP

Par: Yeah

Int: how easy is it to make that referral?

Par: Er::m, I mean, I can only, I mean the only experience I've got is referring to speaking to the Crisis Team really. But I haven't had any experience of referring direct to Beaconsfield. I don't think, I think it would be quite difficult to be honest, I think they'd want a medical, a basic medical assessment first

Another key route which probation staff discussed was the **Health Support Service** (previously known as the 'Healthy Living Project'). This service is unique to Lincolnshire Probation Trust and employs both Nurses and Health Champions to work with offenders to address their health issues and to refer them into mainstream health services on a voluntary basis:

Int: Mmm, and does erm making referrals into health services take up much of your time, is it something that you do often?

Par: No I wouldn't say it takes up a lot of time, I mean obviously now we've got [name] the Healthy Living Nurse, that's an ideal person to pass them on to and for her to make then

Int: Mm hm

Par: to decide what, what needs, the next step that needs to be taken and so no that's quite simple and er straight forward so

Int: Mmm

Par: no it doesn't [take a] lot of time

Par: I can remember doing that luckily enough erm a young lad came in and he said he was let me just think what he said he said he was hearing voices and it was telling him to do this this and this .h and the Nurse was here that day

Int: Yeah

Par: so she came in and sat with me

Int: Mm

Par: and we er (1) we got him to go to erm [place] Hospital to present himself there

Int: Right

Par: So that was a that was OK

Int: Yeah

Par: so the Nurse it I was lucky cos I think the Nurse was around that day

Par: Erm, I'll we have a Nurse here working for us, she's an excellent resource of information, she would be my first port of call that I would discuss any issues that I had with regards to mental

health with her .hh and then she often, erm finds out any information that I need

Probation staff valued this service for its ability to act as an intermediary/bridge
into health services:

Par: we also have who I use er a lot on my cases is our Healthy Living Nurse here
Int: OK
Par: and I you know perhaps as a first step get them to go and and see her as as well you know to
        sort of get a second opinion and then [name] you know can some sometimes sort of act as a
        erm an intermediary with the you know with the surgeries and the medical staff because I think
        well my opinion is that they deal better with one of their own [(laughs) so to speak]

Int: Yeah OK and are there any, erm kind of common problems that you would encounter when
        you are trying to get people into health services at all?
Par: (2) Erm, before [Healthy Living Nurse] came, yes, [because]
Int: [Right]
Par: I think where they listen to her because she's in the NH', she's a medical professional,
Int: Mm
Par: whereas we are not, so she would get taken more seriously I think, .h by contacting
        Doctor's surgeries or whatever than we would. .h S::o, um, don't really, don't have any
        problems now
Int: No
Par: because that's such a big help

Par: But I think offenders appreciate her because I think quite a lot of mental health instance Doc'
        GPs and mental health, I think there's quite a big barrier between obviously there's there's big
        words that Doctors use, obviously they obviously wear wear suits, they're quite I guess there's
        a cla' also a class barrier I don't know if you still call it that, but you feel quite intimidated by .hh
        some of the posh accents
Int: Mm
Par: But obviously the key thing, that re' offenders love [Nurse] is she's down to earth she won't she
        won't use big words and I think it's quite rather that sometimes when there's a barrier between
        referring straight to your GP or mental health or er because they're intimidated by obviously the
        barrier between obviously er the Doctor using big words judging me, you can go to the Nurse
        first and say "this is what's going to happen blah, blah, blah". Or vice versa, if the Doctor's
        spouted a lot of words that someone doesn't understand, she can kind of translate and put
        them at ease. So I guess it's a link between probation and services if necessary it can be kind
        of like a stepping-stone I guess

Par: What works well?
Int: Yeah
Par: (8) Well they are mostly in services, as I said to you before, they, they are already in
        services usually, already in contact with the services, erm if they're not, then what works
        well is either, erm their own self-help through their GP or go see the Health Support
        Services Nurse. And if they are not getting any co-operation from their GP we would
        normally send them there and she could speak to the GP on their behalf so there's some
        brokering taking place, within i'i' if you like, within the health service there, with some

brokering taking place on behalf of the offender. And that works well, that's always worked well, erm and that's probably our best resource really is, to have a Practice Nurse speaking to a Doctor because he will listen to what she has to say, brokering on behalf of the offender. Erm, who sometimes find it difficult to explain to Doctors within the few minutes they have, what the problem is. Erm, so that, that works well on *all* health issues not just mental health, on all health issues. That liaison is very important. So that, that's a good thing.

In addition, this service was valued because the nurses have the time to listen to the full range of offenders' health concerns and to present them in letter form to a GP, thus enabling offenders to explain their needs in a short period of time and to access the most appropriate services:

Par: our previous Healthy Living Nurse we'd sort of you know cos a lot of people go to their GP I mean in my personal experience as well you might have a load of problems when you go in there but you're sort of sat down you got your five minutes and
Int: Yeah
Par: you just don't (laughs) can't think of what to say .hhh so again sort of Healthy Living has sort of acted as that you know so perhaps done a letter or something just a bit of background there
Int: Mm
Par: so when that person goes to make the appointment so you know they're not sort of fobbed off and perhaps more likely to to then you know be referred onto the Community Mental Health Team or or you know Counselling or whatever it is that's most appropriate for them
Int: So the er the Healthy Living act may act as an intermediary?
Par: Mm yeah

Par: the ones with mental health problems as well. [Name] can make referrals for them or write to their GP which is also useful, because often when they go to their GP on their own, they're not .h very able to present what their problem is
Int: Right
Par: so if they've had a letter from her to take with them
Int: Mmm
Par: that does help I think

Par: I've rambled [a bit] there
Int: No no, I think you're saying erm, that service can kind of offer offenders a bit more time
Par: Yeah
Int: than the GP
Par: Because, yeah GPs, they don't, and people we are all the same aren't we? We don't go to our Doctor unless we have to do
Int: No
Par: and you need to know you are going to be ill, two weeks in advance [anyway to get your your appointment]
Int: [Yeah (laughs)]
Par: you do feel that there's a waiting room full of people and you know, OK I've got to rush through this and get it over with, [so that] you can see that
Int: [Yeah]
Par: somebody who has got vague problems, like they want a help to stop drinking or, or they're

Par: just loosing the plot, .h going to your GP is not probably the answer is it? Initially
Int: Mm
Par: Obviously you need to go to get it referred but you need that assistance to get to that stage
Int: Yeah, and [name] can kind of act [as that bridge then]?
Par: [which is where she] comes in, yeah
Int: Yeah yeah
Par: Definitely

Moreover, staff felt that service users valued the **guarantee of confidentiality** which this service provides in relation to health issues:

Int: And to what extent are you aware of the Healthy Support Service within probation?
Par: .hh wh' to what degree am I aware of the Health Support Service in probation? Hh erm: good point! (laughs) Er I should have mentioned it earlier actually! But that's one of the one of the ways in as well erm that we actually provide er a qualified erm NHS NHS registered Nurse as well as a Health Trainer erm so it is again it's voluntary it's confidential erm again depending on the circumstances it's confidential if they're saying they're gonna go out and kill somebody that information would be passed on but .hh the the ins and outs of their con the conversation is kept kept [secret]
Int: [yeah]
Par: completely confidential from myself .h erm:: where sometimes people do feel more comfortable with that somebody knowing that it is gonna be that cast iron confidentiality and not go any further than that room erm whereas if someone tells me I've got to use that information to assess that person in terms of their offending their risk their needs
Int: Yeah
Par: erm so they're aware of that .h erm which could put kind of put close people down a little bit

Par: Erm, and more importantly the offender can go to her and in confidence say you know, "I do have this problem", you know, "I've got a STD", (laughs) you know, "I don't want to tell my Probation Officer I've got a STD" especially if it's a female she wouldn't want to tell me she's got a STD
Int: Mm
Par: but she can say that to the Nurse and the Nurse will sign post her and tell her where to go and when and how to make an appointment and reassure her it's not going to be too embarrassing so I'll put a bag over my head or anything like that, that kind of stuff, you know, erm so that's, that that's really helpful to have that for an offender

Another positive aspect of the organisation of this service is that the health staff are **co-located** alongside the criminal justice staff:

Par: she's very good for us as well because she'll come in, if we've got a question, a medical question, it's always good to have
Int: (laughs)
Par: somebody here with a little bit more medical knowledge to say "What's this for"? And if they come through and say, "I've been put on this particular drug", you know I, we would, when she come in say "what's this for, what would you use it for"?
Int: Yeah

Par: "What would be the effects of that"?
Int: Yeah
Par: And if he's using it with alcohol, or using it with other drugs, so if we can then say "you know, that's not a good idea". His GP may not know that he's on
Int: Right
Par: a particular illegal substance and we would probably contact them (). So yeah, she's very useful, she's brilliant

This was also something which was apparent as an enabler for accessing other services:

Par: I mean like Addaction erm we have a really really good working relationship with Addaction .h the drug misuse side
Int: Mm
Par: I keep saying that but
Int: Yeah
Par: it is the drug misuse [side]
Int: [yeah]
Par: .h erm and that's because they're tested in the office so that's because they they're here
Int: So you see them
Par: That's right and I think that works really really well
Int: Yeah
Par: Whereas in [place] .h the DRR clients have to go to
Int: Yeah
Par: the Addaction office to be tested so

Par: I mean in [place] we're quite fortunate because erm (1) we, the other agencies use the probation office to see people so like even to administer depots and stuff like that as well but erm you wouldn't get that in other offices
Int: No
Par: It's only because it's a smaller office like there's two er two staff there erm and like an Admin but you (1) it's in the Police Station that helps as well you feel more confi' confident in there but I think it's more to do with the fact that it's smaller
Int: Mmm
Par: People know each other it's more
Int: Mm [hm]
Par: [Close] knit
Int: So basing the services together [is beneficial]?
Par: [yea:h] yeah

In addition, **clear communication** both within and between agencies was felt to be key to enabling access to services:

Par: I've ha I have referred someone before erm and it hasn't been adopted erm but that was like six months ago erm but instead they were re they were then re-referred back to the Community Mental Health Team
Int: Mm
Par: Erm but then that worked well as well

Int: Mm
Par: because obviously they recognised that the Forensic Team recognised that it wasn't within their
         remit and then they re-referred back to [place]
Int: Mm hm
Par: so yeah that worked quite well

Int: And communication between mental health services and probation or drug agencies and
         probation is there two-way communication?
Par: There is, there is with the likes of Addaction, Addaction will come to this building they
         are due here every Monday actually, somebody turns up on a Monday and we sit down
         with them, we, we discuss every case, erm so that's, that's really good. Erm as far as
         attendance goes with Addaction they tell us every time they attend and tell us every time
         they don't attend. They tell us what the results are of any drug test they may take and they
         tell us about any work they are doing on a one to one basis or any courses that they' they're
         erm attending at Addaction or any referrals that Addaction make so they can refer them
         as well to housing agencies and other partner agencies that they deal with. Erm so we will
         know that, that works quite well.

This is a theme which will also be examined in more detail later in relation to 'improvements'.

Relationships

Another factor which probation staff felt was key to enabling access to health services was that
they **'know the face'** of the health service worker that they are dealing with:

Par: Erm (1) but I would say that that's more to do with the Nurses rather than how it's promoted I
         would say. Erm (2) the fact that (2) we've got a good rapport with the Nurses makes it easier to
         refer people because you know them and you know that actually it would be good for them to
         go

Par: Erm, but we don't have a close connection with mental health services in in this area like we do
         the drug services, because we know them people, the the other workers like face to face, we
         know names and stuff like that so .h you build up a better rapport with them, whereas if if we
         was in mental health I might struggle more

Similarly, the **relationship between a member of probation staff and the offender** was
crucial in ensuring that the worker is able to identify their health issue and thus facilitate access
to services appropriately:

Int: What do you think works well in getting offenders into services?
Par: Engaging them and working with them and showing that you're there to support them really and
         that there is help available, motivation. Erm if all us agencies working together rather than all
         individual goals and targets it sometimes gets too much for the offender so

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Par: you know they may or may not have been diagnosed themselves and if you once you get to know an offender they open up a bit and they'll say "yeah I I've got all this medication" and you know whereas they wouldn't say that at the first interview so

Int: OK yeah

Par: but as you see the signs and symptoms you can say .h "you know are you feeling alright"? and "this looks wrong" and you know and then they'll open up

This was an idea which offenders expressed in particular, and thus will be examined again in more detail later.

Awareness

Finally, the staff interview data indicates that the extent to which a) a member of probation staff is aware that an offender has a health issue, and b) the offender recognises their own health issue influences the ease with which individuals are able to access services.

In a few cases, staff felt that their **training had been adequate** to allow them to recognise the signs and symptoms of mental illness and to refer into appropriate services:

Par: I can obviously I can feel if people have changed, and if I know that er they've got a diagnosis I can tell when they're unwell, because I've got indicators .hh er but obviously but erm and if I do get an indicator I know what to do, I've got the er Outreach Team, the CPNs. .hh Er but a lot of the time, I guess it's just about listening really. And obviously if they they say they dep they're depressed or:: get any symptoms that obviously from your training you knew oh that might be mental health then I then I can refer them on so, so I guess I've got, I can erm I've got a feel for it

Par: well I it was quite a long time hh it was a long time ago (laughs) and it and so when I say I I've had training and I'm quite happy with it I think .h I'm quite happy with erm with myself if you know what I mean

Int: Yeah

Par: what I can what I can pick out and what I can do so I don't even though I haven't had a lot of training I don't

Int: Mm

Par: I don't feel as if .h I need training does that sound?

Int: Yeah that makes sense

Par: Yeah

Int: So I think you're saying erm although you may not have had any kind of formal training

Par: Yeah

Int: you kind of learnt

Par: that's right

Int: on the job [and]

Par: [that's] right as you go along yes

Int: So you're at a place where you feel quite happy

Par: Yeah

In addition, some staff felt confident that they could find out about health services as and when the need arose and thus would be able to make appropriate referrals:

Int: .hhh so, and just further in that question, so do you have a good knowledge of local mental health, drug and alcohol services and referral procedures?
Par: Erm drug and drug and alcohol yeah I know them quite well, erm referrals to mental health, I've done it before, erm it's a while ago, but there's always someone in the office that I can erm speak to .hh so whenever I need the information it's at hand really
Int: Are you confident at making referrals?
Par: .hh Erm, I could I could confidently filling in forms and asking for help. Yes, yes, no problem

Lastly, staff felt that it is easier to support offenders to access a service when the **offender is aware of/accepts that they have a health problem**:

Par: if they're aware it tends to be a little bit easier .h erm to get them that sort of help erm: because they actually recognise it and well recognise the problems it has in their life er:m it's far more easy then to get somebody to .h access the help and support that they need rather than somebody who's in total denial .h erm or doesn't recognise maybe they do have mental health issues and er problems it becomes a lot more harder then .h

Par: Not necessarily, erm but sometimes people don't see what their own problems are. Erm and sometimes they need a bit of support, to identify that. But until they .h see a problem themselves it's not necessarily gonna get revolv' resolved, is it? Because if, if you know, they've got a drug problem and they take drugs every day, but they're happy with that and they don't see it as a problem, they're not likely to address that need if they've got other issues, i.e. I don't know being homeless, that would be their priority, so we would have to work on that as a priority before we dealt with any other problems

Par: Sometimes liaising with GPs and getting them to actually help the offender's been difficult because it's on the onus of the offender to go and make the appointment with the GP to get referred but if the offender doesn't see it as a problem then obviously we can't even get them into the service in the first place.

Barriers to Access

Staff raised a number of issues which they believed created barriers to service access for offenders under supervision. Firstly, there are several aspects of the way in which current service provision is organised which create barriers to access. Secondly, staff discussed a number of barriers which appeared to them to be put up by mental health professionals. Thirdly, the issue of training was raised, and finally, staff discussed the offenders' ability to engage and reasons why they may struggle to engage with health services.

Service Organisation

Staff outlined a number of issues which form barriers to service access for offenders. Again, many of these are to do with the way in which health service provision is organised. Firstly, the **referral system** for services can form a barrier to access for offenders. As stated earlier, many services are unwilling to take referrals directly from probation, and will only accept referrals from an offender's GP:

Par: I've had people that have told me: that they've been self-harming or::: attempted suicide .h erm: and again like we know there's a Crisis Team there but they won't touch them unless they've gone through the GP and got a referral through a GP .h
Int: Mm
Par: So although we know the issues and they're real and they exist .h erm unless they have a referral from a GP they won't not interested .h erm so that's another sort of side to it as I said before erm unless somebody has something diagnosed .h

However, in some cases offenders are not registered with a GP. Furthermore, in other cases, staff gave several examples of problems which they encounter when trying to get offenders to see their GP – both in terms of motivating offenders to make the appointment, and the waiting lists when trying to get an appointment:

Par: if you're trying to get them to go see the GP or do whatever then "oh I don't need to why do I need to do that?"
Int: Mm
Par: "I've not got a problem" .h and *usually* they will say th' if I make an appointment I won't get to see anybody for two weeks anyway so
Int: Mm
Par: do you know what I mean that sort of thing cos in [place] it's really difficult to get an appointment
Int: for a Doctor?
Par: Yeah so if they went into see the GP .h they would go in say this afternoon to make an appointment to see the GP and it would be more than likely two at least ten days to two weeks before they get an appointment .h they could ring as an emergency but they have to ring before eight o'clock in the morning or from eight o'clock
Int: Mm
Par: and by the and some of them haven't got mobile phones
Int: Mm
Par: some of them if they're feeling got mental health problems they're not awake
Int: Yeah
Par: at that time in a morning

These same issues of *motivation* and *waiting lists* also applied when trying to gain access to other types of services, including requesting psychiatric reports for pre-sentence reports for the courts (PSRs):

Par: Forensic Psychology has long long long waiting lists so:

Par: what I'm having trouble with at the moment is getting people into employment guidance appointments really. Er:m and I guess its difficulties with motivation is does flitter, you can get some really motivated, want to better themselves by going into employment, but you might only have a window of motivation before you have to start that process again. And obviously when the appointment's three or four week's time, it's kind of, it's very difficult to keep someone motivated for a whole month, to want to go and seek w' seek a job really when they can just adequately live by doing nothing really.

Int: but what about say requesting a psychiatric report?
Par: Yeah we can do that through the courts erm (1) it doesn't always happen
Int: No
Par: the court will sometimes see erm a lengthy adjournment to get a psychiatric report because sometimes you know you are looking at perhaps two month's adjournment to get one these days
Int: Right, yeah
Par: erm as sometimes being unnecessary even though you've requested one
Int: [Yeah]
Par: [and] you've got those concerns .h erm

In fact, some probation staff felt that the health services should share in responsibility for motivating an individual to attend:

Par: What was I talking about (laughs)? Erm oh erm alcohol services
Int: Yeah
Par: I mean I you know we would text people you know
Int: Yes
Par: give them that little bit more support to get them to their appointment
Int: Right
Par: but again er you know they don't work like that I think you know somebody's got to be (1) get themselves there and you know to to (1)
Int: Yes
Par: show show willing you know they they don't go that sort of meet them halfway to get them there with the appointment they don't turn up then they've you know they've FTA'ed and two of those and they're discharged so

Par: Well they'll offer one appointment and if they don't come
Int: Yeah
Par: Well or say they offer two appointments and they don't come well they can't be that bothered they're not they're not motivated
Int: Right
Par: to do anything about it
Int: Yeah
Par: however I would argue well isn't that part of *your* role to motivate someone to feel they need to do something about it?

Thus staff pointed to a **lack of flexibility** in service provision which makes access to services

difficult for offenders, who often have very complex needs. This was particularly the case in relation to alcohol service provision:

Par: You, know, "oh you've missed an appointment, you've not come in that way, you don't want to see us we'll, we're going to discharge you"
Int: Yeah
Par: I find that frustrating

Par: People with alcohol treatment er conditions .hh as opposed to the ones with the drug condition
Int: Mm
Par: requirements, I've found that actually, I've not known anybody get any treatment with those conditions .h because they are seen by the NHS section that deal with the alcohol problems, and they have to fill in a questionnaire which identifies how serious their problem is
Int: Right
Par: with questions like, "do you need a drink when you wake up in the morn[ing]"?
Int: [yeah]
Par: you know "do you miss appointments"? due to your et cetera so and they need to be on the high spectrum about those questions, so that they really are reliant
Int: Mmm
Par: for them to take any action, .h otherwise they'll say well, they're not bad enough for us to do anything
Int: Huh!
Par: The problem being that then, the ones that are the high spectrum are the ones that probably aren't going to attend appointments
Int: Yeah
Par: for the obvious reasons .h and therefore they, they will make them an appointment, maybe two appointments and if they have not attended .h or they've come drunken and not able to engage properly then they've not got the motivation so we're discharging them
Int: Huh! Yeah
Par: and that is a huge, huge problem
Int: So basically you are saying they'll only see the highest risk?
Par: and then it would just
Int: and then its not going to work?
Par: Nobody I know who have actually been treated under one of those
Int: Yeah
Par: the most they've done is have us you know an assessment, yeah we'll take them, well they haven't turned up for that appointment and so they are not motivated and so we cant [work] with them

Par: Erm, when I have worked with, for instance, the Crisis Team in the past, if the offender doesn't turn up for their appointment they're, I think instantly discharged. Erm and I think that needs to be looked into a bit more because if they're the individual *is* having problems then .h there might be a good reason why they didn't get to their appointment. But, they see it "oh he didn't turn up so we've discharged him, if you want to re-refer, please do"

Another area which staff often raised in terms of service organisation is **poor**

communication between services, with probation staff stating that often they feel
that they are 'doing all the running' rather than communication being two-way.

Par: our biggest problem at the moment has been the alcohol treatment orders.
Int: Yeah
Par: Whe:re someone's been given a six month alcohol treatment and we send them off to Addaction, they then send them off to the NHS Alcohol Team, they won't work with us (laughs) they won't pass on information about what's whether they've attended and if the offender says "I don't want to work with you anymore" they say "fine" and discharge them. We're then left with an order that we've got to take back to court because the Alcohol Team say they don't want to work with them. And we're not getting any information back and it it's not a two-way flow like it is with a drug order
Int: Right
Par: With a drug order we're getting information back
Int: Yes
Par: They work with us, they have to go twice a week, we get the information back. They won't even tell us whether this person's been drinking!
Int: Yeah
Par: You know and they won't even tell us if they've attended, you know. Er::, if they say, "I don't want to work with you", that's it. They won't work with them and they discharge them.
Int: OK .hh
Par: So, alcohol-wise I think we need a lot more in, in Lincolnshire than what we've got

Int: Mmm and how easy do you find it to actually link people up to the right services?
Par: E::r, not especially
Int: No? can you tell me a bit more about that?
Par: (laughs) Erm well for example even when they've got a mental health treatment condition on their order, I've found that very very difficult. I should think I've had about six and every one of them I've had to obviously contact the professionals and tell them that this person has been given the order, ob' well obviously, and explain again what it means, and that, you know that it is an order of the court and we do need some feedback and
Int: Mm
Par: so on and so forth, but you never got any, it's always us ringing to find out

Par: Erm, I'm in regular contact with the CPN .h with the guy I was talking about who I am currently supervising and he has now got a mental health flat at with NACRO [at [place]]
Int: [Oh right]
Par: in one of those nice little mental health flats on his own, and he's really happy so he's being monitored by his Key Worker, he also sees his CPN twice a week and I do regularly check with the CPN that things are going well and
Int: Mmm
Par: but as I say, they they don't
Int: Mmm
Par: I do find it hard that they don't ever contact us
Int: So it's a bit of a one way street communication wise then really?
Par: I can see probably, they don't feel that they have any obligation even if it is a court order
Int: Mmm
Par: because they are busy and oh well, as long as they are doing their bit, whereas, I guess from our point of view, .h it is our responsibility to make sure it is happening so
Int: Yeah

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Par: But I say it would be nice if it was a little bit two way at times

Communication was also hampered by confusing/conflicting legislation at times:

Par: I mean there's conflicting legislation we have the er erm Crime and Disorder Act 1998, 1998 Act which sort of enforces that authorities must comply when it comes to offending or risk of harm
Int: Yeah
Par: yet then we have the Data Protection re' legislation which says "ooh don't share information" [you know] so
Int: [Yeah]
Par: it's so it is really difficult really and sometimes you find yourself getting quite frustrated as when you're talking to sort of a Social Worker that's saying well "I can't share that information"
Int: Yeah
Par: it's just like how ridiculous is this situ[ation]?

Int: Right so part of the issue is around erm the health services not understanding why you're asking for the information then?
Par: .hhh I'm not sure if it's that or sure if it's about feeling comfortable with sharing the information
Int: OK yeah, yeah
Par: Mmm I think it's more about that
Int: Yeah
Par: Obviously they've got their own codes of practice that they're sworn to but when it comes particularly comes to public protection I don't think we should be having that dialogue I think it should be automatically shared
Int: Yeah
Par: I really really do[::]
Int: [yeah]
Par: and I think it (1)
Int: So you'd ask for clearer guidance on that then or?
Par: (1) Yea::h erm .h there's too much legislation
Int: Mm
Par: it's just people just hang onto the bits that they like
Int: Yeah
Par: and they can pick and choose and I think it needs to be scrap it and just be very clear
Int: Yeah
Par: one data protection policy [that]
Int: [yeah]
Par: addresses harmful behaviour and you know and risk to self as well

However, there seem to be inconsistencies in this area, with some staff or services being more willing to share information than others:

Par: there seems to be a lot of we can share this information we can't share that information about them in relation to alcohol
Int: Mm
Par: Erm whereas there's already set up forums to exchange information with er Addaction for like people on DRRs and things like that

Par: for example one of the classics is information sharing
Int: Yeah

Par: Erm some pe' some agencies are quite willing to share stuff over the phone with you erm but
        other ones you've got to send them a fax that you've got a signed consent from that person erm
        which you know I can understand but if you've only got I don't know half an hour erm and then
        you're trying to send send a fax and then someone's got to ring you back
Int: Mm
Par: that half an hour's gone and you might not have that opportunity to follow it up again until the
        next day .h and then something else pops up and it has to wait until the next day so it can be a
        bit .hh of a erm hh pardon my French a ball-ache (laughs)
Int: (laughs) yeah
Par: Erm trying to sort sort those sort of stuff out and like I say it's not as straight forward as it could
        be

Par: Sometimes you, you, you just draw a blank, it's confidential, that's it and they won't talk to
        you, another time and they will fully involve you in the case. So you you you get hot and
        cold responses all the time from them depending who you bump up against

Related to this, staff gave examples of **silo working** – where agencies do not understand each
other's remits and thus do not communicate as well as they might:

Par: some of the workers there are are brilliant and they understand it because they've come from a
        probation background
Int: Right
Par: So they understand the importance of what we're trying to do
Int: Mm
Par: but there's others that just look at it, they've come in for testing or they've come in for
Int: Yeah
Par: their drugs and their script and that's all we have to do

Par: Erm: in doing it part of that is the classic problems of GPs or some of the mental health
        providers not being aware of what probation do and the reasons for why we're calling
Int: Right
Par: erm and in that sort of respect and vice versa .h we don't really know their policies and
        procedures [and]
Int: [yeah]
Par: .h you know that sort of stuff which causes all the problems or it's yeah it's difficult sometimes

Staff also raised the issue of **travel** – in some cases offenders have to travel quite large distances
in order to access services, which can be both costly and time-consuming, and makes it difficult
to attend several appointments in one day:

Par: Erm there's a problem with rural' rurality round here erm and lack of bus service and transport
        to get to certain erm appointments
Int: And does that make it difficult to get some offenders into services?
Par: It can be, yeah, definitely, erm especially if they're on benefits and they've got a drug problem
        or something as well then obviously er, money's tight and then we expect them or the services
        expect them to travel, into [place] and you know it's difficult for the offenders to get in. And
        obviously they expect the money to be refunded. Plus the bus service isn't brilliant it doesn't go
        out in the sticks very often, if at all

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Par: I mean we've got offenders in Stamford, .hh they can take two hours on public transport to get here. So and obviously wh' when they've got several appointments a week possibly it's such a barrier and especially if you've got a health needs .hh cer' certainly obviously in mental health then the prospect of having to get public transport obviously you ca' er it's a big barrier to treatment really. So yeah, yeah, I forgot about that one, geography is a key to this, to er the service really because we did have a place in [place], but that's closed down, .hh you see and obviously public transport is not that reliable and obviously in certain rural areas it's not that frequent, so er you can you can be faced I guess for example, erm, .h someone with mental health who doesn't like being in open spaces, they have to get a train here for nine and they have to stick around in town until five to get a bus back, so yeah, good point and I agree with it, yeah, yeah so erm .h it doesn't always support er the offender's needs

Inevitably the issue of a **lack of resources** was also raised:

Par: I would like to think that there could in the future be some more help for people with alcohol problems, because there isn't
Int: Right
Par: There's a *real* lack, I've found people, am I going off the plot here?
Int: No no
Par: [This is relevant?]
Int: [Not at all], yeah
Par: People with alcohol treatment er conditions .hh as opposed to the ones with the drug condition
Int: Mm
Par: requirements, I've found that actually, I've not known anybody get any treatment with those conditions .h because they are seen by the NHS section that deal with the alcohol problems, and they have to fill in a questionnaire which identifies how serious their problem is
Int: Right
Par: with questions like, "do you need a drink when you wake up in the morn[ing]"?
Int: [yeah]
Par: you know "do you miss appointments"? due to your et cetera so and they need to be on the high spectrum about those questions, so that they really are reliant
Int: Mmm
Par: for them to take any action, .h otherwise they'll say well, they're not bad enough for us to do anything

Int: Mm hm, (3) and erm if there was anything you could improve about health provision for offenders, what would you suggest?
Par: .hhh health provision generally?
Int: Yeah
Par: (4) I suppose, erm, well it would be unrealistic, but I think generally, for GP's to have more time to actually listen to people's problems
Int: Yeah
Par: and actually identify what, what the real cause of it is
Int: [Mm]
Par: [rather] than just saying, oh here's a tablet, you know
Int: Mm hm
Par: go

Int: Yeah!
Par: Which is, but that's not realistic because time and finances aren't going to allow that are
         they?

In some cases, staff also pointed to **stigma** as a barrier to service access:

Par: in [place] they won't touch them they won't touch people once you once you're a heroin user
         you're forever a heroin user even though you've been clean for like eight years
Int: Yeah
Par: You're still seen as a heroin user by the GP erm (2) which limits people's access to other
         services
Int: [Mm hm]
Par: [because they]'re seen within a specific light if you know what I mean

Par: although someone sometimes admits they've got mental health problems they probably don't
         want or put barriers up in terms of going to the a GP especially mentioning mental health team
Int: Yeah
Par: cos it's got a stigma and the [and puts]
Int: [yeah]
Par: quite a few barriers up for them .h erm so the mental health sort of side of it is slightly harder
         erm: given like I said the stigma that's attached to the mental health team .h erm
Int: Mm
Par: given their own individual barriers especially if you've got someone that's chaotic erm they're
         not really attending appointments with you they're not really gonna go to [a mental]
Int: [yeah]
Par: health appointment .hhh erm so yeah it can be quite tricky

Thus staff point to numerous aspects of the way in which services are organised which form
a barrier to access for offenders. They also pointed to some barriers put up by mental health
professionals as detailed below:

Mental Health Professional Barriers

Health services appear to be reluctant to accept individuals with **complex presentations**.
Offenders also identified this theme, in particular in relation to personality disorder as outlined
later.

Par: We've had problems in the past where again, whether the erm primary issue is mental health
         or whether it's drug erm induced, and we've had difficulty in the past then with services passing
         the individual to either mental health or they're passing it back to Addaction and then Addaction
         saying "no the mental health needs to be dealt with first" and vice versa, that's sometimes been
         a problem.

Par: I would be trying to sort of signpost them to (2) all the relevant services .hh and I think it's then it's kind of er pot luck for them whether they well not pot luck but what wh' what service will take them on cos you know we do come across .hhh "oh there's no point in addressing his you know mental health cos he's you know a raging alcoholic" or you know drugs is [his]

Int: [oh] really

Par: until that's you know so sometimes it can be, if there is you know dual (1) need it is

Int: Yeah

Par: difficult although (2) I think we did they are suppos' supposed to be more services for people with dual erm diagnosis now

Int: OK

Par: if someone has got mental health that's self-diagno' they're self-medicating alcohol and drugs, the mental health side is saying well we can't do anything with them while they're self-medicated, can't properly diagnose .hh and obviously I have, perhaps have trouble getting them to to sort out their alcohol and drugs because obviously their mental health isn't stable enough to keep up appointments so it's kind of like, it's like a chicken and egg situation. .hh do I do I try and get the drug and alcohol under control before they can be diagnosed, but surely they need to be more stable with mental health before they can receive the services. So, so obviously I can go on all day about the services, but that that's the key issue, it's the diff' it's the self-medication and dual diagnosis issues

In addition, some mental health professionals put up barriers to service access as they were unwilling to take responsibility for patients on mental health treatment requirements (MHTRs):

Par: do you know what else really annoys me as well?

Int: [(laughs)]

Par: [I've] got started now .h mental health treatment requirements

Int: Right

Par: Because people it doesn't work for everybody .h but erm I've got an like another example of this erm (1) it people psychiatrists not putting their name to people so because they don't put their name to somebody some person then they won't authorise a mental health treatment requirement. So even if people need it

Int: Mm

Par: even if people are engaging with the service anyway all all it's doing in effect is formalising their engagement especially people with like the out' Assertive Outreach Team people that are hard to reach

Int: Yeah

Par: it would be a good thing to

Int: Yeah

Par: kind of encourage that erm but then psychiatrists won't put their name to it won't put their name to saying "right I'll be the named person responsible for this person"

Int: Ah huh

Par: Erm and I find that bizarre

Int: So that then means you can't make that recommendation?

Par: Yeah so erm although you can encourage people to go to appointments erm you know you can't actually make it erm part of a requirement [of]

Int: [yeah]

Par: their order .h and some people do need that (2) that kind of
Int: Mm
Par: step that leg up to engage because they don't want to engage they've got so many barriers that
        they need something that's actually going to make them engage

Training

As detailed above, some staff were satisfied with the level of training that they had received/
knowledge that they had around mental health. However despite having received more mental
health awareness training than many probation staff (see Brooker and Sirdifield, 2009), as
highlighted in Lord Bradley's recent review of liaison and diversion in the criminal justice system,
some probation staff also pointed to a lack of mental health awareness training and knowledge
of services as potential barriers to getting offenders into services:

Par: I think that there's still so much further to go in terms of staff being able to recognise the signs
        and recognise erm the symptoms of certain mental health problems or men' not even mental
        health problems as such but erm emotional instabilities and how to manage them kind of on a
        day-to-day bay basis

Par: erm more training I suppose as well really in terms of like I say I've only done a two-day training
        course that was mainly based on identifying mental health rather than working with it erm cos I
        think that's quite hard sometimes that .h erm like with borderline personality disorder case that
        I worked with they're quite what can I say some of the most challenging people I've worked
        with .h erm so it's about er the kind of techniques or or how to kind of .h engage that person
        cos what I find is with borderline personality disorder they're all over the place and as much as
        you try and focus them they so they'd sooner talk about something else rather than what you've
        asked them .hh erm or very good at kind of manipulating conversations erm so yeah that sort
        of training about how maybe to engage someone with borderline personality disorder how to
        engage somebody with schizophrenia erm and maybe to be aware of issues that .h signs or
        indications that it's deteriorating because I only know the basics
Int: Mm
Par: like I said
Int: Mm
Par: like appearance and hygiene you know that sort of stuff and ask them directly about
Int: Yeah
Par: there's all sort of stuff I don't know about that they might be saying that goes over my head and
        for a professional they might be saying OK th'
Int: Mm
Par: that's indicating that things are getting worse or things are getting better erm so yeah it's
        training I suppose in that sense and having somebody that we can actually contact to advise
        and guide or maybe that comes to the office for somebody that we think has got mental health
        issues that
Int: Mm
Par: might want that help to go and see somebody and if that person .h has got the right tools and
        then the professionalism to kind of deal with that I suppose

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Int: Mm
Par: Erm in that respect

Par: we're not being funny or anything but you know I I'd like to know what the role of Assertive
        Outreach Team is for instance [you] know and
Int: [yes]
Par: what do they do? (laughs)
Int: (laughs)
Par: who are they? (laughs)
Int: (laughs)
Par: you know and and perhaps if we knew what was available and what their remit was
Int: Yes
Par: then you know it would be helpful you know I I would personally would find that quite helpful
        (laughs)

Par: erm knowing who to call is half the battle sometimes or knowing what to say sometimes when
        you call is you know what's the other side to it you know I'm not an expert erm and you know
        you ring a doctor or somebody and they're talking about something you don't really know about
        it's quite difficult for yourself to deal with but having that person that's .hh got the necessary
        training the expertise the know-how erm: that comes to the office is you know like a drop-in
        centre [might]
Int: [mm]
Par: be like a way to getting some help for some of the people that do actually want it
Int: Yeah
Par: and get it quicker I suppose in that sense

Thus criminal justice staff may benefit from further mental health awareness training and
ideally this should be done jointly with mental health services in order to overcome some of the
communication barriers outlined earlier i.e. to provide staff from different organisations with an
opportunity to learn about each other's remits and to get to know each other.

Ability to Engage

Finally, staff highlighted that in some cases, offenders struggle to engage with services. This
may be due to **anxiety**:

Par: and you know if we knew .hh erm she had an appointment coming up for counselling because
        she was sort of very nervous and anxious about about attending .hh you know we'd sort of see
        if one of us could you know just go along and sit with you know literally sort of make you know

Or **problems with expressing needs**:

Par: I know [Nurse]'s written to the GP before
Int: Yeah
Par: Erm with a letter for them to take .h I've done letters for them to take with them
Int: Mm hm

Par: We've done lists for them to take to the GP this young chap in particular .h
Int: Mm
Par: he made a list of things he wanted to say to the GP cos he says when he goes he forgets
Int: Yeah
Par: or I don't [know what] to say
Int: [Yeah]
Par: So I said well we'll do a list and this is what you've got to ask him and this is what you've got to .h say how you feel
Int: Yeah

Or the **complexity of the case**:

Par: without that stability it's gonna be very difficult to successfully engage them in the interventions because they're gonna be constantly worrying about being street homeless so

Also, some offenders may have encountered problems when (trying to) access services in the past, and are thus reluctant to try again as they have formed '**rubbish opinions**' of the services:

Par: I've worked with they've got really rubbish opinions of certain agencies and .h and you think well there has to be that level of trust there has to be that level of kind of rapport building or effort

Par: a lot of people will say to you it's a bit of a self-fulfilling prophecy in that they've asked for help don't get it so "I won't bother asking any an' anymore" so it's that sort of
Int: Yeah
Par: sort of sort of er attitude erm .h which again like I was talking about barriers they've got to address that sort of issue and it's little bit bit of a kick in the teeth cos you try and say to them well yes you need that help and I'm here to try and help you or but there's things you can do to help yourself erm so you might get the motivation back but then they go and try and do it and then they get knocked back again so it's
Int: Yeah
Par: it's that sort of limbo really that they need the help they want the help but don't necessarily get it

Finally, in some cases staff stated that offenders are simply **unwilling to engage** with services:

Par: the Doctor wanted to for him to go into PHC but he wouldn't go

Par: Erm but again even the experienced when we have an induction we ask them do they want to see a He' erm a Nurse erm or a Health Trainer and a lot of them will say no even if they've got depression or stress anyway [they'll]
Int: [mm]
Par: they'll say they've got those issues or alcohol issues but they don't particularly want to see them even though you go through that's what they're there for and you know the stuff that they'll do with with the individual a lot of them will say no straight away anyway

Positive Experiences

Staff were also asked about positive experiences if referring offenders into services – what works well for getting this hard-to-reach group into services. The points which staff made all related to aspects of the way in which some services are organised:

Staff stated that they valued services which had straightforward **referral procedures**:

Int: Mm hm OK .hh so in terms of from your sort of perspective in in making referrals is that an easy process to Addaction Is it easy to make a referral?
Par: Er yeah it is because I mean basically if you've got somebody who's who's got you know you want to sort of start that ball ball rolling
Int: Yeah
Par: they just have open access so that would be the starting point really
Int: Yeah
Par: so you know somebody could either go down there most days and attend open access you know and have an a' an assessment you know
Int: Yeah
Par: erm we can sort of li you know liaise and sort of you know make a an appointment for them [to]
Int: [yeah]
Par: go down. You know they need that otherwise they can you know just tell them go down there and that they'll be seen hhh

Int: So what kind of sets erm the Healthy Support Service apart from other services then what makes it better?
Par: Erm simply being able to speak with [name] and being able to *usually* not always but .h being able to get an appointment pretty quickly
Int: Mm (1) so more
Par: I mean there are occasions when we can't because [name] tries to come every week but she doesn't always get every week
Int: Yeah
Par: So but if she can .h but if [name]'s available and she's coming she will always fit somebody in
Int: Yeah
Par: That that is brilliant I know she will
Int: Yeah
Par: So that's a positive thing

They also appreciated services which were able to **work flexibly** with offenders, offering an **individual approach** and varying the nature of service provision according to individual need:

Par: Yeah but they do do it I mean they'll do it for anyone who they feel is at a disadvantage because .h for instance if they've never had their own property before
Int: Mm
Par: so they need help in setting up the water rates and the sewage rates and everything else gas bill

Int: Yeah

Par: They will just become involved maybe for two or three weeks 'til all that's set up and if they don't think they need any extra support they won't give it

Int: Mm

Par: but if they need ongoing support then to keep reminding them of appointments and that sort of thing .h I think they can become involved for up to two years

Int: So did you erm, how would you describe the Health Support Service then [within probation],

Par: [I think it's]
excellent, ,really good really useful to have it

Int: Mm hm

Par: Mm. (2) I mean sometimes people just want a one off appointment, .h which probably puts their mind at rest about whatever issues they've got, .h and sometimes they have several, just as they need it

Int: [Mmm

Par: [Basical]ly but, a lot of them just want putting in touch with a Dentist or something .h others want testing for various (laughs) things

Int: Mm

Par: I believe (laughs)

Par: I'm a fan of work with the erm a bloke called [name] from L&H Homes erm and like I say he's the kind of special specialist mental health erm homes type worker .hh

Int: Yeah

Par: Erm so but yeah I mean he comes in erm once a fortnight an' and we do a three-way with with my offender once a fortnight .h so yeah I mean there's I think there's quite a bit of joint working an and certainly from my own perspective when there's mental health issues I'd get [name] involved and there's masses erm an and the thing is [name] with [name] he's got the *time* an available to him and he'll actually take them to appointments

Int: Right

Par: So he'll actually attend the counselling CMHT and he'll take them to sort out things with the GP and you know quite often they'll actually say look you know I'm a bit scared will you go with me? And he goes in [to]

Int: [yeah]

Par: appointments with them. Er which is something that I can't do I just haven't got the time erm or or the resources to kind of do that. So it's it's smashing that [name] can do that you know and then he gets them involved with you know erm the little bits like sorting out their teeth and all that sort of stuff

Int: OK

Par: Erm so he'll just get them registered with the you know and also like the Phoenix for

Int: Yeah

Par: smoking cessation and all that sort of [name] has got the time and .h an' and the resources to do it so

Par: But I think the CPN's are really good

Int: Yeah, what's what's particularly good about them then?

Par: Well the just the regular support and again because they get to know the person because they're seeing them regularly and they can sort of judge if, if someone's mental health is declining again

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Moreover, given the often complex nature of offenders' needs, staff were positive about services which took the time to listen to the full range of offenders' needs and were able to support them fully:

Par: the GP said to him which I was really pleased about .h erm he started to tell him and he said to him I haven't got time to spend with you today [because]

Int: [Mm]

Par: I've got a lot of people waiting .h however I will give you some medication but I want you to come I think this was Wednesday I'm not sure .h but I need you to come back Monday and I'll make an appointment Monday where I'll be able to spend a lot more time with you .h and I thought that was really good [because]

Int: [great]
Par: I've not heard that done before
Int: No
Par: so I thought that was really positive

Par: And we've already talked about the Nurse, the Nurse will: has the time really to sit and listen to the problems or, or will make the time er to sit and listen to any problems or issues that the client will have and will let us know if there's any issues, particular issues there that we need to be dealing with. .h Erm and and as I said we will broker with GPs and er, hospitals and things if erm if needed
Int: So it works well that?
Par: It works well for us yes, it does yeah

Negative Experiences

Staff discussed several aspects of the way in which health service provision is currently organised which produce negative experiences either for them when trying to get offenders into services or for offenders when accessing services. Perhaps the most frequently mentioned shortcoming was **inadequate provision** of alcohol services. Here, staff felt that an insufficient level of support was provided for individuals with alcohol treatment requirements on their community order:

Par: We can make referrals (laughs) what happens afterwards I mean .hhh I don't think the services are brilliant (laughs)
Int: Really?
Par: Mmm (1) erm
Int: Can you tell me a bit more about that?

Par: Well I I just don't think in in this particular we get a particularly good service [from]
Int: [OK]
Par: Addaction er:m I mean it's Drug Rehabilitation Requirements I suppose I can talk you know (2)
        they don't get an or you know somebody may have that requirement on their order .hh but they
        don't necessarily get that doesn't mean I think people think when they've got that requirement
        it means they you know .hh are gonna get quite a bit of input which really isn't necessarily the
        case [they]
Int: [OK]
Par: perhaps you know they'll have a couple of an hour a week down there
Int: Mm
Par: a couple of drug tests and that's it
Int: Mm
Par: and I think .hhh for a somebody who's motivated or to get somebody motivated I think they
        need more than that.

In addition, at times staff felt that the **appointments** which some services offered to offenders
were **not frequent enough** and as a consequence, probation staff needed to do extra work with
the individual to keep them 'on track':

Par: So erm he's been working with a CPN for ten years
Int: Mm
Par: erm and erm sort of they do take although it's quite frustrating because it's an out-of-area CPN
        and he's only seen once a month so I end up picking up quite a lot of the anxiety I get quite
Int: Mm
Par: a lot of anxious phone calls from him

Par: the erm case I was referring to earlier and it's an out of cos he's moved and it's been a ye:ar
        now since he's moved and I just cannot understand why he's not got local services here
Int: Mm
Par: and it's I've you know he's seen once every three to four weeks it's just not enough really
Int: No
Par: and erm and he's really struggling .h so: you know I don't think that works very well

One other aspect of service organisation which staff were critical of is **continuity of care** –
where offenders are struggling to ensure that they maintain the care that they received in prison
after their release:

Par: Well certainly you if you are going to be interviewing the guy this afternoon who has had
        some, some problems er accessing his services. Er, he's, his erm, Psychiatrist er moved
        working at [prison] and he hasn't been told who his new Psychiatrist is or going to be and
        his CPN has gone on maternity leave and will pick him up when she comes back, .h erm
        and he has tried, he has asked for help during this period when there's he has had nobody
        there, and has received no response

Staff were also critical of two aspects of the nature of the support that offenders were offered.

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Firstly, many staff gave examples of when they felt that offenders had been **'fobbed off' with medication** rather than offered access to other types of support such as counselling:

Int: Mm hm, (3) and erm if there was anything you could improve about health provision for offenders, what would you suggest?
Par: .hhh health provision generally?
Int: Yeah
Par: (4) I suppose, erm, well it would be unrealistic, but I think generally, for GP's to have more time to actually listen to people's problems
Int: Yeah
Par: and actually identify what, what the real cause of it is
Int: [Mm]
Par: [rather] than just saying, oh here's a tablet, you know
Int: Mm hm
Par: go
Int: Yeah!
Par: Which is, but that's not realistic because time and finances aren't going to allow that are they?

Par: I do find as well while we're ( ) though the they're very hh they'll talk about medication but they very rarely do any kind of therapeutic kind of work they don't do any talking stuff there's no Counsellors
Int: Really
Par: Erm (2) I I can only think of one person who was has any kind of counselling at all with the GP
Int: Oh really?
Par: Erm and to be fair that was that was with violence issues not necessarily mental health in fact I think it was kind of linked in [but]
Int: [mm hm]
Par: erm I've never know anyone get any you know sort of erm around the Counselling ( )

Secondly, in some cases, probation staff felt that health services were not always willing, or able, to work with clients who may be problematic and who (as detailed earlier) may not always keep appointments:

Int: and the kind of shutting the doors a frequent problem then or is that just something that happens
Par: Erm
Int: once in a while?
Par: (3) I think it's quite a common problem really
Int   Yeah?
Par: I think it er not just health service I think you know drug and alcohol services as well
Int: Yeah
Par: I mean it's just sort of easy to say right that's that's that but actually the problem's still there
Int: Yes
Par: there's still that risk to the public
Int: Yeah, yeah

Par: Er [I just]
Int: [and why] why do they do that?
Par: (3) mm (laughs)
Int: (laughs)
Par: We:ll (3) I think it comes down to resources and money doesn't it?
Int: Right
Par: It's got to
Int: Yeah
Par: At the end of the day somebody is (2) perhaps problematic to a service and you know been
        missing an appointment and blah blah [blah]
Int: [yeah] pain in the neck
Par: so it's easier to just discharge them
Int: Yeah, yeah
Par: than actually well work with them about why perhaps they've missed their appointment
Int: Yeah
Par: I don't know anyway
Int: Yeah
Par: but I think it's for me it's about money really and if somebody's er
Int: Yeah OK
Par: I would say anyway
Int: Yeah yeah! (laughs) right
Par: they tend to like the compliant ones
Int: Yeah
Par: we don't tend to have those here (laughs)!
Int: No
Par: We've got rule breakers!

The final negative experience which staff commented on was that some individuals on their
caseload appeared to take a very short-term view, and thus did not persist with the help that
they had been offered for long enough for it to improve their condition:

Par: they (2) don't seem to quite get you know it is if they're going for counselling it's gonna be very
        traumatic I think in the for a certain time until they get over whatever it is and then it you know
        it's probably going to get better but I think our offenders sort of just see (2) what how it is at the
        moment they don't have that long-term view of you know if I get through this then it's you know
        I'm going to be it's gonna be better long-term they just see what it and they tend to .hhh give up
        on it really

Par: others have actually gone and come back and shown me the medication they've got
Int: Right
Par: erm and said I've taken it for a day or two and it doesn't work so "ho:::ld on you know your GP's
        told you this"! (laughs)
Int: (laughs)
Par: "this medication might take three months to start working" yeah just stick with it encourage them
        and motivate them through
Int: Right
Par: you know so a lot of it's motivational interviewing I think from that point onwards

Improvements

Finally, probation staff were asked how they thought that current health service provision could be improved to enhance offenders' engagement with services. Many of their responses built on their earlier discussions around barriers to service access and negative experiences of trying to get offenders into services. A number of responses related to the over-arching theme of 'communication' – outlining ways in which communication could be improved between health services and criminal justice agencies. Previously, staff had outlined ways in which they feel that current service provision is in adequate in some areas. Thus, when asked about improvements, many responded in terms of potential improvements to the range/volume of services that are available. Finally, staff pointed to ways that they thought service organisation could be improved.

Communication

In terms of communication, staff stated that they would benefit from information sharing being improved between health services and criminal justice agencies so that information is automatically shared rather than criminal justice agencies having to 'chase' health staff for information:

Int: Right so part of the issue is around erm the health services not understanding why you're asking for the information then?
Par: .hhh I'm not sure if it's that or sure if it's about feeling comfortable with sharing the information
Int: OK yeah, yeah
Par: Mmm I think it's more about that
Int: Yeah
Par: Obviously they've got their own codes of practice that they're sworn to but when it comes particularly comes to public protection I don't think we should be having that dialogue I think it should be automatically shared
Int: Yeah
Par: I really really do[::]
Int: [yeah]
Par: and I think it (1)
Int: So you'd ask for clearer guidance on that then or?
Par: (1) Yea::h erm .h there's too much legislation
Int: Mm
Par: it's just people just hang onto the bits that they like
Int: Yeah
Par: and they can pick and choose and I think it needs to be scrap it and just be very clear
Int: Yeah
Par: one data protection policy [that]
Int: [yeah]
Par: addresses harmful behaviour and you know and risk to self as well

As outlined earlier, one way in which staff were already working to improve communication was

through **co-working** cases and sharing information between agencies in order to find the best
approach to working with a service user to address their health problems:

Par: Addaction come in
Int: Yeah
Par: once a month and we have a little bit of a meeting about our er DRRs
Int: Yeah
Par: and say, because that way we're getting information back from how they are there, because
they react totally differently *here* than they do with Addaction
Int: Right
Par: And they'll often tell them more than they will us
Int: Mmm
Par: And again that that would happen right the way through and we've got information coming back
Int: Yeah
Par: you know and you can build a picture up and that way we can do our supervision a lot easier
because we're getting *far* more information to be able to work with it there's no need to know
where it comes from
Int: Mm
Par: but we've got that information to say right, maybe I need to change my supervision
Int: Yeah
Par: And work with him that way. It might be that he comes and says "I don't like the way that
[name]'s talking to me"
Int: Yep
Par: you know and then we can, again alter it and you know and us sort of change the questions
round and change the supervision.

However, in some cases, staff felt that offenders' access to services could be further improved if
there were mental health or substance misuse **specialist workers** based in probation for staff
to discuss cases with. This would also improve staff confidence that they were 'doing the right
thing' in referring a service user to a particular service:

Par: think (1) probation would benefit from having a specialist mental health worker and and a
specialist drug and alcohol worker in the teams but .hh [you know]
Int: [Based in] probation?
Par: Yeah that would help with the communication aspect as well
Int: Yeah
Par: all work on a joint system
Int: Right, so tell me a bit more about that then, how would that work?
Par: Well they do it over at the Youth Offending Service it works excellently you know you're talking
to somebody while you're making a cup of tea and it
Int: [Yeah]
Par: [just] stops those barriers of writing a letter or picking up the phone
Int: OK
Par: if you've got a communal system. I mean they've got their own agency systems as well but then
you've got the you know the system where you just put brief notes on
Int: Right
Par: but you know you would need to know but you wouldn't need to know the full you know
counselling session you would just need to know that were they had counselling that day and
that they attended you know

Int: I see yeah

Int: Mm hm. So if you could improve anything about all that what would you say?
Par: Erm (clears throat) .hh what I think would be a good idea is having somebody erm a bit like
          Addaction a bit like LAT erm somebody tha' that comes down to probation .h that's accessible
          that you know can advise or can see a person with any mental health sort of issues or
          substance dependency or whatever it is and kind of advise or guide them .h with the expertise
          and the knowledge
Int: Mm
Par: erm knowing who to call is half the battle sometimes or knowing what to say sometimes when
          you call is you know what's the other side to it you know I'm not an expert erm and you know
          you ring a doctor or somebody and they're talking about something you don't really know about
          it's quite difficult for yourself to deal with but having that person that's .hh got the necessary
          training the expertise the know-how erm: that comes to the office is you know like a drop-in
          centre [might]
Int: [mm]
Par: be like a way to getting some help for some of the people that do actually want it
Int: Yeah
Par: and get it quicker I suppose in that sense

Par: It would be nice if we had somebody within the service
Int: [Mm]
Par: [who we] could just or two people so when one's off the other one's there who you can just
          [sort]
Int: [yeah]
Par: of ring up and say .hh just bat something by really
Int: Yeah so how would that improve things?
Par: I think it would give I' it would give me more confidence in thinking I've done the right thing
Int: Yeah
Par: Cos the worst thing you would want to feel is that could I have done this should I have done this
          did I do it the right way?
Int: Yeah
Par: Perhaps I should have done it this way
Int: So it's reassurance?
Par: It is yes as much as anything ye[ah]
Int: [Yeah]
Par: Yeah because you want to know you've done it right or you want to know you've done what you
          can for that person [really]

Likewise, at times staff felt that health services might benefit from a member of probation staff
going over to discuss a case with them:

Par: Erm I think going along the lines of kind of multi-agency working I think it would be really
          important to have that (1) whether it be a contact person or just (1) to be able to kind of bash
          ideas off each other in some respects as well what whether that be erm (1) like inter-agency
          training
Int: Mm hm

Par: I don't know that sort of thing
Int: Mmm
Par: Like for example this issue with the sex offender that I had like somebody could go over to the
        mental health service and say well this is actually don't be scared this is what a sex offender is
        [and]
Int: [yeah]
Par: this is this that and the other and this is what we use to assess .h
Int: Yeah
Par: people and then likewise erm they can come over to us and say [this
Int: [yeah]
Par: is] what erm you know this is the provisions we've got with the mental health or substance use

Expanding Provision

As well as suggesting ways in which communication between agencies could be improved, staff also made suggestions on ways in which (in an ideal world) current **service provision could be expanded** to better meet the needs of offenders. For example, providing alcohol services for cases with low levels of need, and (as discussed earlier) providing alternatives to medication where appropriate/desired:

Par: People with alcohol treatment er conditions .hh as opposed to the ones with the drug
        condition
Int: Mm
Par: requirements, I've found that actually, I've not known anybody get any treatment with
        those conditions .h because they are seen by the NHS section that deal with the alcohol
        problems, and they have to fill in a questionnaire which identifies how serious their problem
        is
Int: Right
Par: with questions like, "do you need a drink when you wake up in the morn[ing]"?
Int: [yeah]
Par: you know "do you miss appointments"? due to your et cetera so and they need to be on the
        high spectrum about those questions, so that they really are reliant
Int: Mmm
Par: for them to take any action, .h otherwise they'll say well, they're not bad enough for us to do
        anything
Int: Huh!
Par: The problem being that then, the ones that are the high spectrum are the ones that
        probably aren't going to attend appointments
Int: Yeah
Par: for the obvious reasons .h and therefore they, they will make them an appointment, maybe
        two appointments and if they have not attended .h or they've come drunken and not able to
        engage properly then they've not got the motivation so we're discharging them
Int: Huh! Yeah
Par: and that is a huge, huge problem
Int: So basically you are saying they'll only see the highest risk?
Par: and then it would just
Int: and then its not going to work?
Par: Nobody I know who have actually been treated under one of those

Int: Yeah
Par: the most they've done is have us you know an assessment, yeah we'll take them, well they haven't turned up for that appointment and so they are not motivated and so we cant [work] with them

Par: I do find as well while we're ( ) though the they're very hh they'll talk about medication but they very rarely do any kind of therapeutic kind of work they don't do any talking stuff there's no Counsellors
Int: Really
Par: Erm (2) I I can only think of one person who was has any kind of counselling at all with the GP
Int: Oh really?
Par: Erm and to be fair that was that was with violence issues not necessarily mental health in fact I think it was kind of linked in [but]
Int: [mm hm]
Par: erm I've never know anyone get any you know sort of erm around the Counselling ( )

Staff also felt that in some cases, services could be expanded to provide **more local provision** rather than offenders having to travel to services, or health staff having to travel large distances to see service users. In this way, it was hoped that the frequency of appointments might be able to be increased:

Par: the erm case I was referring to earlier and it's an out of cos he's moved and it's been a ye:ar now since he's moved and I just cannot understand why he's not got local services here
Int: Mm
Par: and it's I've you know he's seen once every three to four weeks it's just not enough really
Int: No
Par: and erm and he's really struggling .h so: you know I don't think that works very well

In addition, one member of staff raised the idea of having 'structured groups' which meet at regular times and are aimed at supporting offenders with specific needs such as heroin use:

Par: like a support network group
Int: Mm hm
Par: That offenders have to engage in cos they because they're on their DRR
Int: Yeah
Par: so it's enforceable they have to engage in it and that kind of set-up's really positive
Int: Mm
Par: for people if their needs allow it
Int: Yeah
Par: because obviously some people don't like work well in a group or might have other issues [learning]
Int: [mm]
Par: issues as well
Int: yeah
Par: erm but I think that that those kind of things need to be more structured
Int: Yeah
Par: so that people do engage with that so that they can have the support of other people that have got similar issues

Int: Yeah and when you say more structured erm what do you mean do you mean meets more
        regularly or?
Par: Erm no well just erm (1) identified times like this group for specifically for erm intravenous
        heroin users [will]
Int: [right]
Par: be on a Wednesday at ten am this group for
Int: Yeah
Par: you know
Int: Mm hm yeah OK

This was something which some offenders also stated that they would benefit from.

Finally, when discussing the Health Support Service in Lincolnshire Probation Trust, one
member of staff commented that the organisation of services could be improved by matching
the experience of different members of staff to the needs of individual service users, rather than
allocating cases to staff on the basis of other criteria such as geographical area:

Int: Mm and when you said erm you feel that the role of that service should be clarified what did you
        mean by that?
Par: In terms of what they can offer. Did are they qualified Mental Health Nurses? Or are they
        qualified General Nurses?
Int: Mm
Par: Or what experience have they got?
Int: Mm
Par: Who's you know they've all come from different backgrounds so would it not be better to: if
        one's got more experience in mental health but the other one's got more experience I don't
        know
Int: Yeah
Par: in whatever substance use then use that.
Int: Ah huh
Par: Don't just put one person in one area and one person in the other
Int: Yeah
Par: If you know match the needs of the client group to the experience of the staff
Int: Yeah, yeah
Par: It's obvious surely?

B: Offender Interviews

Enablers for Access

This section of the report examines the themes coming out of the data from interviews with offenders under supervision, looking firstly at factors which offenders described as **_enabling access_** to services. These themes all related to the meta-themes of 'service organisation' and relationships.

Service Organisation

Many of the offenders that were interviewed were extremely positive about **the role that probation had played** in supporting them with health problems and facilitating access to services for them:

Int: (3) OK. Erm and and can you tell me to what extent the probation services help you access the health services that you needed?

Par: Er:: well yeah I can actually because they made appointments for me which was something I'd never know where to go, and I wouldn't know where to go I really wouldn't have the experience of that kind of thing so, yeah they did help me in sending me to places I needed to go really and giving me advice on what I needed to know

This is something which is further explored under 'positive experiences' later through the theme of 'ongoing support from probation'.

Like many probation staff, many offenders under supervision made the point that their **GP** was the main route of access into numerous services:

Int: Mm erm you've talked about erm
Par: (Coughs)
Int: problems trying to access your GP
Par: Yeah
Int: Have you tried to access any other type of health service?
Par: No because they if you want to go on mental health team you've got to go through your GP first
Int: Right so for your needs you've got to go through your GP

Par: I don't think probation can can ring up the Mental Health Team and say "I think, we've got this person who we think we should be" refer me to them. It's got to go through your GP

Relationships

Likewise, many offenders echoed the view that the **relationship between a member of probation staff and the offender** was key to enabling appropriate access to services:

Par: [Er], well, I've been, I've been in and out jail system since erm, well I was in care from being 6, 18, and from18 till on' onwards and onwards and I'm now 43 years old. And er [name] the probation officer that I've just, just had, was the best one I've ever got on with so I could fa' I could trust her. You understand what I'm saying

Int: Yeah

Par: whereas in the past I never could be able to so::, it was just having a good person who can realise the situation that I could be honest with.

Int: OK

Par: Personally personally my er:: it depends on the ca' it depends on the person like I said, I've never trusted people in my life so, I didn't trust 'em so I see them as a hindrance more than a help. That's down, partially cos of me really

NT: Right

Par: Do you know what I mean?

Int: Do you feel you trust them a little more now?

Par: Yeah, I do because like, [name] the one I've got at the moment's the best one I've ever had in my life to be honest with you.

Int: Right

Par: And I did kind of sort of we got to a situation where she helped and like I kind of opened up to her rather as before I could come and see the probation and say well, they'd ask you a question and alright and my life like was fucked, sorry about the language like, but that's

Int: That's alright, that's fine

Par: and I'd still lie to her and say "yeah everything's great, hunky dory yeah I'm laughing" like that, cos I didn't trust 'em, really, personally

Par: But yeah, she helped tremendously and then the last probation woman that I had she was really good as well

Int: What was she good at?

Par: hhh. When I'd done something and it was good, instead er, having the attitude of, 'well yeah you're supposed to do that anyway', she was like, "well done"

Int: Yeah

Par: Because you've actually, you know, done it

In addition, several offenders went onto stress the importance of **being honest with the probation service** about your problems in order for them to be able to facilitate access to services:

Par: Erm I think everyday events effect everything so having your Probation Officer there you need to speak to them you need to be open honest

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Int:	Mm
Par:	.hhh and speak to them about everything
Int:	OK
Par:	Erm and then if they can help they wi::ll
Int:	Yeah
Par:	but if they can't then they'll always find someone or point you in the right direction
Int:	OK
Par:	about who can and can't help you I mean I had a lot of .hh financial problems so it was recommended I went to see the Citizens' Advice Bureau
Int:	Mm hm
Par:	but you know it was I spoke to my Probation Officer and she helped me out she pointed me in the right direction

Int:	.hhh OK, erm, but you feel that erm probation service do recognise the mental health problems that are
Par:	Yeah I do actually yeah
Int:	Yeah? You do?
Par:	Yeah, yeah
Int:	OK
Par:	If you're honest with them
Int:	If you are honest with them?
Par:	If you are honest with them yeah, cos I have lied to them for years like, but er it's come to a stage where you think well it's about time I started telling the truth really, you know what I mean? Then they can recognise it, they can't recognise it if you're not honest with them. That's all I can say really.

Barriers to Access

In terms of barriers to service access, offenders raised a number of key points which were grouped under the meta-themes of 'service organisation', 'relationships' and 'ability to engage'.

Service Organisation

Firstly, offenders pointed to the '**regimented'** way in which services are provided as a barrier to access:

Par:	Health services are very hh (2) regimented
Int	Right
Par:	in their approach in their .hh I suppose it's their rules and regulations their guidelines what they can and can't do what they're allowed to do what they're not allowed to do .hhh erm (1) apart from their waiting times actually getting someone because you can't get out to an appointment
Int:	Mm
Par:	they wouldn't come and see you
Int:	Right
Par:	They would make another appointment to see if you can get to that one

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Int: Mm hm
Par: which is grea::t bu::t you need that help and that support there and then
Int: Yeah
Par: not in two weeks' time not in six weeks' time you want it there you need it there and your family need them there
Int: Mm
Par: Erm but no they couldn't do that

Int: and is there kind of any other example you'd like to give of your experience of accessing a service?
Par: Erm they're difficult to get hold of out of hours
Int: Right
Par: very difficult to get hold of out of hours
Int: Mm
Par: erm (2) and they can (3) they can be quite short with you at times you know
Int: Mm
Par: erm it's like they don't have time .hh and it's if the person that you need to speak to isn't available then you have to phone back or wait for a phonecall [.hhh]
Int: [mm]
Par: unlike probation
Int: Right
Par: er where I said if I phoned up and my Probation Officer wasn't here
Int: [Mm]
Par: [I could] speak to somebody else
Int: Mm
Par: there was never anybody else I could speak to I could only speak to the Nurse that I was assigned to speak to because they're the only ones that know my case
Int: Mm
Par: whereas here everybody knows about you

This is an area which is further investigated under 'negative experiences' later in this report.

Like probation staff, offenders often saw the **referral system** for services as problematic:

Int: Mm, OK when you said you found it difficult to access health services why was that?
Par: Because there's such a so much red tape it's unbelievable you've got to go through your Doctor then go to your doctors and that's more stressful than ever before (1) I mean I don't know if you live in [place] but here .h you phone up and then the Doctor phones you back it's not a case of phone up book an appointment to see him he phones up and then thinks whether he'll see you. So it's stupid how the actual thing's gone

Par: There was a time when you could phone up and say "right can I book an appointment for next week?" "No" now you can't even do that. And if you don't phone at half eight you can't you're screwed so half the time I go to the hospital they say why don't you go to the doctors? You can't get in
Int: So you end up what in A&E?

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This could be a particular problem for individuals who were homeless, or who had not been in touch with community services for a considerable length of time:

Int: so erm, part of your experience was you had to lie [about where you was living]
Par: [Yeah, yeah yeah]
NT: Erm
Par: Well at the time I was living on my friend's settee, in his flat at the time and, that local Doctor were there so I just went and give him give him a false address really, just so I could get in there, because when I phoned up earlier, you've got to be in that catchment area, if you haven't got an address you can't get a GP (4)
NT: What about er
Par: But apart from that you've got walk in centres [
NT: [I was going to say, what about drop in centres?
Par: I'm going back a few years with that like, you know, I mean I've been back since but apart from that you can just have a walk in centre which eight, seven or eight years ago you didn't have.
Int: You didn't have [that facility then]
Par: [()] then, so that's the difference really (9)

NT: I was thinking of about three to five months [to see the Psychologist].
Par: [three to five months, yeah], I think it's a bit ridiculous like but er, like I say, they were chasing my medical files up which they couldn't find because I couldn't give them the information they wanted. It's like normally you go to the Doctors, "right, where's your what's your mum's maiden name, where do you live, where do you living", right there's no way to () like for the last twenty year like, you know and it's o::r, and I () when you say to them in reception "I haven't had a Doctor for twenty years" they look at you like you're thick. Like "you must have done", "I haven't". My Doctors have been jail, I've been in and out of jail since I was 14 years old like, that were my Doctors. Do you know what I mean?
NT: Was the fact, do you feel that the fact that you didn't have and medical records, do you think that's why the waiting time was three to five months [or do you think that's]
Par: [I think that's what]
NT: what the waiting list was?
Par: Well that's what I was told, that's what I was told but whether that's right I don't know.
NT: So you was told because you didn't have accessible records
Par: They couldn't find my records, yes

Offenders also pointed to **waiting lists** as being a problem at times:

Par: and (2) you need that that help there and then
Int: Mm
Par: It's not something that can wait a few days
Int: Mm
Par: and you go and present yourself at A&E because you're depressed

Int: Mm
Par: they don't really care they're not really interested in that it's a case of well wait until Monday and
         go and see your GP [.hh]
Int: [Mm]
Par: well on Monday I might be dead because I feel like killing myself you know it's that
Int: Yeah
Par: it's it's really hard it's hard work

In addition, some offenders stated that there was a **lack of resources** to support their particular
needs. This was especially true for sex offenders and individuals with personality disorder:

Int: OK (3) OK (2) .hhh how easy have you found it to access the right mental health services to
         help you with your depression and personality disorder?
Par: Not very good because (2) PHC won't touch you, they don't really wanna know because,
         OK you've you've got depression which is a mental illness, so they tend to put you on anti-
         depressants and discharge you within a matter of days
Int: Mm hm
Par: and as for anything else i.e. personality disorder, it costs too much money and too much time
         that they kind of, they don't wanna to know. Its kind of, personality disorder is not a mental
         illness, so
Int: OK
Par: on your way

Par: I say, if there'd been a su' if there'd been alcohol, and I could have gone to Alcoholics
         Anonymous or or to a support group, obviously they've got ( ) and you've got that access to
         that. The biggest thing is having support, you haven't got no support. There isn't, there isn't, you
         can't go on the internet and find a sex offenders' support group. You can't go, it ain't advertised
         on the notice board, you see everything else. Because it's a taboo thing, and the thinking
         behind that is, we don't want erm, a group of of paedophiles, a group of sex offenders together.
         Because all they're going to do is share information, listen to each other's stories and that's
         what they think everybody, the problem is everybody's tarred with the same brush.

Offenders also saw the need to **travel** long distances in order to access some services as a
barrier to access:

Par: The first, the first lot, the [place] team could offer me nothing. So I then had to go for an
         assessment for another team, obviously I was referred to another team. So all the local stuff
         that I could access, or or was there available, was not, not for me. So there was nothing, there
         was nothing in [place] that that was suitable for what I needed. So then I had to be referred to
         this thing, I I had to travel to [place] or [place], to access a service that other people can just
         walk down the street and access. So that's the different thing for me, that it's not, it's not in
         [place]. (Clears throat) It's not in [place] anywhere so I've got to, I've had to travel to [place] or
         [place] to meet this guy, because he doesn't come as far as [place] so there's nothing in [place]
         for, that's accessible to me

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Furthermore, offenders also pointed to difficulties in **communication between services**:

Par: hhh because apparently jails don't like passing medical files onto normal Doctors, which I don't believe, which I *don't* believe, but that was what I was told

NT: So maybe if the jail had liased with the Hospital here, you'd have got seen quicker?

Par: It might have been quicker, yeah

Finally in terms of service organisation, offenders talked about the **stigma** attached to certain topics such as sexual offenders which can act as a barrier to service access:

Par: The biggest thing I found when you talk to people, they weren't, I want to say disgusted they weren't shocked, but you always got the reaction, erm, "well that's not my field, I've had no experience in that". Because I think, a lot of people with my, my my offending, same as me, are reluctant to access help for that reason, because 95 or 90% or society don't like us. We should be burnt, shot, stabbed, dragged and buried in the middle of the sea.

Int: Mm mm

Par: And it's the fear of the reaction that, st' didn't stop me but made me wary of approaching somebody. I knew health professionals, even going to the Doctor's, I couldn't tell the Nurses, about my offences, my past, my thing. And it's just a part of your life that you're very guarded, and and you let, you tell very little, because it's the fear of the reaction and also the fear of being found out erm and that is one of the biggest things with me, was the fear of somebody finding out my offences because at that

Int: Mm

Par: time, I felt that if I was found out, well that's my job gone, that's my flat gone, I can't live where I am, so I'm back to square one when I started coming out of prison. And that's the biggest thing that built up and built up and that fear overtook me.

Relationships

As outlined earlier some offenders discussed having a good relationship with probation staff as an enabler to service access. However, the flip-side of this was also pointed out: where an individual's relationship with probation staff could actually form a barrier to service access:

Par: this is the only one I've ever got on with and I've been on probation all my life on and off like and this is the only [name] is the only one I've ever really got on with

Int: That's your current   [

Par: [The only one I could be open and honest to be honest with, to be honest with you

Int: OK

Par: Whereas rest it was just like er, I've lost my word, it's er, it's just it's words innit, you know what I mean, you go in "everything's great yeah yeah see you later, yeah see you next month". That's

Par: all it was really. Partly down to me, I must admit it is partly my fault

Int: OK. So with your current Probation Officer do you actually feel now more relaxed with her

Par: I do yeah

Int: and do you feel that she actually listens to what [you are saying you need]?

Par: [Yeah I do, yeah]. Yeah, whereas some, I can understand where the situation, you've got that many people and that, this that and the other and they're busy and this that and other and what can you do?

Ability to Engage

Finally, like probation staff, offenders discussed their ability to engage with services. In some cases, they stated that they had simply been **unwilling to ask for help**:

Par: And at that time I thought helping asking for help was a failure, so I didn't do it. It's my problem, I've got to solve it.

Par: I've just never asked people for help in my life, I never have done, you know what I mean?

NT: Mm

Par: I've done me jail, I've got out of jail, I've then gone back in jail, I've done my jail, got out and I just I didn't ever ask anybody for anything really. Which was stupid it was, but in life I'm not forty-three and it's took me all these years to realise it you know what I mean?

In others, they were **unwilling to accept support** which they had been offered:

Int: OK erm, an' and when chatting with your Probation Officer, have they offered any: of the other health services to you?

Par: Yes they have done, yes. They have done in the past yeah they've offered me things, this, that and the other but I just didn't take no notice to be honest with you

Int: You haven't taken advantage of [those]?

Par: [No], I haven't no.

Positive Experiences

Service Organisation

The researchers also asked offenders about positive experiences of accessing services. They echoed some of the points which staff made about service organisation. For instance, they valued services which are **quick and easy to access**:

Int: OK, what about any, er, how easy was it to get help from places like, er, Addaction?

Par: Easy

Int: Easy, do you want to tell me about that?

Par: You pick the phone up, you ask for help, you get an appointment, the thing is, you've got to go,

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	if you don't go, you don't get the help
Int:	OK
Par:	It's that simple
Int:	Yeah
Par:	There is help for everybody with Addaction. You might have to wo' wait a couple of weeks or something for your appointment but, or if you're really really messed up, they will put you in somewhere

In addition, they valued services which **worked flexibly**:

Int:	And s' and something you said, which flags up for me something good about the service was, you said she came round to see me
Par:	Yeah they come to see *me*, they'll come to see me every week or two weeks
Int:	In your home?
Par:	In my house yeah.
Int:	Does that make it easy for is that easier for you?
Par:	Yeah that makes it easier for me [name]. Ooh [name], (laughs) that's easier for me [name]. Yeah, a lot better than me traipsing up there and I'd rather her come and see me
Int:	So you'd say that was something good about the service?
Par:	Yes
Int:	That they come and see you
Par:	And if you ring them up and say you're, say you don't feel very good one day, and you're in a bit of er, er, bit of er, feel a bit of psy- phychotic or something like that, cos of my, I think my er diagnosis is mental er psychotic manic depression and er, if you ring em, say I ring em up and say ah, I'm not very well today, they'll come out and see me
Int:	OK
Par:	Straight away. Or as quick as they can (4)

Par:	you can ring and speak to anybody. There's like ten people, there's, in the, in the agency where my CPN lives like, like, twelve or thirteen Nurses do you know what I mean? Like [name] [name] another [name] erm [name] .h you know what I mean there's like ten people when you if you need [name] for instance, if she wasn't there, I could get someone else to come and see me, you see, you know what I mean, so that's good

Offenders also appreciated services which had **time to listen** to all of their needs. Indeed many offenders really benefited simply from having someone to talk to about their problems:

Par:	they had time for you they made it feel like it was your time as opposed to as it was their job

Par:	and the other thing is, I know *now*, that if I have a problem (2) that, I can't solve or do anything about myself, I know that in a fortnight of three week's time, I'm going to see him and I can talk to him about it. So I can manage that problem, or put it on hold, or live with it, until I've actually seen the person. And that, that is a great thing to me, I haven't got to leave it in my head, I don't go and think, I've got to solve it straight away, I've got to do it myself. I can leave it now and think I'm going to see [name] in a fortnight's time, I will talk to him about that. He may not be able to help me, but at least I've got somebody that I can talk to, and, and, and get it out of my head.

Furthermore, when recounting positive experiences of service access, it was apparent that some individuals favoured a '**no pressure'** approach when receiving support from health services:

Int: OK. What sort of things, I don't work in probation, so what sort of things does that Nurse do? What can she help you with?
Par: The more, obviously the health side of it
Int: Yes
Par: Erm, cos, I was a bag of shit, lady. Do you know what I mean, I really was rough
Int: Right, OK
Par: Erm, (3) [She made] well, I tell you what, there was no pressure from her
Int: [And did]
Int: Lovely, yeah
Par: Nothing at all. Erm, first time I see her, it's strange, erm she said, she done all the bits and pieces that (laughter) Nurses do and whatever, I had a chat with her. Erm, it was the end of my time, because my taxi was there, and she said all I want you to do is eat a banana every day
Int: Yeah
Par: Just one banana every day
Int: Yeah
Par: And I thought, e::r, and she just went, "bananas, one a day". (Laughter). Yeah and it was like, o::h, so I did, I had a banana every day and now I have fruit and
Int: [Yeah]
Par: [veg] and stuff and it's like (Laughter) Yeah, thanks!

Many interviewees also mentioned that one very positive aspect of being under probation supervision was the **ongoing support** that probation staff provided in the form of offenders having someone to talk to about any problems which they were having:

Par: it was something that I kind of looked forward to
Int: Yeah
Par: after a while because .hh it was someone to talk to it was someone that sort of points you in the right direction gives you reassurances and I don't know just they *are* quite helpful actually
Int: Mm?
Par: Erm
  Int: In what way?

Par: Support network when if you have questions cos obviously having a criminal record it it's like that's it the whole world's over
Int: Yeah
Par: you know you're never gonna get a job you're never gonna be able to move on with life you're never gonna be able to do anything else .hh and it's it's actually they they teach you that that isn't (1) necessarily the case
Int: Mm
Par: There are opportunities after and it can be overcome and how to deal with it really

Par: My Probation Officer so she knows it's like everyday for me it's either I'm up or down if I'm down I'll talk about what's going on what's making me down so this is how she helps me with my mental

Also, as above in relation to health services, offenders stated that they valued the **flexible approach** to work that probation staff adopted at times:

Int:	And erm to what extent do you think health problems are recognised by the probation service?
Par:	By the probation service [fantastic]
Int:	[yeah] yeah?
Par:	They were actually better than mental health service. Their support and their compassion their empathy .hhhh they were a lot better and and a lot more adaptive
Int:	Mm hm
Par:	erm and very very understanding
Int:	OK
Par:	Erm [name] my Probation Officer here was just brilliant
Int:	Mm
Par:	Erm there were times when I couldn't get here because of er .hh a bout of anxiety or anything like that and she would come and visit me at my ho::me and .hh delay appointments work my appointments around appointments with my Psychiatric Nurse
Int:	Mm hm
Par:	So she was really really good they were really really good and really really helpful here

Professional Approach

In addition to these aspects of service organisation, offenders also raised a number of issues related to the 'professional approach' of individual health services staff. For example, offenders stated that they had positive experiences with services where staff appeared to understand their position and to have a **genuine desire to help** them:

Par:	The good thing was, it, it was somebody who, who seemed to understand what I was feeling. Erm (3) I felt confident and at ease with him the first time I met him. Now whether that's because of his his professionalism or his way, but, I did, I felt that there's somebody now that, erm, and it was somebody for me to talk to. So I felt confident and secure talking to this guy. Erm, (2) and he, he seemed to understand my needs and what what was going on in my head.

Int:	What else is good about that mental health service?
Par:	E::r, (5) they listen to you. They listen to you, exactly what you're telling them.

One individual also stated that they had benefited from a service teaching them about their health problem — in this case helping the individual to understand how much they were drinking

in relation to recommended daily limits:

Int: What in what was good about the service? Why was it so helpful and so useful?
Par: Yeah er (2) er recognising how much you're drinking we did a lot a lot of work on how many units you're drinking not the pints and that it was a lot of unit work so
Int: Right
Par: What they do is you get er you know take a form home with you in the week and you'd have lists of Monday to Friday and you write down your drinks how many then when you go we used to go into Addactions they used to look at it all and put it into units for you
Int: Yeah
Par: Instead of you doing it yourself because a lot of people wouldn't bother with it units they don't want to know but if you brought what you'd drunk they did it for you and when you start to see the units you're drinking and what the sensible daily allowance is and you realise how much you're over drinking really so that was a huge help you know that was er yeah they did quite a few things to be honest with

This is a theme which other interviewees raised when discussing ways in which services could be improved and thus will be returned to later.

Finally, some offenders stated that they had valued services providing a professional voice to speak on their behalf:

Par: But when it comes to like people putting pressure on me, I can they
NT: The professionals are there to [make them stand back a bit]
Par: [They're the professionals to sort the other professionals out] and just to get me through life.

Negative Experiences

When offenders were asked to discuss negative experiences of accessing health services they echoed probation staff in discussing aspects of service organisation such as **inadequate provision** and **continuity of care**. In some cases, they were also critical of the nature of the help that they had been offered.

In terms of **inadequate provision**, in some cases, as outlined earlier under 'barriers to access', offenders felt that they had been discharged from a service to soon:

Par: Erm (5) PHC, they, I've been there four times and I think the longest I've actually spent in there was two weeks
Int: Yeah
Par: and even I tried to kill myself whilst I was in there
Int: OK

Par: and jumping out of a window and stuff like that and they still discharged me after a matter of days
Int: OK
Par: They don't seem to erm (3) have the resources that certain individuals need

Par: Erm (2) but I could only have eight appointments because that's all I'm allowed on the NHS (1) and after that if I'm still poorly then .hhh I have to be discharged back to my GP and then if I still feel like I need prob need help [I]
Int: [mm]
Par: have to go back to my GP to be re-referred to wait another six weeks
Int: [Right]

Int: Is there anything else that you would change?
Par: (4) erm I don't know really (3) (laughs) difficult to say
Int: Mm
Par: (3) erm (2) the number of appointments the the amount of time you're allocated on the NHS .hh to me at everybody with depression bi-polar any mental health issue everybody's different everybody recovers at a different rate

In other cases, like probation staff, they felt that the appointments that they were offered were not frequent enough:

Int: An and did your counsello:r help you significantly with your anxiety?
Par: Erm yeah yeah I'd say yeah he did I mean the sessions were once a month so it was a long wait it was a long time between his sessions so it wa' I obviously I was I'm living at home but imagine if you're living by yourself and that imagine it's a long time to .h see someone once a month isn't it? It's a long [ti:me]
Int: [Yeah]
Par: A lot can happen in a month can't it so?
Int: Yeah

Par: The other thing is, I can't ring him up. It's again it's not ( ) I can't ring him up, and say, I need to talk to you. I, I've done that a couple of times and he has phoned me once back, but he, his his diary is always full. So it's not that easy access to something. Like I say, it's not like I can come here and go to a drop in centre and talk to somebody, there isn't there isn't nowt like that, I have to wait until I get the appointment and although it's great, he's there, but it, it's not available to me when I need it sometimes. Which means I have to manage, .h myself until I actually see him. I have to deal with the problems or try and deal with them I try and deal with them until I can actually get to see the Counsellor and that's difficult at times

Moreover, some interviewees felt that there was inadequate support for sex offenders:

Par: I say, if there'd been a su' if there'd been alcohol, and I could have gone to Alcoholics Anonymous or or to a support group, obviously they've got ( ) and you've got that access to that. The biggest thing is having support, you haven't got no support. There isn't, there isn't, you

can't go on the internet and find a sex offenders' support group. You can't go, it ain't advertised on the notice board, you see everything else. Because it's a taboo thing, and the thinking behind that is, we don't want erm, a group of of paedophiles, a group of sex offenders together. Because all they're going to do is share information, listen to each other's stories and that's what they think everybody, the problem is everybody's tarred with the same brush.

In terms of **continuity of care**, some offenders encountered problems with repeatedly having to go back through the system, explaining their problems to numerous people rather than being able to continue to receive care from a member of staff that had provided care to them previously:

Par: so you get discharged and you're straight back to the Doctor's being re-referred .hh but you then have to go through it all over again .hh it's not a case of being re-referred back to your Psychiatric Nurse you get re-referred into the mental health system .hh and you have to go back through triage who you meet somebody else new you have to tell them what your problems are you then get told who you will see whether it's er a Mental Health Nurse a Psychiatric Nurse or whoever
Int: Mm hm
Par: a Counsellor what[ever]
Int: [Mm]
Par: so it's it's hard work it's repetitive hard work
Int: Yeah
Par: and if you're not in the right frame of mind and you don't have that support from family friends other people
Int: Mm
Par: You've got no chance
Int: Mm

As stated previously, some offenders were also critical of the nature of the help that they had been offered by health services. For example, some offenders discussed bad experiences that had led them to believe that health services had **no desire to help** them:

Par: Erm my husband had stopped me erm but I went and sat out in the garden in the pouring rain on the lawn rocking back and forth and just wouldn't communicate with anybody
Int: Mm
Par: Just basically went into a trance .hhh erm and I became quite violent with him because he stopped me killing myself it was his fault
Int: Right
Par: and he actually phoned our GP our GP put him in touch with the mental health team who he phoned .hhh who just really couldn't give a crap they really didn't care they it was it was out of hours erm he could hear them stirring mugs of tea in the background .hh and we had to go through he had to go through a triage system .hh where he had to tell them what was wrong .hh erm and then they would decide what to do with me

Par: I think when you become a difficult case to people, I think they just, kind of switch off and you

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know what I mean I think they just kind of switch off. I really do, that's what I believe. I might be wrong in that but that's what I believe

Like the staff, offenders gave examples of when they felt that they had been 'fobbed off' with medication:

Int: OK (3) OK (2) .hhh how easy have you found it to access the right mental health services to help you with your depression and personality disorder?
Par: Not very good because (2) PHC won't touch you, they don't really wanna know because, OK you've you've got depression which is a mental illness, so they tend to put you on anti-depressants and discharge you within a matter of days
Int: Mm hm
Par: and as for anything else i.e. personality disorder, it costs too much money and too much time that they kind of, they don't wanna to know. Its kind of, personality disorder is not a mental illness, so
Int: OK
Par: on your way
Par: I went to see my Doctor, who was happy to provide me with some happy pills but, I had to fight with him erm and really be erm, what's the word I'm looking for, really be firm that I didn't want to go down that route. I needed counselling of some sort

Again echoing probation staff, in some cases, offenders stated that they did not keep taking their medication as they didn't feel like it was the 'right' treatment for them:

Par: like I say er, when I did when I did see the Mental Health Services, they put me on er medication that put us just, it wasn't for me it wasn't for me at all
Int: You didn't benefit from [that]?
Par: [No]. Not at all, it was just it just, I was walking round like a zombie
Int OK, did did they offer any alternative medication?
Par: No because I didn't stick at it, but actually that's part of my responsibility

Par: I went to see the Nurse, through the GP, and it was just like, they just advised me to go, I explained what my problem was, because I were ill at the time, so I was really paranoid and I couldn't even stand going in shops and things like that you know what I mean, it was too many people round me, I don't like being round people, you know what I mean, I really really don't and er, she said like go see a Psychologist, I seen him once er: wrote me up for Olanzapine and some other things th' which I can't remember the name of, I tried it for a week and it was just hhh not for me.
Int: OK
Par: Not for me at all

Improvements

Finally, offenders were asked about how they thought health service provision could be improved.

Like staff, they discussed how communication between services could be improved. However, they also went beyond this, to discuss how agencies could improve their communication with service users. Offenders also outlined ways in which service provision could be expanded to better suit their needs. Finally, building on earlier comments regarding barriers to service access and negative experiences of accessing services, offenders also discussed ways in which the organisation of services could be improved.

Communication

Like probation staff, offenders felt that **communication between services** could be improved:

Par: And I think er, where it's probation, Doctors et cetera they should, all these services should get themselves together a bit more. Do you know what I mean? I really really believe that it'd be a lot better thing, you know what I mean? Cos we all understand about a Doctor's got to be a personal thing, they can't pass information et cetera et cetera, but I do believe if they got together a little bit more and it might be a bit more speedier. to be honest with you, because they're going through all this red tape it's "oh we can't say this to this service and they can't say anything to this service" et cetera and I think they must start working together more I do, really
NT: So multi-agency working
Par: I do, yeah I think they ought to get together more
NT: And the sharing of records?
Par: Yeah. And if you sign to share the records and it's down to you, alright, you might get a man who says no, we don't want to share, but you might get a lot of people who say yeah we do, but I think they should share more information more rapidly. Can't move for all the red tape

In addition, offenders felt that **internal information sharing** within individual agencies could be improved so that more than one member of staff is in a position to help a service user, rather than them having to wait for a particular individual to be available:

Par: erm it's like they don't have time .hh and it's if the person that you need to speak to isn't available then you have to phone back or wait for a phonecall [.hhh]
Int: [mm]
Par: unlike probation
Int: Right
Par: er where I said if I phoned up and my Probation Officer wasn't here
Int: [Mm]
Par: [I could] speak to somebody else
Int: Mm
Par: there was never anybody else I could speak to I could only speak to the Nurse that I was assigned to speak to because they're the only ones that know my case
Int: Mm
Par: whereas here everybody knows about you
Int: Mm
Par: .hhh which to a certain degree was a bit paranoing (laughs)

Int: (laughs)
Par: oh my god they all talk about me! But it's nice that it doesn't matter who answers the phone they can help you
Int: Mm
Par: they can give you advice .hhh

However, in contrast to this, some service users were keen to have one identified member of staff who knows their case that they could be linked back in with each time that they use the service rather than being directed back through triage:

Par: So if you assigned a Psychiatric Nurse it would be nice to be able to say right that's my psychiatric nurse if I've got a problem
Int: Mm
Par: .hh I need to be able to get an appointment with that Nurse

In addition to these factors, one offender suggested that services could improve their practice by **explaining illnesses** to service users rather than simply giving them a diagnosis. That way, service users would understand more about their condition and what to expect:

Par: all they said was personality disorder and that meant nothing, I didn't know what it meant
Int: OK, OK. So:: you're saying that they (2) could have spent a bit more time actually with you, talking to you, is that right?
Par: Yeah, just erm, what's the word when you get diagnosed. Just talking about what you've actually got
Int: Yeah
Par: and how it could possibly affect you
Int: OK
Par: Cos then if you're aware of it you don't kind of freak out and you can put things into place
Int: Yeah
Par: so it's so it's not as bad or you can stop the outcome
Int: OK, OK. So you feel that would have improved the service?
Par: Yeah

Expanding Provision

Like staff, offenders also outlined ways in which the range of provision could be expanded:

Par: they should have had more therapy and counselling and
Int: OK
Par: maybe groups and maybe actually sat down with you and told you about your mental illness
Int: OK
Par: erm cos I didn't understand what was going on at the time
Int: Mm hm

Some offenders, in particular those convicted of sexual offences, were keen for there to be **continued support beyond their community order**:

Int: OK we've reached the end of the questions is there anything else that you'd like to add?
Par: No just everyone bitch right to get that safety net in
Int: Yeah
Par: I'm telling you yeah everyone that's from an ex-offender I don't really want to go through this again
Int: Mm hm
Par: and I'd had someone I wouldn't have offended and that's not feeling sorry that's the bottom line because .h if I had someone to talk to I wouldn't have done it

Par: they were part of my of the support group that that I tried to create for myself. Erm it's more difficult now because I've finished my probation
Int: Mm
Par: So I haven't, I've lost that link. Erm, so that's one bit I've lost, well I've lost two because I've lost probation and I've lost [Nurse] so two, two parts of my support group lost now and that's something that we wor' I worked towards and talked about before they come, so I was ready for that

Likewise, sex offenders felt that there should be some **specialist provision** for them:

Par: Well, yes. I'd like erm information or something. Where to go for it, erm, the only the only access I got anything was my Doctor. There wasn't no, "well this" the thing is, you see, I think it's because if I was erm reliant on on drugs or alcohol, or substances, there is charities and or[ganisations]
Int: [Mm]
Par: that they can say, well you go to this, you know drug awareness or you go to connect or somewhere like that but because my offences was, sexual natured, there isn't a support group or anybody you can go to for that. Because it it's still erm, I won't say a taboo subject, but erm, as I say if you got health, other issues that need it,
Int: Mm
Par: there is support people out there that will help you, but there is nobody that supports a sex offender

Par: I say, if there'd been a su' if there'd been alcohol, and I could have gone to Alcoholics Anonymous or or to a support group, obviously they've got ( ) and you've got that access to that. The biggest thing is having support, you haven't got no support. There isn't, there isn't, you can't go on the internet and find a sex offenders' support group. You can't go, it ain't advertised on the notice board, you see everything else. Because it's a taboo thing, and the thinking behind that is, we don't want erm, a group of of paedophiles, a group of sex offenders together. Because all they're going to do is share information, listen to each other's stories and that's what they think

Offenders also stated that things could be improved through **providing services locally**:

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Int: And, and the final part of that really is, what could be improved with that service?
Par: Well, easier access, isn't it, (1) more local access, (1) maybe ( ) maybe on a par with other other addictions or other things.

Finally, some offenders felt that they would have benefited from attending **structured groups** where they could learn from others with a similar condition:

Par: I think looking back now I know when I was drinking that I think erm probably meeting people that had drinking problems as well like er people with severe they had real drinking problems severe drinking problems who would do talks and that maybe that would have
Int: OK
Par: been something to
Int: Yeah
Par: talk to I suppose it's yeah that was the only thing I can remember thinking back then I was thinking it would be nice if there was like a group session with someone coming and tell us what problems they've had and they were really heavy drinking and they was at the stage of alcoholism where they couldn't really come off the alcohol [if you know what I mean]
Int: [Ye::ah]
Par: Sorry I keep
Int: That's alright
Par: Er where they're er coming off it yeah so mm
Int: So you would have liked a perhaps some group work?
Par: Yeah probably more group work yeah

Service Organisation

Offenders also discussed various aspects of service organisation which they thought could be improved. Firstly, ideally services would have **shorter waiting lists**:

Int: So if you could change anything improve the services what would you suggest?
Par: It would be in waiting times
Int: Right
Par: because when you are in an all time low when you are .hhh suicidal but you have your family around you your family don't want to have you committed to a psychiatric ward they don't want to let you go through that because there is that sig stigma of [the p]sychiatric
Int: [Mm]
Par: ward .hhh they don't want you to do that but they need the help the support you need help the support even though you .hhh kind of don't really know that you need it
Int: Mm
Par: It's not until after the fact
Int: Yeah
Par: that you know that at that time .hh when I was feeling that lo::w that depressed
Int: Mm

Par: and that bad I really could have done with someone to just come along and said "it's gonna be
        alright"
Int: Mm
Par: "we're gonna help you and we're here and we're gonna do it now"
Int: Mm
Par: .hh because over that period of six weeks well I can't be that poorly I can't be that bad if they're
        not that worried about me they'd have done something sooner
Int: Mm
Par: you know and then in that six weeks you can become so much wo:rse and you .hh it it can be
        quite detrimental to your recovery period because you can sink into a further depressive state
Int: Mm
Par: and become .hh even more irrational more irrational behaviour

Secondly, services would be provided more flexibly; so, rather than being offered a set number
of appointments, provision is tailored to an individual's needs and appointments are more
frequent if required:

Int: Is there anything else that you would change?
Par: (4) erm I don't know really (3) (laughs) difficult to say
Int: Mm
Par: (3) erm (2) the number of appointments the the amount of time you're allocated on the NHS
        .hh to me at everybody with depression bi-polar any mental health issue everybody's different
        everybody recovers at a different rate

Par: The other thing is, I can't ring him up. It's again it's not ( ) I can't ring him up, and say, I need to
        talk to you. I, I've done that a couple of times and he has phoned me once back, but he, his his
        diary is always full. So it's not that easy access to something. Like I say, it's not like I can come
        here and go to a drop in centre and talk to somebody, there isn't there isn't nowt like that, I have
        to wait until I get the appointment and although it's great, he's there, but it, it's not available to
        me when I need it sometimes. Which means I have to manage, .h myself until I actually see
        him. I have to deal with the problems or try and deal with them I try and deal with them until I
        can actually get to see the Counsellor and that's difficult at times

Finally, whilst most offenders were extremely positive about the support that they had received
from probation, some felt that probation could have done more to facilitate access to services
for them:

Par: I, the Doc, well Probation Service itself, left it up to me to do it. So they didn't give me no
        contact numbers or, they just said I said I was going to go and see my doctor, they said yeah
        that's OK do that. So they didn't actually give me any information of where to go or or "well if
        you talk to this person then".
Par: I don't think they can give you what they should give you
Int: OK, it like you say, you you come out and you're homeless, have they provided you with any
        [help]?

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Par: [No], no. Not at all
Int: No help to get [accommodation].
Par: [Still homeless], still homeless. I have been for the last 17 years
Int: Right, OK

Summary

Staff and offenders discussed many positive experiences of accessing or facilitating access to services. These were often characterised by straightforward referral procedures, resulting in quick and easy access to services and flexible working on the part of health services, meaning that provision was tailored to an individual's needs rather than a 'one size fits all' approach being taken. Offenders stated that they valued services which took the time to listen to their needs, adopted a 'no pressure' approach to recovery and had a genuine desire to help them. In addition, many offenders highlighted how much they valued the ongoing support that they were receiving from probation — having someone to discuss their problems with was making a huge difference in their lives.

When asked what currently works to enable access to services for offenders, both probation staff and offenders discussed the idea of referrals from either probation or a GP as potential routes into services. In addition, probation staff also stated that sometimes they felt it was advantageous for an offender to self-refer to a service, as this would mean that they were then more likely to attend any appointments which they received. In addition, staff discussed the use of joint meetings with health service staff, and using the Health Support Service based within Lincolnshire Probation Trust as effective routes into services. Other enabling factors included establishing a good and honest relationship between an offender and a member of probation staff, so that staff are more likely to spot changes in behaviour which may indicate a problem, and offenders feel able to openly discuss health issues with probation staff. In addition, it was helpful if probation staff knew health services staff personally and thus had a set contact point for accessing a service. Moreover, some staff stated that they felt they had sufficient knowledge to recognise the signs and symptoms of mental health disorders and to know where to refer and how to refer a client. Finally, staff stated that access to services was aided if an offender was aware that they were in need of support with a health issue.

Some of the above topics were also raised in relation to barriers to service access for offenders under supervision. For example, both staff and offenders stated that having to access a service via a GP rather than through self-referral or through a direct referral from probation could be problematic at times. This could be because an offender is not registered with a GP and has not been for some time, or encounters difficulties in getting registered due to issues such as

homelessness. It could also be due to difficulties in getting an appointment to see a GP, or in an offender being able to express their needs clearly to a GP within the allocated timeslot. In addition, whilst some staff felt that they had sufficient knowledge to identify mental health problems and to make appropriate referrals, others felt that they would benefit from further training around mental health, ways of working with mentally ill individuals and the range of provision on offer to support individuals with mental health problems. Likewise, whilst a good relationship between an offender and probation could facilitate access to services, a poor relationship could act as a barrier to access.

Other factors which both offenders and staff identified were the need to travel large distances to access some services, poor communication between services, a lack of resources which meant that there was either no provision to meet particular individual's needs, or else only a limited number of appointments were offered/appointments were not felt to be frequent enough. In addition, health services were seen as inflexible in their provision, meaning that some offenders fell short of referral criteria or were discharged from services after missing just two appointments.

Staff also felt that in some cases, mental health professionals created barriers to service access for offenders as they were unwilling to accept clients with complex needs or to take responsibility for mental health treatment requirements on probation orders. Finally, staff also pointed to offenders' unwillingness or inability to engage in some cases, something which was also evident in the qualitative data collected from probation case files in Stage 2 of the research. Offenders also discussed unwillingness to ask for help or to engage with services which were offered.

When staff and offenders were asked what improvements could be made to further access to services for offenders, many of their suggestions built on the above themes. Thus they discussed the need for improved communication between agencies – with agencies having a greater understanding of each other's remits and a more straightforward framework for information sharing. Staff also discussed the idea of co-working cases as a means of improving communication between agencies and of improving compliance with both probation and health services. Some staff raised the idea of having specialist mental health and/or substance misuse workers based in probation that they could call on to discuss particular issues and to seek advice on making appropriate referrals. In addition, both staff and offenders pointed to the need to expand the range of health service provision on offer in some cases. In particular, there was felt to be a need for more local provision of some services, alcohol service provision for individuals with lower level need and for support for sex offenders once their contact with probation has ceased. Offenders also pointed to the need to reduce waiting lists for some services and for services to take more time to explain an illness to a client rather than simply giving them a

diagnosis/label that they don't understand.

Thus there are a number of possibilities on how access to services for offenders could be improved, and these are examined in more detail in the 'discussion' section of this report.

Stage 4

Aims

The fourth stage of the study is a sub-component of Stage 1 and consists of an investigation into the concurrent validity of a short screening tool for likely caseness of personality disorder (SAPAS) in a sub-sample of participants in the wider study. These individuals were screened using both SAPAS and the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) — the 'gold standard' measure for personality disorder.

Background

A systematic review published in 2002 of international surveys reporting on the presence of PD among prisoners estimated an overall global prevalence of 65%. The range of prevalence estimates in samples from different countries was relatively narrow, being between 61 and 68% (Fazel & Danesh, 2002). Despite the strong association between PD and imprisonment, there is very little work on the presence of PD in general probation populations. As has been shown, in England and Wales during 2008, there were around 83,000 people in prison and 147,000 under probation service supervision in England and Wales (Ministry of Justice, 2009). Thus, at any one time in the United Kingdom, those individuals attended by the probation service considerably outnumber those offenders actually in prison. A similar pattern is seen in the USA. In 2008, there were 5.1 million sentenced individuals under community supervision in the USA, compared with 2.3 million prisoners (Glaze & Bonczar, 2009).

As those under probation supervision are also living in and interacting with the general community, it is surprising that attempts at recognising and understanding PD in this population are not given higher priority. The general probation population might be expected to have a high rate of PD; however this issue has rarely been examined directly. A small number of studies have described PD in people under supervision, but these studies have been of particular groups, such as sex offenders or life sentenced individuals released on licence (e.g. Craissati, Webb & Keen, 2008; Taylor, 1986). In these selected samples, the reported prevalence of PD varies widely between 17% and 67% (Blumenthal, Craissati & Minchin, 2009; Craissati *et al.,* 2008; Dolan, Evans, & Norton, 1995; Taylor, 1986) — a variation which is likely to reflect the heterogeneity of populations sampled in these studies. By analogy, wide variations in the incidence of PDs are shown when highly selected or opportunistic prisoner samples are compared (Sirdifield, Gojkovic, Brooker & Ferriter, 2009).

High rates of PD among the general probation population could be inferred from those studies

of the general prison population (e.g. Roberts, Yang, Zhang & Coid, 2008, Ullrich *et al.*, 2008). However, individuals supervised by probation services will generally have committed less serious offences than those in prison. Furthermore, probationers are not exposed to the prison environment, which itself can exacerbate underlying personality difficulties (Rotter, Way, Steinbacher, Sawyer & Smith, 2002). For these reasons we cannot assume that the prevalence of PD amongst prisoners is equal to the prevalence among probationers.

The presence of PD among offenders negatively impacts on engagement with prison mental health services (McMurran & Ward, 2010) and is likely to have a similar negative impact on attendance and engagement with probation services. Moreover, PD (in the form of psychopathy) is an important predictive variable of future recidivism (Hare, Clark, Grann & Thornton, 2000). For these reasons alone, there is a good rationale for identifying the presence of personality pathology in probation populations. A recent development in personality assessment has been the advent of 'mini-interviews', such as the Standardised Assessment of Personality-Abbreviated Scale (SAPAS; Moran, Leese, Lee, Walters, Thornicroft, & Mann 2003). This is a brief 8-item screen that is simple to use and displays good psychometric performance as a screening measure. The SAPAS has been validated for use in general psychiatric samples and also among those with substance dependence (Hesse, Rasmussen & Pedersen, 2008; Hesse and Moran, 2010). However, it has not been validated for use in forensic settings. In this study, the concurrent validity of the SAPAS was examined in a sample of UK probationers, in order to evaluate its potential utility for use in the probation system.

Method

Sample Selection

One of the researchers (GP) assessed a consecutive series of 40 cases for PD and data presented here in Stage 4 are based on this sub-sample of 40 individuals. The mean age of the probationers in the subsample was 36.2 (range 18-80, SD=14.2) and 34/40 (85%) were male. Age and gender demographics were not significantly different from those of the larger sample. The most common recorded offence in the subsample was violence against the person, committed by 13/40 (32.5%) of the sample. The next most common offence types were, robbery/ burglary/theft (8/40, 20%), drug offences (3/40, 7.5%) and sexual offences (3/40, 7.5%). The length of probation orders ranged from four months to one open-ended order for a life sentence prisoner released on licence; the median length of probation order was 16 months.

Measures

All participants were assessed with the SAPAS which is fully described in Stage 1 (page 33). All 40 participants were also interviewed with the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First, Gibbon & Spitzer, 1997). This is a comprehensive 119-item structured clinical interview which allows clinical criteria-based identification of the ten PDs listed in DSM-IV (American Psychiatric Association, 2000). The SCID-II takes around 60 minutes to complete.

Procedure

All subjects gave informed consent as detailed in Stage 1 above. Participants were initially approached and recruited by probation staff and all but two were interviewed at their probation office; two were interviewed in their homes. All clients were assessed with the SAPAS at the beginning of the interview, and the SCID-II at the end. This was done deliberately as we were keen to eliminate the possibility of knowledge of SCID-II status biasing the SAPAS assessment.

Analysis

The primary aim of this sub-study was to determine the optimal cut-off score on the SAPAS for predicting a DSM-IV diagnosis of PD. To this end, sensitivity, specificity, overall accuracy and positive predictive values were calculated for various cut-off scores on the SAPAS. A receiver operator characteristic (ROC) curve analysis was also performed to assess its ability to predict the presence of DSM-IV PDs on the SCID-II. All statistical procedures were carried out using SPSS 14.0.2 (SPSS Inc, Chicago, IL).

Findings

Overall 30/40 (75%) of the sample met DSM-IV criteria for at least one PD on the SCID-II and multiple diagnoses were common. Of the 30 who were positive for any PD, the mean number of PD diagnoses was 2.2 (SD=1.5, range=1-7). The most common PD in this sample was antisocial PD, with 20/40 (50%) of the cases scoring positively. Other common disorders were schizotypal PD, for which 9/40 (22.5%) cases were positive, similarly 9/40 (22.5%) were positive for paranoid PD. Borderline PD was also relatively common (8/40, 20%).

Using the general psychiatric cut-off score on the SAPAS of three to dichotomise into those

probable with and those probable without PD, the prevalence in the sample was estimated at 23/40 (58%). The kappa for these dichotomised SAPAS scores compared with the SCID-II was .51, which would indicate 'good' agreement between the two assessment tools (Pines & Everett, 2008). To investigate alternative cut-off scores of the SAPAS, sensitivity, specificity, positive predictive value and the percentage correctly classified on a range of cut-offs were calculated, these are shown in Table 12 below.

Table 12. *Sensitivity, specificity, positive predictive value and overall accuracy of different cut-off scores on the SAPAS at identifying Personality Disorder in the probation sample*

Cut-off score	Sensitivity	Specificity	Positive predictive value	% Correctly classified
1	1.0	0.4	0.86	85
2	0.9	0.6	0.87	83
3	0.73	0.9	0.96	78
4	0.47	0.9	0.93	58
5	0.2	1.0	1.0	15

Although the suggested cut-score of three did not have the greatest overall accuracy, this score provided the best balance between sensitivity (.73) and specificity (.9). To further investigate the correspondence between the SAPAS and the SCID-II, a ROC curve analysis was performed. The plot of the true positive rate against the false positive rate revealed an area under the curve of .87 (95% CI: .76-1.0).

Discussion

The purpose of the current investigation was to examine the psychometric properties of the SAPAS in a probation population. The suggested cut-score for identification of cases in general psychiatric contexts is a score of three or more on the SAPAS (Moran *et al.*, 2003). We have confirmed that this cut-score is also appropriate for use with the probation population. A score of three or more has an overall accuracy of 78% and good sensitivity (.73) and specificity (.9). Also of interest is the high positive predictive value of .96, which would be of use if the SAPAS were to be used as a routine screen by probation services. The observed positive predictive value indicates that when an individual scores three or more on the SAPAS, one can be 96% confident that a correct identification of PD has been made.

Although a cut-score of three is recommended in this report, a case could also be made for using a cut-score of two. This would be appropriate if the particular use of the SAPAS called for a greater emphasis on not missing true cases of PD. We found that a cut-score of two has a sensitivity of .9 and would adequately fulfil this function. However, this increase in sensitivity is gained in the context of a drop in specificity to .6 and in positive predictive value to .87. Nevertheless, this alternative cut-score of two could be appropriate in some contexts and is in accordance with proposed criteria for screening tools which suggest that they should optimally have a sensitivity of >.8 and a specificity of >.5 (Bagby, Rogers & Buis, 1994).

The observed relationship between the SAPAS and the SCID-II, as represented by the area under the curve of a ROC analysis, is .87. Putting this statistic into context, a diagnostic test would be considered to have 'good' accuracy at disease identification if the area under the curve was between .80 and .89, and 'excellent' if above this (Pines & Everett, 2008).

In our sample, three-quarters of the probationers were positive for a PD with the gold standard SCID-II interview. Therefore, there may be a considerable number of personality disordered individuals within the UK national probation system. Our findings are broadly similar to studies of PD within the UK prison system, which have reported that about 66 to 73% of inmates score positive for any PD (Roberts *et al.*, 2008; Ullrich *et al.,* 2008) and also estimates of PD in the prison population worldwide of around 65% (Fazel & Danesh, 2002). Given that the SAPAS is an adequate screen of DSM-IV PDs as assessed by the SCID-II, screening for PD within probation services could easily be introduced with the SAPAS.

The ability to screen for PD however, raises the issues of whether it is necessary or even desirable in routine criminal justice settings. It has been argued that when routine screening is

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introduced there are often both harmful and useful consequences, and these should be evaluated in advance (Getz, Sigurdsson & Hetlevik, 2003). Considering the large numbers of people within the criminal justice system that would likely score positive, would this realistically alter their care or management? Furthermore, when labels of PD are applied these often have negative consequences for the person with the diagnosis. Many people with PD assert that their treatment deteriorates after receiving the description (Ramon, Castillo & Morant, 2001). Nevertheless, studies of people with PDs under probation supervision have reported that it is associated with a poor quality of life (Bouman, Van Nieuwenhuizen, Schene, & De Ruiter, 2008). Furthermore, a recent study on various PDs within the USA prison system found that PD in general was associated with suicide proneness and raised psychological distress (Lamis, Langhinrichsen-Rohling & Simpler, 2008). In addition to this, PD is an important predictor of recidivism (Hare *et al.*, 2000). In the light of this, we would argue that knowledge of a probationer's personality status provides invaluable prognostic information, and to ignore these factors could do the individuals and society as a whole a great disservice. Our study supplies evidence about the suitability of a particular screening tool and further research and debate may be needed on the potential benefit and harm of routinely screening for PD within the Criminal Justice System. Despite these difficult issues, given its brevity and ease of administration, we foresee no practical reason preventing the SAPAS from being successfully employed in a range of criminal justice settings.

Our findings need to be interpreted in the light of certain methodological limitations. First, we used a relatively small sample size, thus limiting the precision of our derived estimates. Second, for practical and economic reasons, the same researcher administered both the SAPAS and the SCID-II, raising the possibility of information bias. Given these constraints, we deliberately chose to administer the SAPAS first, in order to ensure that SAPAS assessment was uncontaminated by knowledge of SCID-II status. It is possible that the reverse phenomenon may have occurred, i.e. contamination of SCID-II assessment by knowledge of SAPAS status. However, we think this is unlikely, given the semi-structured nature of the SCID-II. Our results provide evidence of the concurrent validity of the SAPAS as a screen for DSM-IV PDs in samples of probationers. In addition, although preliminary, our findings suggest that the SAPAS is a valid screening tool of PDs in general forensic contexts and is potentially of value to those working in the Criminal Justice System.

Discussion

The overall aim of this study was to pilot a methodology for assessing the prevalence of mental health disorders and/or substance misuse in a sample of offenders serving probation orders (Stage 1). Once a case was determined probation staff's notes were examined to check whether the probation service was aware of the diagnosis/condition and furthermore whether the probationer was receiving appropriate treatment/intervention (Stage 2). Qualitative interviews were also undertaken with probation staff and probationers in order to elicit factors that promoted or hindered access to mental health/substance misuse services (Stage 3). A more technical study was nested within the prevalence study in Stage 1 this aimed to examine the psychometric properties of SAPAS to detect personality disorder in a probation sample.

Limitations of the Study

Very little research has ever been undertaken to ascertain the extent to which community-based offenders experience mental health disorders (see review pages 21 – 23). The primary aim of this pilot study was to examine methodological issues which might arise when engaging with this population. We originally predicted a prevalence of 50% for all mental illness, and knew that a random sample of 1 in 7 of the Lincolnshire probation sample, would give our final estimate a precision of +/- 6% for 95% confidence intervals. The data collection team experienced severe problems in recruiting to the study (the reasons for this are detailed on page 35-37). At the end of the timetabled data collection phase we had only recruited 117 out of the 228 target sample despite strenuous efforts. A four-month extension was obtained which allowed the team to obtain a further 56 interviews leading to a final sample of 173.

The study setting was not in any way representative of the UK (nor was it intended to be). The county is highly rural, deprived (leading to reduced employment opportunities for example), probation offices are dispersed widely, and unusually the probation service runs its own Health Support Service which has been regarded as a national model. In addition, probation staff had participated in a countywide training programme in mental health two/three years previously. Nonetheless, the random sampling procedure ensured that, in terms of initial selection, the 173 selected were representative of the Lincolnshire Probation population (see Table 2).

Nonetheless we examined the position in Lincolnshire in relation to the known prevalence of mental health disorders throughout England, and drug misuse aside, most indices of mental ill health in the county were lower than for the country as a whole[6].

Clearly if this study were to be repeated, perhaps on a national scale, research resources would need to be increased so that either more interviewers were available or the period for recruitment is extended. Engagement with this sample involved high levels of commitment from the research team: the administrator was in constant phone communication with the probation area teams; the researchers moved instantly once an interview was confirmed (sometimes great distance was involved); and despite the inducement of a Tesco Voucher the probationers often found the interview lengthy (although it usually took an average of 48 minutes).

The main diagnostic tool that we employed was the MINI (Mini International Neuropsychiatric Interview). Our interviewers were trained by an American expert in the use of the tool but despite several discussions in the Steering Group about how we might formally assess inter-rater reliability we were unable to do this. It should be noted, however, that no research team that has ever used the tool has ever reported a method for formally obtaining such agreement. This includes a team led by Keith Hawton at Oxford that has recently reported prison research that has looked at near-fatal suicides (Marzano *et al.*, 2010).

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6 The Lincolnshire's 'area index' for mental health needs is scored is 0.946 - very slightly lower than the UK average (EMPHO, 2011). If the mental health incapacity benefit rate for Lincolnshire is examined again the rate for Lincolnshire is slightly lower than for England as a whole (22.9 vs 27.6). A similar pattern emerges for 'binge drinking' where the proportion of binge drinkers in Lincolnshire is lower than England as a whole (15.7% vs 20.1%).

In terms of drug-related a recent DAAT report states that "Lincoln and Boston are reported to have a higher rate of offences per 1000 population than the county rate, Boston is almost triple the county rate and equates to 23.5% of all drugs offences in Lincolnshire". The local DDAT thus made it a key priority in 2009/10 to "further develop the pathway for dual diagnosis with the mental health services to improve access, treatment and engagement of service users who have co-morbid needs" (p5).

There were also limitations to Stage 2 of the study. It was clear that when probation staff recorded that an individual on their caseload had a mental illness, they were unlikely to use the same diagnostic terminology employed on the MINI in Stage 1 of this study. Thus, there was a small degree of subjectivity when investigating whether or not probation had a record of a specific type of disorder. Secondly, due to the time gap between the commencement of Stage 1 and Stage 2 of the study, some files had been stripped for archiving prior to data collection. This meant that the researchers were not able to access the full range of data collated by the probation service during the course of an individual's community order. Thus the analysis was adapted to reflect any potential differences between 'complete' and 'incomplete' file data.

Although not strictly a limitation, in the qualitative interviews carried out in Stage 3 it should be pointed out that the interviews were undertaken jointly by both by trained researchers (n=2) and service users (n=2). The researchers collected data as one interview team as did the service users. In the final analysis of these data we report the probationer and staff interviews each as one data set although some interviews were undertaken by researchers and some by service users. It has been speculated previously that service user interviews encourage more open and honest responses to interviews questions (Simpson and House, 2002). If we were to repeat the study we might organise this differently and ensure that the service users collected all the data from offenders, for example.

The Prevalence of Mental Health Disorders in Probation

There have been few studies that have examined the prevalence of mental health disorders in a probation setting. The studies that exist are summarised in the Table 13 overleaf. The Lincolnshire information is by far the most complete to be reported yet as the Table demonstrates.

*Table 13: Studies of mental health prevalence in probation settings*

Author	Setting	Method	Proportion of the Sample with a Mental Illness
Geelan S, Griffin N and Briscoe J, (1998)	A profile of residents at Elliott House, the first approved bail and probation hostel specifically for mentally disordered offenders	Examination of existing records for male residents	81% of cases had a current diagnosis
Hatfield B, Ryan T, Pickering L, Burroughs H and Crofts R, (2004)	The mental health of residents of approved premises in the Greater Manchester probation area	Questionnaires completed by staff	25.1% had a known diagnosis
Huckle P, Travier T and Scarf S, (1996)	Psychiatric clinics in probation offices in South Wales	Clinical diagnoses made by psychiatric clinic staff, method of diagnosis unknown	Not reported
Collins P, Ball H and Costello A (1993)	The psychiatric probation clinic	Diagnoses made by Psychiatrist at the probation clinic, method of diagnosis unknown	Not reported
Cohen, A, Bishop, N, Hegarty, M, (1999),	A mental health worker scheme in a probation service in Wandsworth	Forms completed by a Mental Health Worker	47% one previous diagnosis 19% multiple previous diagnoses
Pritchard C, Cox M and Cotton A, (1990)	Analysis of Young Adult Clients in Probation and Social Service Caseloads: A Focus on Illegal Drugs and H.I.V Infection,	Questionnaires completed by staff	Mental disorder was identified as a problem in 25% of cases
Pritchard C, Cotton A, Godson D, Cox M and Weeks S (1991)	Mental Illness, Drug and Alcohol Misuse and HIV Risk Behaviour in Young Adult (18-35 Year) Probation Clients.	Questionnaires completed by staff	21% had recently been treated by a GP or Psychiatrist for a mental illness
Lurigio AJ, Cho YI, Swartz JA, Johnson TP, Graf I and Pickup L, (2003)	Standardized Assessment of Substance-Related, Other Psychiatric, and Comorbid Disorders Among Probationers,	MINI diagnoses	Not reported
Brooker C, Fox C, Barrett P, and Syson-Nibbs L, (2008) A Health, University of Lincoln	Nottinghamshire and Derbyshire Probation Services	Structured Interviews and use of the SF-36	27% had been referred to mental health services (15% in the last year) 42% at risk of substance misuse
This study (2009-11)	Lincolnshire Probation	MINI diagnoses and screening tools for PD, alcohol and drug misuse	38.7% current mental illness 48.6% any diagnosis ever Likely PD 47.4% 55.5% likely hazardous drinking 12% substantial /severe drug misuse

However, whilst this information has been much needed, the caveats about the sample size, the generalise-ability of this sample from Lincolnshire, and the lack of inter-rater reliability in the use

of the MINI all need to be borne in mind.

How do the prevalence estimates that have been yielded by this study compare both with a prison population and the general population? Figure 6 below gives this comparison using the data from this study, the ONS survey of psychiatric morbidity in prisons (Singleton *et al.*, 1998), and the general population (Singleton *et al.*, 2001).

Figure 6:   *Comparison of the rates of mental illness in the general population, prisons and the Lincolnshire probation sample.*
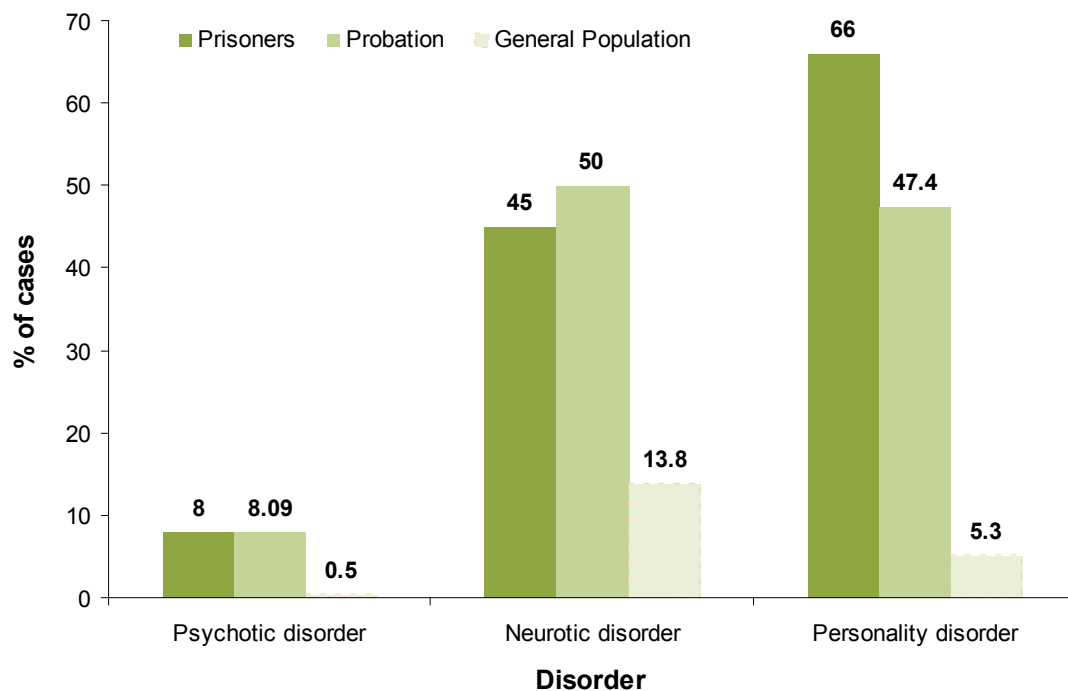
The comparison clearly shows that the profile of mental illness for probation in Lincolnshire allies more closely to the prison population than to the general population and as a consequence the estimates are high for depression, psychosis, and personality disorder. In addition to the overall prevalence of 38.7% for all current mental illnesses the lifetime prevalence for mental illness for the Lincolnshire sample was 48.6% with 18.5% experiencing psychosis at some point in their lives compared to 3.5% in the general population (Perala *et al.*, 2007).

Previous studies of the prevalence of mental health disorders in prison populations have all

pointed to the complexity of presentations and co-morbidity of mental illness with substance misuse and personality disorder (see Sirdifield *et al.*, 2009 for a review). This Lincolnshire sample exhibited many of the same features. Over half the group (55.5%) had an AUDIT score of 8+ indicating a strong likelihood for hazardous drinking. The cut-off score to access alcohol services in the local Mental Health Trust is 10 with 44.5% attaining this score. A much smaller proportion, 12%, indicated a severe level of drug abuse using a cut-off score of 11+ on the DAST. Table 6 demonstrates the strong associations with substance misuse and mental illness. Furthermore, the data show how much more common alcohol problems are in combination with a mental illness with alcohol about three times more likely than drugs. Nearly three quarters of this sample had a substance misuse problem in tandem with a mental illness. These figures mirror those found in prisons (Singleton *et al.*, 1999) male remand (71%); male sentenced (59%); female remand (87%) and female sentenced (77%). The association between personality disorder and mental illness was similarly strong with a likely PD in 89.4% of all those with a mental illness compared to 36.6% in those without a mental illness.

*The Psychometric Properties of SAPAS in a Probation Population*

We say 'likely' PD advisedly as one of the sub-studies nested within the overall design was to examine the performance of SAPAS, an eight item screening tool, designed to elicit the likely caseness of PD which has been validated (Moran *et al.*, 2003). This sub-study is reported here as Stage 4 (see pages 134 – 137). Briefly, the Bradley Review (2009) noted that probation staff lacked the means to identify not only mental illness but also PD (a lack of recognition which has obvious implications for the community management of offenders). In this smaller study we investigated the performance of SAPAS against the gold standard assessment of PD, SCID II with forty cases. We concluded that the same cut-off scores recommended for use in general psychiatric settings (3+) was appropriate for use with the probation population where the accuracy, sensitivity and specificity were all high. That 75% of our sample could be classified as suffering from a PD suggests there are many such people throughout probation services in the UK and a similar proportion to those with PD in prisons (Fazel and Danesh, 2002). We agree with Bradley that detecting PD in probation is an important issue especially as Bouman *et al.* (2008) have shown that those with PD under probation supervision experience a poorer quality of life. SAPAS, given the brevity and ease of administration, could and should be routinely used in probation settings and wider afield in the Criminal Justice system.

The Needs of Offenders with Mental Illness

The CANFOR-S (25-item version) developed by the Institute of Psychiatry was used to assess

self-reported needs both met and unmet. The original instrument was used to assess the needs of service users with a serious mental illness (SMI) and we used the version developed for use with those accessing forensic services with an SMI. The data presented in Table 8 on page 47 clearly show that in our sample the needs of probationers with a mental illness are significantly higher than for those under probation supervision that do not have a mental illness. The CANFOR-S has been used in many other studies both in the general mental health context and in forensic settings. It's useful to compare the self-reported levels of need of offenders under supervision in Lincolnshire with other groups. This comparison is to be found in Figure 7 below.

Figure 7: Comparison of mean 'Met', 'Unmet' and 'Total' CANFOR scores in different populations
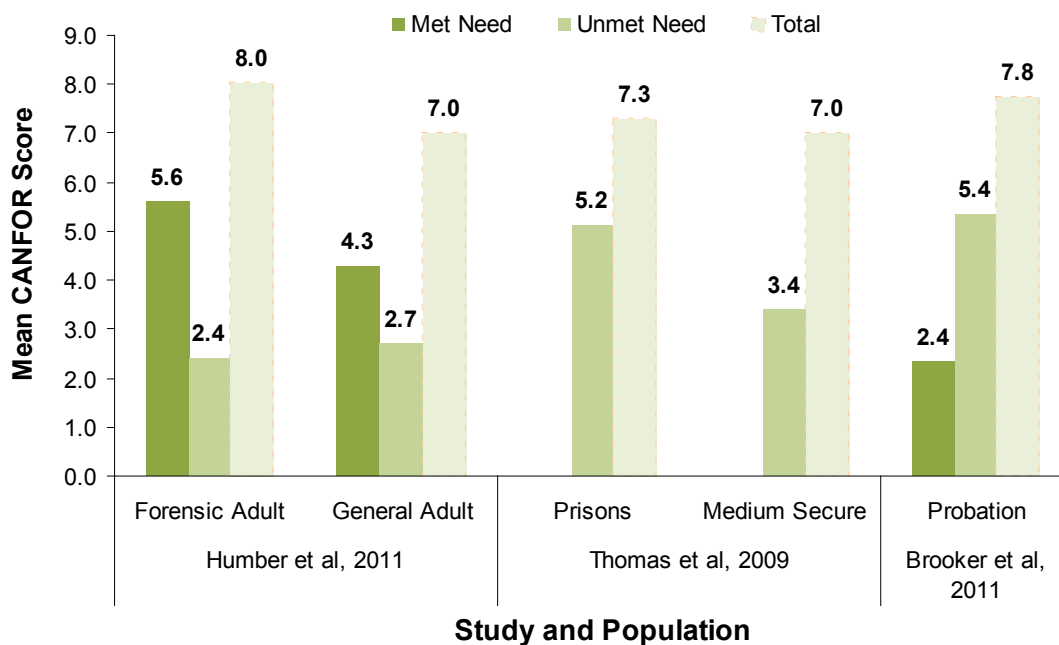
The chart above shows that overall offenders under supervision have comparable levels of need to offenders located in other areas of the criminal justice system. In addition, we know that when individual items of the CANFOR-S are examined more closely there are a cluster of needs that might have been predicted that remain unmet. A significant proportion of these relate directly to being an offender with a mental health disorder, and are either clinical (psychological distress, psychotic symptoms, safety to self, alcohol) or social (daytime activities, information about condition, company or money) in origin. We would argue that many of these needs might be better met if these probationers were connected to the appropriate services as all those in the graph above have lower unmet needs when in NHS care than when somewhere in the criminal justice system.

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Access to Mental Health Services for those on Probation with either a Past or Current Mental Illness

We collected and analysed data about probationer's mental health service use from a variety of perspectives: the CSSRI-EU and an interrogation of the probation files in Stage 2 which yielded both quantitative and qualitative data. It is clear from all this information that probationers find it problematic to access appropriate mental health services. In order for a probation officer to attempt to refer a client to a mental health service they need the skill to recognise that such a problem exists and our analysis of case files demonstrates that this recognition varies by type of disorder. Depression is recognised in nearly three-quarters of identified cases but thereafter the ability to detect a mental health disorder declines steeply from 47% of anxiety disorders, 33% of psychosis, no eating disorders (there were only four cases) and finally 21% of personality disorders are recognised. Interestingly for substance misuse the recognition was much higher —83% of drug problems and 79% of alcohol problems. This might be because there are more obvious direct links between substance misuse and offending compared to other mental illnesses. The Bradley report suggests that mental health training is urgently required by probation officers but we have been involved in a major initiative across the East Midlands that shows that the impact of short post-qualifying training soon 'washes out' (Sirdifield *et al.*, 2010). Our belief is that it would be far more sensible to ensure that POs receive mental health training in their pre-qualifying programme and that this is regularly updated.

There were clear observable differences in the information collected by researchers about mental health service access and the information recorded in probation files and these have been laid out in depth in the report (see Stage 2). In a third of cases probationers told researchers that they were accessing services that were not recorded in the files. However, in many cases there was appropriate information.

Qualitative data was collected from the probation case files (every fifth case) on potential barriers to accessing mental health services and one key theme that arose was that of the offender's motivation to obtain treatment/interventions. In all the cases we quote as examples it was referral to substance misuse services where this issue arose. There were, however, particular problems for people with both a substance misuse problem and a mental illness, i.e. a dual diagnosis. Here, services themselves created the barriers with exacting referral criteria.

Finally we interviewed probation staff and offenders about their experience of mental health services. The themes above were amplified by this interview data. Both staff and offenders described many good experiences of accessing a mental health service. In these instances,

referral was straightforward often through a GP; services were flexible; offenders felt staff created good relationships; but valued the on-going nature of their relationship with a PO. On the other hand, key issues for PO's were that the offender recognised that they had a mental health problem; knowing mental health staff personally; and the use of the probation health service.

Barriers to accessing mental health services were also cited by interviewees. The fact that most referrals had to be expedited to mental health services was problematic for offenders especially those that were homeless. Occasionally services were provided at great distance and there could be lack of resources meaning that the frequency of appointments was fixed, i.e. six sessions. There was feeling from probation staff particularly that mainstream mental health services were unwilling to accept clients with complex needs or to take responsibility for mental health treatment order requirements.

A range of ways in which services might be improved were outlined. Co-working was cited as one way in which communication might be improved. It was felt that specialist mental health and/ or substance misuse workers should be based within probation itself maybe in the Probation Health Support Service. This would improve access but also provide the local educational expert resource so badly needed. In a number of probation services in England such developments have already occurred within the context of implementation of the Bradley report.

Conclusion

We recognise that Lincolnshire does not represent the country and that here might be a danger of over-generalisation in reporting this study. This research though has elucidated many issues that will be helpful for other researchers in the future. Although the study might have limitations, we have shown that the prevalence of mental health disorder in probation is high, many needs are unmet, service access can be problematic with mainstream services often creating barriers to deny access to offenders who present with complex needs. In addition, offenders themselves might be ambivalent themselves about interventions. Maybe we should not be surprised by these findings. Unlike other elements of the criminal justice system, historically, probation has not benefitted from direct central investment in mental health service improvement unlike the courts (court diversion) or prison services (prison in-reach). Indeed in many ways the previous mental health skills of the probation workforce have been gradually lost as a generic training programme, where mental health is not emphasised, has replaced the former post-qualifying social work course.

What we believe is clear is that mental health issues for those under probation supervision require a much higher priority in terms of service delivery, education, and research. Writing over sixty years ago (but with considerable contemporary resonance), Mullins (1949) commented on the relative success of treatment programmes at the Tavistock and Institute of Psychiatry for those serving supervision orders:

> 'Both these organisations were typical of English institutions; they were built on faith, enthusiasm, and an ardent conviction that plenty of neurotics and psychotics, even when they are criminals, can be cured while they remain at liberty. This lesson has now been learned by the State and it is now for the courts to make full use of their powers..........'

(page 59)

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Appendices

Appendix A – Letter of Ethical Approval from Nottingham LREC

NHS

National Research Ethics Service

Nottingham Research Ethics Committee 1

1 Standard Court
Park Row
Nottingham
NG1 6GN

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02 March 2009

Prof Charlie Brooker
Professor of Mental Health and Criminal Justice
HLSS, University of Lincoln
Brayford Pool
Lincoln, LN6 7TS

Dear Prof Brooker,

Full title of study:	**An Investigation into the Prevalence of Mental Health Disorder and Patterns of Health Service Access in a Probation Population**
REC reference number:	**08/H0403/151**

Thank you for your letter of 11 February 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Appendix B – Analysis of Subgroups

Table 14: Current Disorders by Gender

Disorder	Males (n=150)			Females (n=23)		
	N	%	CI (95%) (%)	N	%	CI (95%) (%)
Mood disorders						
Major depressive episode	22	14.7	9.0-20.3	3	13.0	0.0-26.8
Mania (manic episode/ hypomanic episode)	4	2.7	0.1-5.2	0	0.0	N/A
Any mood disorder	23 (28)	15.3 (18.4)	9.6-21.1 (11.4-28.4)	3 (3)	13.0 (13.0)	0.0-26.8 (2.6-45.8)
Anxiety disorders						
Panic disorder	2	1.3	0.0-3.2	0	0.0	N/A
Agoraphobia	17	11.3	6.3-16.4	0	0.0	N/A
Social anxiety	11	7.3	3.2-11.5	0	0.0	N/A
Generalised anxiety	4	2.7	0.1-5.2	2	8.7	0.0-20.2
OCD	2	1.3	0.0-3.2	1	4.4	0.0-12.7
PTSD	8	5.3	1.7-8.9	0	0.0	N/A
Any anxiety disorder	34 (43)	22.7 (28.8)	16.0-29.4 (19.3-40.5)	3 (3)	13.0 (13.0)	0.0-26.8 (2.6-45.8)
Psychotic disorders						
With mood disorder	5	3.3	0.5-6.2	0	0.0	N/A
Without mood disorder	9	6.0	2.2-9.8	0	0.0	N/A
Any psychotic disorder	14 (19)	9.3 (12.4)	4.7-14.00 (6.6-22.0)	(0) N/A	0.0 (0.0)	N/A
Eating disorders						
Anorexia nervosa (including binge eating/ purging type)	0	0.0	N/A	0	0.0	N/A
Bulimia nervosa	4	2.7	0.1-5.2	0	0.0	N/A
Any eating disorder	4 (9)	2.7 (5.7)	0.1-5.2 (1.8-16.4)	0 (N/A)	0.0 (0.0)	N/A
Any current mental illness	43 (74)	28.7 (49.1)	21.4-35.9 (29.1-53.7)	4 (4)	17.4 (17.4)	1.9-32.9 (3.8-52.9)
Personality disorder	70	46.7	38.7-54.7	12	52.2	31.8-72.6

Table 14: Proportions are calculated out of 150 for males and 23 for females (i.e. as a proportion of the whole sample rather than simply those completing the full screening). For the major diagnostic categories, weighted prevalence figures are shown in brackets – to account for false-negatives on PriSnQuest

Table 15: Past/Lifetime Disorders by Gender

Disorder	Males (n=150)			Females (n=23)		
	N	%	CI (95%) (%)	N	%	CI (95%) (%)
Mood disorders						
Major depressive episode past	54	36.0	28.3-43.7	8	34.8	15.3-54.3
Recurrent depressive episode	32	21.3	14.8-27.9	5	21.7	4.9-38.6
Mania (manic episode past/hypomanic episode past)	19	12.7	7.3-18.0	0	0.0	N/A
Any mood disorder	58 (67)	38.7 (44.8)	30.9-46.5 (32.7-57.5)	8 (8)	34.8 (34.8)	15.3-54.3 (8.1-76.4)
Anxiety disorders						
Panic disorder lifetime	15	10.0	5.2-14.8	2	8.7	0.0-20.2
Psychotic disorders						
With mood disorder lifetime	14	9.3	4.7-14.0	2	8.7	0.0-20.2
Without mood disorder lifetime	11	7.3	3.2-11.5	0	0.0	N/A
Any psychotic disorder	25 (30)	16.7 (19.8)	10.7-22.6 (12.4-29.8)	2 (2)	8.7 (8.7)	0.0-20.2 (1.4-38.5)
Any past/lifetime disorder	64 (75)	42.7 (49.8)	34.8-50.6 (36.8-62.8)	8 (8)	34.8 (34.8)	15.3-54.3 (8.1-76.4)

Table 15: Proportions are calculated out of 150 for males and 23 for females (i.e. as a proportion of the whole sample rather than simply those completing the full screening).

For the major diagnostic categories, weighted prevalence figures are shown in brackets – to account for false-negatives on PriSnQuest

Table16: Current Disorders by Imprisonment

Disorder	Been to Prison (n=108)			Never Been to Prison (n=65)		
	N	%	CI (95%) (%)	N	%	CI (95%) (%)
Mood disorders						
Major depressive episode	14	13.0	0.1-19.3	11	16.9	0.1-26.0
Mania (manic episode/ hypomanic episode)	2	1.9	0.0-4.4	2	3.1	0.0-7.3
Any mood disorder	15 (19)	13.9 (17.5)	0.1-20.4 (9.9-29.2)	11 (11)	16.9 (16.9)	0.1-26.0 (7.8-33.0)
Anxiety disorders						
Panic disorder	2	1.9	0.0-4.4	0	0.0	N/A
Agoraphobia	14	13.0	0.1-19.3	3	4.6	0.0-9.7
Social anxiety	7	6.5	0.0-11.1	4	6.2	0.0-12.0
Generalised anxiety	2	1.9	0.0-4.4	4	6.2	0.0-12.0
OCD	2	1.9	0.0-4.4	1	1.5	0.0-4.5
PTSD	8	7.4	0.0-12.4	0	0.0	N/A
Any anxiety disorder	27 (35)	25.0 (32.3)	0.2-33.2 (21.2-45.8)	10 (10)	15.4 (15.4)	0.1-24.2 (7.2-30.8)
Psychotic disorders						
With mood disorder	2	1.9	0.0-4.4	3	4.6	0.0-9.7
Without mood disorder	7	6.5	0.0-11.1	2	3.1	0.0-7.3
Any psychotic disorder	9 (13)	8.3 (12.0)	0.0-13.6 (5.7-23.5)	5 (5)	7.7 (7.7)	0.0-14.2 (2.8-19.5)
Eating disorders						
Anorexia nervosa (including binge eating/purging type)	0	0.0	N/A	0	0.0	N/A
Bulimia nervosa	3	2.8	0.0-5.9	1	1.5	0.0-4.5
Any eating disorder	3 (3)	2.8 (2.8)	0.0-5.9 (0.8-8.5)	1 (10)	1.5 (14.6)	0.0-4.5 (2.6-52.8)
Any current mental illness	33 (45)	30.6 (41.5)	0.2-39.2 (28.6-55.7)	14 (23)	21.5 (34.6)	0.1-31.5 (15.1-61.1)
Personality disorder	57	52.8	43.4-62.2	25	38.5	26.6-50.3

Table 16: Proportions are calculated out of 108 for those who have been to prison and 65 for those who have not been to prison (i.e. as a proportion of the whole sample rather than simply those completing the full screening).

For the major diagnostic categories, weighted prevalence figures are shown in brackets – to account for false-negatives on PriSnQuest

Table 17: Past/Lifetime Disorders by Imprisonment

Disorder	Been to Prison (n=108)			Never Been to Prison (n=65)		
	N	%	CI (95%) (%)	N	%	CI (95%) (%)
Mood disorders						
Major depressive episode past	40	37.0	0.3-46.1	22	33.9	0.2-45.4
Recurrent depressive episode	25	23.2	0.2-31.1	12	18.5	0.1-27.9
Mania (manic episode past/ hypomanic episode past)	12	11.1	0.1-17.0	7	10.8	0.0-18.3
Any mood disorder	42 (46)	38.9 (42.5)	0.3-48.1 (29.8-56.3)	24 (33)	36.9 (50.0)	0.3-48.7 (25.1-74.9)
Anxiety disorders						
Panic disorder lifetime	11	10.2	0.0-15.9	6	9.2	0.0-16.3
Psychotic disorders						
With mood disorder lifetime	11	10.2	0.0-15.9	5	7.7	0.0-14.2
Without mood disorder lifetime	8	7.4	0.0-12.4	3	4.6	0.0-9.7
Any psychotic disorder	19 (23)	17.6 (21.2)	0.1-24.8 (12.8-33.2)	8 (8)	12.3 (12.3)	0.0-20.3 (5.2-26.3)
Any past/lifetime disorder	47 (53)	43.5 (49.0)	34.2-52.9 (34.9-63.2)	25 (33)	38.5 (50.0)	26.6-50.3 (25.1-74.9)

Table 17: Proportions are calculated out of 108 for those who have been to prison and 65 for those who have not been to prison (i.e. as a proportion of the whole sample rather than simply those completing the full screening).

For the major diagnostic categories, weighted prevalence figures are shown in brackets – to account for false-negatives on PriSnQuest

Table 18: Current Disorders by Location

Disorder	Urban (n=117)			Non-Urban (n=56)		
	N	%	CI (95%) (%)	N	%	CI (95%) (%)
Mood disorders						
Major depressive episode	17	14.5	8.1-20.9	8	14.3	5.1-23.5
Mania (manic episode/ hypomanic episode)	0	0.0	N/A	4	7.1	0.4-13.9
Any mood disorder	18 (24)	15.4 (20.3)	8.9-21.9 (11.1-34.0)	8 (8)	14.3 (14.3)	5.1-23.5 (6.7-28.0)
Anxiety disorders						
Panic disorder	2	1.7	0.0-4.1	0	0.0	N/A
Agoraphobia	15	12.8	6.7-18.9	2	3.6	0.0-8.4
Social anxiety	7	6.0	1.7-10.3	4	7.1	0.4-13.9
Generalised anxiety	3	2.6	0.0-5.4	3	5.4	0.0-11.3
OCD	1	0.9	0.0-2.5	2	3.6	0.0-8.4
PTSD	6	5.1	1.1-9.1	2	3.6	0.0-8.4
Any anxiety disorder	25 (36)	21.4 (31.1)	13.94-28.79 (18.9-46.8)	12 (12)	21.4 (21.4)	10.68-32.18 (11.2-37.0)
Psychotic disorders						
With mood disorder	3	2.6	0.0-5.4	2	3.6	0.0-8.4
Without mood disorder	6	5.1	1.1-9.1	3	5.4	0.0-11.3
Any psychotic disorder	9 (9)	7.7 (7.7)	2.9-12.5 (3.8-15.0)	5 (9)	8.9 (16.1)	1.5-16.4 (5.9-36.8)
Eating disorders						
Anorexia nervosa (including binge eating/ purging type)	0	0.00	N/A	0	0.00	N/A
Bulimia nervosa	2	1.7	0.0-4.1	2	3.6	0.0-8.4
Any eating disorder	2 (2)	1.7 (1.7)	0.0-4.1 (0.4-6.8)	2 (6)	3.6 (10.7)	0.0-8.4 (2.7-34.4)
Any current mental illness	31 (42)	26.5 (36.2)	18.5-34.5 (23.0-51.9)	16 (24)	28.6 (42.9)	16.7-40.4 (24.7-63.2)
Personality disorder	55	47.0	38.0-56.1	27	48.2	35.1-61.3

*N.B. A total of 8 participants were either homeless or refused to answer this question

Table 18: Proportions are calculated out of 117 for those who are urban and 56 for those who are non-urban cases (rural and urban/rural fringe cases) (i.e. as a proportion of the whole sample rather than simply those completing the full screening). For the major diagnostic categories, weighted prevalence figures are shown in brackets – to account for false-negatives on PriSnQuest

Table 19: Past/Lifetime Disorders by Location

Disorder	Urban (n=117)			Non-Urban (n=56)		
	N	%	CI (95%) (%)	N	%	CI (95%) (%)
Mood disorders						
Major depressive episode past	41	35.0	26.4-43.7	21	37.5	24.8-50.2
Recurrent depressive episode	25	21.4	13.9-28.8	12	21.4	10.7-32.2
Mania (manic episode past/hypomanic episode past)	4	3.4	0.1-6.7	0	0.0	N/A
Any mood disorder	44 (50)	37.6 (42.5)	28.8-46.4 (28.4-57.9)	22 (26)	39.3 (46.4)	26.5-52.1 (27.7-66.3)
Anxiety disorders						
Panic disorder lifetime	8	6.8	2.3-11.4	9	16.1	6.5-25.7
Psychotic disorders						
With mood disorder lifetime	11	9.4	4.1-14.7	5	8.9	1.5-16.4
Without mood disorder lifetime	7	6.0	1.7-10.3	4	7.1	0.4-13.9
Any psychotic disorder	18 (18)	15.4 (15.4)	8.9-21.9 (9.1-24.9)	9 (13)	16.1 (23.2)	6.5-25.7 (10.8-42.9)
Any past/lifetime disorder	47 (52)	40.2 (44.2)	31.3-49.1 (29.7-59.8)	25 (31)	44.6 (55.1)	31.6-57.7 (34.1-74.8)

*N.B. A total of 8 participants were either homeless or refused to answer this question

Table 19: Proportions are calculated out of 117 for those who are urban and 56 for those who are non-urban cases (rural and urban/rural fringe cases) (i.e. as a proportion of the whole sample rather than simply those completing the full screening).
For the major diagnostic categories, weighted prevalence figures are shown in brackets – to account for false-negatives on PriSnQuest

Appendix C – Stage Two Data Collection

Stage Two Data Collection Sheet

N.B. Please only examine files up to the date on which the individual was interviewed

1. MISAP Case Number _____
2. Date Interviewed   _____

3. Please record the answers to the following questions within the probation file:

a) SPORF: **(Please tick here if this form is NOT in the file ☐)**
Healthy Living Index:
Are you registered with a GP?   Yes☐ No☐ Not recorded ☐

Are you currently undergoing treatment or accessing another health service? Yes☐ No☐ Not recorded ☐
Are you currently taking any medications?   Yes☐ No☐ Not recorded ☐

Would you describe yourself as any of the following? *(tick as appropriate)* Depressed☐ Anxious☐ Stressed☐ None ☐
Do you use drugs other than prescription medication?   Yes☐ No☐ Not recorded ☐
What, how much, how often: _____

Overall how would you describe your mental health?   Good ☐ Fair ☐   Poor ☐   Not recorded ☐

UPW Appendix:
History of psychiatric illness?   Yes☐ No☐ Not recorded ☐

Treatment for depression/nervous disability?   Yes☐ No☐ Not recorded ☐

Alcohol or drug problem?   Yes☐ No☐ Not recorded ☐

b) MOST RECENT (Fast Delivery) Pre-sentence Report: (Please tick here if there is no PSR in the file ☐ and here if none of the PSRs are dated ☐)

Is alcohol misuse linked to offending behaviour?   Yes☐ No☐ Not recorded ☐

Does the initial screening show a need for a specialist assessment?   Yes☐ No☐ Not recorded ☐

Is drug misuse linked to offending behaviour?   Yes☐ No☐ Not recorded ☐

Is there current/recent drug misuse on a daily or weekly basis?   Yes ☐ No ☐   Not recorded ☐

Is mental health linked to offending behaviour?   Yes ☐ No ☐   Not recorded ☐

Does the offender have a history of mental health issues?   Yes ☐ No ☐   Not recorded ☐

Is specialist support required?   Yes ☐ No ☐   Not recorded ☐
Details   _____

c) Court Referral Form: **(Please tick here if this form is NOT in the file ☐)**
Drug abuse   Yes ☐ No ☐ Not recorded ☐
Alcohol abuse   Yes ☐ No ☐ Not recorded ☐
Mental health issues Yes ☐ No ☐ Not recorded ☐
Self-harm   Yes ☐ No ☐ Not recorded ☐

d) Offender Assessment System Self-Assessment   (Please tick here if this form is NOT in the file)

	Ticked?	Is linked to offending?	
Taking drugs	Yes ☐ No ☐	Yes ☐ No ☐	Not recorded ☐
Drinking too much alcohol	Yes ☐ No ☐	Yes ☐ No ☐	Not recorded ☐
Loosing my temper	Yes ☐ No ☐	Yes ☐ No ☐	Not recorded ☐
Doing things on the spur of the moment	Yes ☐ No ☐	Yes ☐ No ☐	Not recorded ☐
Getting violent when annoyed	Yes ☐ No ☐	Yes ☐ No ☐	Not recorded ☐
Feeling depressed	Yes ☐ No ☐	Yes ☐ No ☐	Not recorded ☐

e) Compliance Checklist: (Please tick here if this form is NOT in the file)
Do you have any special health needs?   _____

Do you use drugs and / or misuse alcohol which will stop you attending?   _____

4. Please complete any other details of any mental health disorders/substance misuse problems/self-harm or suicide risk recorded in the probation file in the table below (use multiple tables if more than one factor is recorded):

Comments/Coding Framework	Code(s)		Related Qualitative Data (Please align with source data and record dates if given
Factor: See coding sheet on back page			
Subtype: See coding sheet on back page			
Source in File: 1 = Letters (Section 1inc. CRAMS) (*State where from*) 2 = R&E form 3 = Sentence plan/reviews – order requirements 4 = OASys screening 5 = SPORF form 6 = Healthy Living Correspondence 7 = Programmes paperwork (Section 4) 8 = DRR paperwork (Section 5) 9 = UPW paperwork (Section 6) 10 = Reports (Section 7, *please specify type*) 11 = PSR/FDR (Section 7) 12 = Other interventions (Section 8) 13 = Prison documentation e.g. parole report (Section 9, *please specify type*) 14 = Third party report e.g. psychiatric report (Section 10, *please specify type*) 15 = Other (*please specify*) **Assessment Type:** 1 = Offender self-report 2 = Probation/CJS staff (inc. Healthy Living team) 3 = Health Service	**Source in File**	**Assessment Type**	For every tenth case, please record any relevant textual data verbatim for each source:
Is a link between the factor and offending stated in the risk assessment? (Y/N)	Yes ☐ No ☐		For every tenth case, please record any relevant textual data verbatim:

Comments/Coding Framework	Code(s)		Related Qualitative Data (Please align with source data and record dates if given
Factor: See coding sheet on back page			
Subtype: See coding sheet on back page			
ISource in File: 1 = Letters (Section 1inc. CRAMS) (*State where from*) 2 = R&E form 3 = Sentence plan/reviews – order requirements 4 = OASys screening 5 = SPORF form 6 = Healthy Living Correspondence 7 = Programmes paperwork (Section 4) 8 = DRR paperwork (Section 5) 9 = UPW paperwork (Section 6) 10 = Reports (Section 7, *please specify type*) 11 = PSR/FDR (Section 7) 12 = Other interventions (Section 8) 13 = Prison documentation e.g. parole report (Section 9, *please specify type*) 14 = Third party report e.g. psychiatric report (Section 10, *please specify type*) 15 = Other (*please specify*) **Assessment Type:** 1 = Offender self-report 2 = Probation/CJS staff (inc. Healthy Living team) 3 = Health Service	**Source in File**	**Assessment Type**	For every tenth case, please record any relevant textual data verbatim for each source:
Link between factor and offending stated in risk assessment? (Y/N)	Yes ☐ No ☐		For every tenth case, please record any relevant textual data verbatim:

5. Please indicate any mention of the participant taking medication for a mental health or substance misuse problem:

Mental Health Medication ☐ Substance Misuse Medication ☐ None ☐	For every tenth case, please record any relevant textual data verbatim:

6. Please note if the file does NOT contain a full OASys screen which has been completed within the 13 weeks prior to Stage 1 interview:
Missing OASys   Yes ☐ No ☐

7. Is the participant known to be on the CPA?   Yes ☐ No ☐ If yes, which level?   _____

8. Please indicate how 'rich' you feel the data contained in this file is on the scale below:

Poor quality data   **1** ☐   **2** ☐   **3** ☐   **4** ☐   **5** ☐   Rich data

9. Has the file been 'stripped' following termination of the case? Yes ☐   No ☐

10. **Services Accessed (MH/Substance misuse reasons only)**

Does the probation file contain a record of the services that the participant stated they were accessing in Stage 1?
[Service type]   Yes ☐ No ☐ For every tenth file please record any relevant textual data verbatim _____
[Service type]   Yes ☐ No ☐   _____
[Service type]   Yes ☐ No ☐   _____
[Service type]   Yes ☐ No ☐   _____
[Service type]   Yes ☐ No ☐   _____

Does the probation file contain a record of any other health service being used? (Including for physical health issues)? Yes No

If yes, what?   _____

11. To what extent does the researcher feel that information about mental health has been used to inform the community sentence plan (i.e. mental health has been recorded as an influence on offending behaviour and addressed accordingly)?

Not at all **1** ☐   **2** ☐   **3** ☐   **4** ☐   **5** ☐ Fully

Please state reasons for the above
ranking: _____

Question Four Codes

N.B. With the exception of entries with an asterisk, 'factors' are based on ICD-10 or DSM-IV (for PD subtypes). In any case where a subtype is not clearly stated in the case file, please code the factor and then code the subtype as '90'.

Factor	Subtype: ICD-10/DSM-IV Code
10 – Substance misuse*	11 – Misuse of drugs
	12 – Misuse of alcohol
20 – Schizophrenia, schizotypal and delusional disorders	21 – Mood disorder with psychotic features (current or lifetime)
	22 – Psychotic disorder (current or lifetime)
30 – Mood [affective] disorders	31 – Depression (any broad mention)
	32 – Bi-polar disorder (any kind)
40 – Neurotic, stress-related and somatoform disorders	F40.0 - Panic disorder with agoraphobia
	F41.0 - Panic disorder without agoraphobia
	F40.0 - Agoraphobia without history of panic disorder
	F40.1 – Social phobia
	F42.8 – OCD
	F43.1 – PTSD
	F41.1 – Generalised anxiety disorder
50 – Behavioural syndromes associated with physiological disturbances and physical factors	F50.0 – Anorexia nervosa (including binge eating/purging kind)
	F50.2 – Bulimia nervosa
60 – Disorders of adult personality and behaviour	F60.6 - Avoidant PD
	F60.7 – Dependant PD
	F60.5 – Obsessive-compulsive PD
	F60.0 – Paranoid PD
	F21 – Schizotypal PD
	F60.1 – Schizoid PD
	F60.4 – Histrionic PD
	F60.8 – Narcissistic PD
	F60.31 – Borderline PD
	F60.2 – Antisocial PD
70 – History of self-harm*	N/A
80 – Suicide risk*	N/A
	90 – Subtype not specified

Appendix D – Stage Three Interview Questions

Interview Questions for Offenders

We are generally interested in the experiences of people on probation who have health problems. Have you had any health or mental health problems whilst on probation?

1. To what extent do you feel that mental health problems are recognised by the probation service?

2. To what extent has the probation service helped you to access health services?

3. How would you describe the purpose of probation?

4. Would you say you had several needs when you were on probation? If so, how did you decide which ones probation could help you with? (**Prompt**: did you feel like your voice was listened to or was it a case of the officer knows best?)

5. To what extent do you think your offending is linked to your mental health?

6. How easy have you found it to access the right health services to help you?

7. Can you tell me a bit about your experience of accessing one service? (**Prompt**: Ideally for mental health problems)

8. What was good about the service?

9. What wasn't so good about the service?

10. What could be improved with the service?

11. To what extent are you aware of the Health Support Service at probation as a source of support for your health issues?

Interview Questions for Staff

1. How would you describe the purpose of probation?

2. To what extent do you feel that it is your role to monitor offenders' mental health?

3. When an offender presents with multiple needs, how do you decide which ones to work on with them? (this is to investigate the issue around whether staff focus on what offenders say their needs are, or whether they feel that they 'know what's best' for their client better than the client does/only focus on issues connected to offending)

4. To what extent do you think offending behaviour is linked to mental health problems?

5. How easy do you find it to identify offenders with mental health problems on your caseload?
    Prompt: Have you received an adequate level of training in mental health to do your role well?

6. To what extent do you feel that it is your role to refer offenders to appropriate mental health and/or substance misuse services?
    > **Prompt**: do they have a good knowledge of local mental health, drug and alcohol services + referral procedures? – are they confident making referrals?
    > **Prompt**: how often do they make referrals to mental health services? – is there much demand?
    > **Prompt**: How easy is it to make referrals?

7. Can you give me an example of how you would approach making a referral, or a recent referral which you have made to a mental health service?

8. Are there any common problems that you encounter when trying to get offenders into services?

9. What do you think works well in getting offenders into services?

10. To what extent are you aware of the Health Support Service at probation as a source of support for offenders' health issues?

11. How would you describe the level of multi-agency working that occurs in probation? (**Prompt**: Do they work in partnership well with other services, or if not what could be improved?)

Appendix E - Transcription Symbols

[Int: in a [bit Par: [mmm	Left brackets indicate the point at which one speaker's talk is overlapped by another speaker's talk
(2) Erm (4)	Numbers in brackets indicate length of silence in seconds
Word	Italics to indicate emphasis in speech
:: Ye:::ah	Colons indicate prolongation of the immediately prior sound. The length of the row of colons indicates how long the prolongation lasted for
.hhh Er well .hhh	A row of h's with a dot before them indicates an inbreath, and without a dot an outbreath. Number of h's indicates the length of this
( ) Offenders ( ) court	Empty brackets indicate where the researcher was unable to hear something when transcribing
(word) Offenders (word)	Word in brackets indicate something that the researcher guessed was the word when transcribing

Service User
Consultancy