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Mental health and probation: A systematic review of the literature

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1. Background

On 30th of June 2018 there were 261,196 people in contact with probation in England and Wales[1] (Ministry of Justice, 2018). Whilst not a homogeneous group, people in contact with probation are often socially excluded, deprived, vulnerable, and have a high prevalence of health problems when compared to the general population (Binswanger et al., 2016; Brooker, Sirdifield, Blizard, Denney, & Pluck, 2012; Brooker, Syson-Nibbs, Barrett, & Fox, 2009; Pari, Plugge, Holland, Maxwell, & Webster, 2012). Many people in contact with probation will experience more than one health problem at any given time and this population often experience other negative social determinants of health such as unemployment and homelessness.

In England, changes introduced by the policy *Transforming Rehabilitation* mean that probation provision was split into the National Probation Service – a public sector service managing high-risk offenders; and Community Rehabilitation Companies – a mix of private and voluntary sector agencies managing medium and low risk offenders. The current policy direction is towards renationalisation (HC Deb, 2019). Clinical Commissioning Groups (CCGs) are responsible for commissioning the majority of healthcare for offenders in the community (NHS Commissioning Board, 2012, 2013) but previous research suggests that many of them are unaware of this responsibility (Brooker & Ramsbotham, 2014; Brooker, Sirdifield, Ramsbotham, & Denney, 2017). This commissioning should be informed by Joint Strategic Needs Assessments prepared by CCGs and local authorities through Health and Wellbeing Boards (Department of Health, 2013). Questions remain about whether people in contact with probation are receiving the care that they need, and how we can best ensure that their needs are met. We conducted a study which aimed to investigate the range and quality of healthcare for people on with probation in England, and to produce a commissioning toolkit including:

- Likely health needs of this population
- Optimal commissioning strategies, and
- Examples of best practice and ways of overcoming barriers that healthcare commissioners, probation workers, and health practitioners can use to measure and improve probationers' health, and the quality of healthcare for this group

Other aspects of the study are being reported elsewhere and the commissioning tool kit can be accessed here: probhct.blogs.lincoln.ac.uk/

Understanding how we can best improve health outcomes for people on probation is important firstly as a means of reducing health inequalities through improving the health of these individuals, secondly because health has been identified as a pathway out of re-offending, and thirdly because addressing health needs may produce a 'community dividend' for the wider population through things such as reducing fear of crime and reducing use of expensive crisis care (Home Office, 2004;

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[1] This figure includes those on community sentences, suspended sentences, pre-release supervision and post-release supervision that are in contact with either the National Probation Service (NPS) or a Community Rehabilitation Company (CRC). Throughout this paper, we use 'on probation' to refer to all of these apart from those on pre-release supervision i.e. all those in community settings.

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National Probation Service, 2019; Revolving Doors Agency, 2017). Consequently, as part of the above project, we conducted a systematic review of the literature to identify studies on the effectiveness of approaches to improving health outcomes for adults on probation. Here, we present findings from this review in relation to mental health.

The main aim of the review was to identify what the literature tells us about the most effective approaches to improving health outcomes for adults on probation. We also had a secondary aim of identifying what the literature tells us about the health needs of people on probation, their patterns of service access, and any potential approaches to improving health outcomes that are being employed, but have not been subject to research or evaluation to date.

2. Methods

2.1. Search strategy

Databases searched were as follows: MEDLINE, PsycINFO, IBSS, CINAHL, The Cochrane Library, EMBASE, AMED, ASSIA, and HMIC.

The search was broad to encompass as many different areas of health and types of intervention or service as possible, and was restricted to papers published between January 2000 and May 2017. The search strategy for MEDLINE is shown in Appendix A, and was translated for the remaining databases.

We hand-searched the British Journal of Criminology, the Probation Journal, the Irish Probation Journal, and Health and Social Care in the Community from 2000 to September 2017, and the reference lists of included papers.

We also searched the grey literature, namely The King's Fund, National Offender Management Service, Public Health England, NHS England, NHS Commissioning Board, Department of Health, Offender Health Research Network, Prison Reform Trust, Centre for Mental Health, HMI Probation, Social Care Institute for Excellence, Turning Point, Addaction, Mind, and Clinks websites.

2.2. Inclusion and exclusion criteria

In line with our first aim, to be included, studies had to *research the effectiveness of an approach* to improving health outcomes (e.g. quality of life, improved access to services, positive patient experience, reduction in substance misuse, hospital admissions avoidance, increased self-management of health conditions) for adults in contact with probation in Western countries (i.e. people on community sentences or post-release licenses). Papers that included people on parole were also included. There were no restrictions for language or study design.

In line with our second aim, we also identified papers that met the above criteria but were not research papers i.e. they purely *described* an approach to providing healthcare to the target population or illustrated aspects of health needs in this group. These were classified as 'background' papers.

2.3. Assessment of relevance for inclusion in the review

Titles and abstracts were independently assessed by CS and RM. Full papers were ordered where relevance was unclear. Areas of disagreement were resolved through discussion with a third reviewer (CB).

3. Results

A total of 5125 papers were identified in the initial electronic searches. This reduced to 3316 after duplicates were removed. Of these, 51 were identified as appropriate for full-text review. Hand-searching identified an additional 8 papers, two of which we were unable to acquire, and two of which on closer inspection were not research papers.

After reading the full-texts of the remaining 55 papers, 25 were included in the review. An additional 20 papers were identified and included from their reference lists. Thus, the total number of includes was 45. Only four of these, however, concerned mental health. In addition, an additional 85 papers were classified as 'background' i.e. relevant descriptive or commentary papers rather than research papers, of which 24 related to mental health (Fig. 1). Finally, we also identified 13 items of grey literature relating to mental health.

3.1. Description of studies

There are a number of studies that did not meet the strict criteria for inclusion to address our primary aim, but that, nonetheless address our secondary aim as they provide important background material on probation and mental health. These were largely descriptive rather than research studies, and are described briefly below alongside the grey literature.

3.1.1. The prevalence of mental health and disorders and probation

One may tentatively conclude from the literature that there is a high prevalence and complexity of mental illness amongst probation populations (Sirdifield, 2012), with many people on probation experiencing more than one mental illness (co-morbidity) or a combination of mental illness and a substance misuse problem (dual diagnosis) which is often unrecognised and untreated (Brooker & Glyn, 2012; Geelan, Griffin, Briscoe, & Haque, 2000; Melnick, Coen, Taxman, Sacks, & Zinsser, 2008; Sirdifield, 2012). For example, Brooker et al. (2012) investigated the prevalence of mental illness and substance misuse in a stratified random sample (n = 173) of people on probation in one UK county. A series of established screening and diagnostic tools were used in this study. Weighted prevalence estimates showed that 38.7% of the sample were positive for a DSM-IV Axis I disorder, with 17.3% being positive for a current major depressive episode, 11% for a current psychotic disorder, and 27.2% for a current anxiety disorder. Overall 47.4% of the sample screened as probable cases of personality disorder, and 41.6% had experienced a major depressive episode in the past. Over half of the sample (55.5%) screened positive for alcohol abuse, and 12.1% screened positive for drug abuse: "Of the 47 participants who screened positive on the PriSnQuest and screened positive for a current mental illness on the MINI … 72.3% also had a substance abuse (alcohol or drug) problem" (Brooker et al., 2012, p. 531).

Geelan et al. (2000) examined prevalence of mental illness and substance misuse in a specialised probation Approved Premises for men with mental illness in the UK. They state that over half of the population studied had previous alcohol abuse or dependence and over half had misused drugs. Over a third (35%) of the population had a history of both alcohol and drug misuse, and 39% had a history of self-harm. In terms of mental illness, 81% of residents received a psychiatric diagnosis including 47% with psychosis, 18% personality disorder, 30% schizophrenia, 29% alcohol abuse or dependence, 10% drug abuse or dependence. 31% of residents received two diagnoses and 8% received three diagnoses. Despite this only a third of residents were seeing a psychiatrist at the time of their index offence.

It is clearly important that commissioners take account of this complexity and co-morbidity in order to ensure that services are available that can address such a variety of needs.

3.1.2. Use of mental health services

Despite this high level of need, people on probation face many barriers to mental health service access including an overall lack of provision (see for example Huxter (2013) who looks at the idea "that a debilitated public psychiatric healthcare system has resulted in large 'trans--migrations' of patients from psychiatric hospital beds to prisons and jails" (Huxter, 2013, p. 735)); a lack of provision that is appropriate for those with complex health needs such as co-occurring substance use and mental health disorders (Bradley, 2009; Melnick et al., 2008; NHS England, 2016); stigma and discrimination; mistrust; problems with inter-agency communication, and negative staff attitudes. Improvements

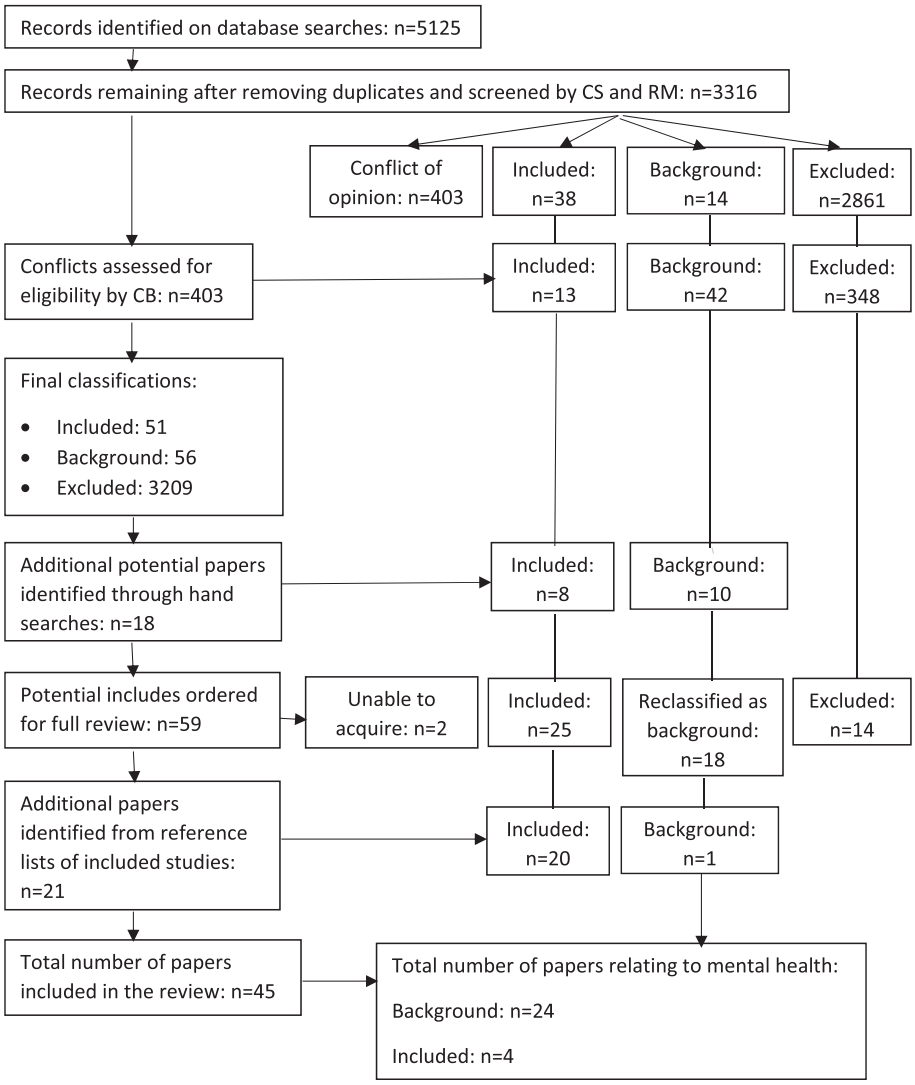

Fig. 1. PRISMA diagram.

are needed to commissioning structures and to achieve continuity of care on release from prison (Brooker et al., 2017; NHS England, 2016; Pomerantz, 2003).

Studies suggest that whilst use of some services by those in contact with the criminal justice system may be higher than that of the general population, it is still low relative to the prevalence of mental illness in this population. For example, Sodhi-Berry, Preen, Alan, Knuiman, and Morgan (2014) investigated community mental health service use by adult offenders (n = 23,755) in the year prior to their first ever criminal sentence in Western Australia compared to a matched community group of non-offenders. This was achieved using routinely collected data from health and criminal justice records (Sodhi-Berry et al., 2014, p. 204). This showed that overall just over 8% of offenders had used mental health services prior to their sentence compared to 1% of non-offenders (Sodhi-Berry et al., 2014, p. 204), with rates of access overall being particularly high amongst non-indigenous women, and rates of service use for substance use disorder being particularly high amongst indigenous offenders. However, despite this higher rate of use, this was still low relative to the prevalence of mental illness in this population. Such studies also point to particularly high use of crisis services like Accident and Emergency amongst mentally ill offenders.

For example, Rodriguez, Keene, and Li (2006) looked at service use over a three-year period in one English county amongst individuals in contact with a community mental health trust that had been charged with one or more offences. Cases were divided into several groups, with 'offenders' being those charged with at least one offence, and 'frequent offenders' being those charged on three or more occasions during the study period (Rodriguez et al., 2006, p. 413). This study pointed to disproportionate use of most health services by offenders, and also showed that 31.7% of offenders had accessed A&E in the study period compared to 11% of the total population aged 16–55 years in the county being studied. A&E use was even higher amongst offenders with a mental illness (53.9%), and frequent offenders with a mental illness (63.2%). Despite the high prevalence of substance misuse problems amongst offenders, just 5.3% had accessed drug services, and just 3.8% had accessed alcohol services. Amongst offenders, those with a mental illness "used all services in significantly larger proportions than the non-mentally ill. However, mentally disordered offenders used significantly less services than non-offending mental health patients" (Rodriguez et al., 2006, p. 416).

3.1.3. *Offending and mental illness*

Whilst the relationship between mental illness and offending may not be completely understood, mental illness does appear to be associated with non-compliance with probation and to influence offending. Studies have shown that those with a mental illness have higher re-arrest rates than those without a mental illness and are more likely to have probation revoked (Skeem & Louden, 2006). The relationship between these

variables may be direct, indirect or spurious i.e. people may be non-compliant with probation as a direct result of their illness, or due to being more likely to experience other factors that lead to non-compliance, or because they are monitored more closely than others (Skeem & Louden, 2006, p. 335). Thus, treating mental illness may potentially improve criminal justice as well as health outcomes.

In addition, there is some evidence to suggest that access to mental health treatment for those with a serious mental illness can produce cost-savings. For example, Robst, Constantine, Andel, Boaz, and Howe (2011) examined data from the Pinellas County (Florida) Criminal Justice Information System, and divided individuals in this system into three groups: 1) those with low and stable criminal justice expenditures, 2) those with high but declining expenditure, and 3) those with high but increasing expenditure. They found that treatment being associated with lower current and future criminal justice expenditure (Robst et al., 2011, p. 359). However, one must note that this study does not take into account factors such as family support, quality of care or severity of mental illness which may influence outcomes.

3.1.4. Treatment orders imposed by the courts

Numerous approaches to improving access to treatment and combining mental health treatment with probation orders have been implemented around the world. For example, Konrad and Lau (2010) present a descriptive paper about the Reform of the Parole System and Amendment of the Provisions for the subsequent Preventive Detention Act in Germany, which became effective in 2007. This introduced a 'therapy order' which could be ordered by the courts, and also gave the courts the power to order people not to drink alcohol or consume other intoxicating substances if it is believed that doing so would contribute to re-offending. This has resulted in closer working between the courts and outpatient treatment centres, and means that forensic outpatient centres now have a dual function which includes monitoring as well as treatment.

Similarly, in the UK the courts can recommend Mental Health Treatment Requirements (MHTRs). These are available for those on community or suspended sentence orders with a mental illness that do not "require immediate compulsory hospital admission under the Mental Health Act" (Khanom, Samele, & Rutherford, 2009, p. 5). However, these requirements are currently under-used due to a variety of issues such as a lack of practical guidance on their use, a lack of understanding about who they are suitable for and how to use them, delays in obtaining psychiatric reports and a lack of appropriate service provision (Bradley, 2009; Durcan, 2016; Khanom et al., 2009; NOMS, undated; Scott & Moffatt, 2012). Much of this could be improved through better partnership working, including probation and healthcare commissioners working together to understand offenders' mental health treatment needs and ensure that they are fully considered in the commissioning process; and through CCGs being made aware of and recognising that responsibility for commissioning healthcare for those on probation lies with them, not NHS England (Durcan, 2016).

Long (2016) describes a response to the under-use of Mental Health Treatment requirements in England and Wales. The rapid response mental health assessment and treatment programme described in this paper was developed as a partnership between Thames Valley Probation Service, St Andrew's healthcare and the charity People Potential Possibilities (P3). This involved P3 staff and probation officers completing an initial assessment of an individual at court using the Kessler 10 as a measure of psychological distress, following which, those scoring above the cut-off are further assessed by assistant psychologists based at probation from St Andrew's healthcare. Treatment is also provided by St Andrew's healthcare in the form of an adapted version of dialectical behaviour therapy skills for borderline personality disorder (Long, 2016, p. 465). There were plans to evaluate this service when the paper was written but we did not find any further references to it in our review of the literature.

3.1.5. Partnership working between probation and mental health services

The literature also contains papers describing models of practice where attempts have been made to improve partnership working between mental health and criminal justice services. For example, Lamberti, Weisman, and Faden (2004) identified assertive community treatment programs that aimed to reduce re-offending amongst adults with severe mental illness that have been involved in the criminal justice system in 28 US states (Lamberti et al., 2004, p. 1286).

Mitton, Simpson, Gardner, Barnes, and McDougall (2007) described outcomes from a programme that aimed to improve links between mental health and criminal justice services. They examined "outcomes and service utilization of clients using the Calgary Diversion Program, a community-based alternative to incarceration for persons with serious mental disorders who commit minor offences" (Mitton et al., 2007, p. 145) in Alberta, Canada. This programme diverted people away from the criminal justice system and into treatment. It "provides services to clients who have committed a minor, low risk offence(s) due to mental illness with a view to stabilizing their mental illness and increasing their capacity to live successfully in the community" (Mitton et al., 2007, p. 146). It both facilitated access to relevant community services, and provided a short programme of psycho-education, skill building and meaningful activity (Mitton et al., 2007, p. 146). For a short time, it also provided a residential programme. Clients received an individual assessment and treatment plan that was reviewed at regular intervals by community mental health workers. Data were collected at baseline and programme exit (three months later) for those enrolled during the study period ($n = 179$), with mental health service use (hospital admissions, inpatient days and emergency room visits) and costs in the Calgary Health Region also being measured pre- and post-enrolment. However, it should be noted that there was a high attrition rate in this study, with 50% of service users being lost to follow-up by six months post-enrolment and there was no control group for comparison.

In terms of service use, "for those whose charges were withdrawn, the number of inpatient admissions went from 97 to 50, the number of inpatient days from 1692 to 940, and the number of ER visits from 217 to 162" (Mitton et al., 2007, pp. 148–149). For those whose charges were not withdrawn, hospital admissions went from 53 to 40, inpatient days from 925 to 499, and ER visits from 106 to 95.

The impact of the programme on users' symptoms and quality of life were measured using the Brief Psychiatric Rating Scale (BPRS), and Wisconsin quality of life questionnaires respectively. "Analysis of the BPRS at baseline and exit showed a statistically significant reduction in symptom severity between clients' entry to and exit from the program" (Mitton et al., 2007, p. 149), and there were also statistically significant improvements on six of the nine quality of life indicators covered in the questionnaire.

In terms of client satisfaction, user feedback was sought through interviews and also the Service Satisfaction Scale-10, which 73% of those enrolled completed at exit, with 94.6% of them indicating that they were 'mostly satisfied' or 'delighted' with the programme.

Finally, costs were compared for the nine months pre- and post-enrolment, a reduction in costs of $1700 per service user was found, but this was not statistically significant. The authors also note that this analysis did not include court costs or some health sector costs like physician visits.

The authors recommend the following as ingredients for a successful programme: a client-centred approach, research and information sharing agreements being established between participating organisations, identified people to act as 'boundary spanners' for sharing knowledge, and having an on-site pharmacy (Mitton et al., 2007, p. 150).

Nadkarni, Chipchase, and Fraser (2000) described a partnership between probation and a forensic psychiatry service to identify mental health needs amongst Approved Premises residents, provide direct access to mental health support for residents, and increase staff knowledge around mental health. Here, the authors concluded that most Approved Premises would benefit from this type of partnership, although more

research is needed due to the small number of cases that were seen within the study period.

Clayton, O'Connell, Bellamy, Benedict, and Rowe (2013) reported findings from a randomized controlled trial of a Citizenship Project that "was designed to address the specific community and social inclusion needs of persons with serious mental illness (SMI) and criminal justice histories" (Clayton et al., 2013, p. 115). Individuals with a serious mental illness being treated at one of two mental health centres who had a criminal charge within the last two years were randomized into the project (n = 73, 64%) or treatment as usual (n = 41, 36%). The intervention consisted of "three integrated components: individual peer mentor support, an 8-week citizenship class, and an 8-week valued role component" (Clayton et al., 2013, p. 116).

The intervention appeared to have a positive impact in terms of reducing alcohol and drug use when comparing the intervention and control groups. Those receiving the intervention also had significantly greater increases in reported quality of life over a twelve-month period than those receiving treatment as usual. However, at the six months point, those receiving the intervention also reported significantly higher increases in symptoms of anxiety or depression than those in the control group (Clayton et al., 2013, p. 118).

Skeem and Louden, (2006) provided an overview of specialty caseloads that have been developed for both probation and parole in the USA. Whilst there is a paucity of research in this area, a national survey found that specialty agencies or caseloads have the following common features: exclusively mental health caseloads with meaningfully reduced numbers of cases (on average around a third the size of a traditional caseload), ongoing officer training, integrated resources between probation and external treatment services, and the use of problem-solving strategies rather than threats of incarceration as responses to non-compliance. Relatively little research has been conducted on mental illness and parole, but the research that has been done suggested that interventions here have the same features as those described above for probation settings. There has been little research into the effectiveness of these ways of working, but two studies suggested that "probationers with mental illness, probation officers, and probation supervisors perceive speciality caseloads as more effective than traditional caseloads" (Skeem & Louden, 2006, p. 339), and "three additional studies – two randomized controlled trials and one uncontrolled cohort study –suggest that specialty agencies are more effective than traditional agencies in linking probationers with treatment services, improving their well-being, and reducing their risk of probation violation. Evidence is mixed on whether specialty agencies reduce probationers' longer-term risk of re-arrest" (Skeem & Louden, 2006, p. 340). Similarly, three studies suggested that specialty parole was "effective in reducing parolees' short-term risk of parole violation, but none of these studies used control groups" (Skeem & Louden, 2006, p. 340). The study concludes that the literature suggests that there are three general principles of practice that look promising: having meaningfully reduced caseloads to allow criminal justice staff to function as "boundary spanners" between criminal justice and other services; a staff-offender relationship that is based on trust, caring and fairness; and the use of problem-solving strategies to address non-compliance.

3.1.6. The impact of, and learning from, an offender personality disorder project

There is a high prevalence of personality disorder amongst people on probation and parole when compared to the general population, and often those diagnosed with a personality disorder also have another mental illness and/or substance misuse problem (Wetterborg, Långström, Andersson, & Enebrink, 2015). There has been increasing focus on how to identify and meet the needs of people with personality disorder in the criminal justice system in the UK, with a particular focus on dangerous and severe personality disorder (DSPD). Individuals with a diagnosis of DSPD are often reconvicted more quickly than other offenders, commit more serious offences than other offenders, and have increased likelihood of dropping out of treatment (Minoudis, Shaw, Bannerman, & Craissati, 2011). We identified three background papers that showed that various methods have been trialled to identify people on probation with personality disorder (Bui, Ullrich, & Coid, 2016; Minoudis et al., 2011; Nichols, Dunster, & Beckley, 2015). Studies have also shown that those with personality disorder are likely to be considered high or very high risk of harm and to be at increased risk of things like self-harm, re-offending, and having experienced physical, sexual or emotional abuse or childhood problems when compared to a wider probation caseload (Minoudis et al., 2011; Nichols et al., 2015; Wetterborg et al., 2015).

Initiatives to meet the needs of those identified as having a personality disorder have included new ways of working in probation Approved Premises (Blumenthal, Craissati, & Minchin, 2009; Castledine, 2015), and the development of the offender personality disorder pathway in England and Wales. Here, criminal justice staff use items in the Offender Assessment System to help to identify some forms of personality disorder, and work together with partnership agencies to take a formulation based approach to rehabilitation (NOMS & NHS England, 2015). Liaison and diversion teams are in place in many areas of England and Wales (NHS England, 2019). Ascertaining the impact that these are having has been problematic due to variation in their structures and approaches (Senior, Lennox, Noga, & Shaw, 2011), but attempts have been made to describe key ingredients for diversion (Durcan, 2014).

In a descriptive paper, Castledine (2015) provides an overview of some of the benefits and challenges of implementing a Psychologically Informed and Planned Environment (PIPE) in a probation Approved Premises. Benefits for staff included feeling more confident in working with individuals with personality disorder, increased job satisfaction, and increased awareness of the importance of looking beyond presenting behaviours (Castledine, 2015, p. 276). From the residents' point of view, existing residents commented on a change in atmosphere, improved relationships with staff, and better experience at the Approved Premises. A number of challenges were also identified from the perspective of clinical and probation staff, including anxiety associated with the new role, balancing risk and responsivity, and "residual feelings of guilt, disappointment and responsibility in relation to cases that have not 'successfully' completed a period of residency having established a positive working relationship" (Castledine, 2015, p. 277); as well as difficulties associated with mapping the PIPE onto an existing service, staffing structures, high turnover of residents, competing priorities, and a need to develop the physical environment in the Approved Premises.

In addition to these 'background' papers, we also identified four research papers on this topic, as detailed below.

3.1.7. Included studies

Four studies on mental health met the criteria for inclusion in the review i.e. addressed our primary goal of identifying what the literature tells us about the most effective ways of improving health outcomes for adults on probation. These studies were published between 2004 and 2016 in the UK (Hatfield, Ryan, Pickering, Burroughs, & Crofts, 2004; Ramsden, Joyes, Gordon, & Lowton, 2016; Ryan, Hatfield, Pickering, Downing, & Crofts, 2005), and the USA (Herinckx, Swart, Ama, Dolezal, & King, 2005).

The papers focused on the impact and learning from an Offender Personality Disorder project (Ramsden et al., 2016), Approved Premises' residents' mental health needs and use of mental health services (Hatfield et al., 2004; Ryan et al., 2005), and the impact of mental health courts on participants' use of mental health services (Herinckx et al., 2005). All of these papers are described more fully below.

3.1.8. The impact of an offender personality disorder project

Ramsden (2016) explored the impact of an Offender Personality Disorder project in one part of England on Offender Managers and probation practice through use of case examples and analysis of data from fourteen focus groups conducted with relevant health and probation staff. This project involved probation and health staff working together in a new way, using psychologically informed case management to support

individuals on probation with a diagnosis of personality disorder. Here, the psychology staff produce case formulations with offenders and offender managers to inform how they are supervised. The focus groups aimed to highlight any areas of good practice and/or any problems arising from the new way of working. Here the case examples show how practitioners valued the partnership working and sharing of expertise. This way of working provided practitioners with a new way of looking at, understanding and working with risk. "The psychologically informed model of practice aims to create an enabling environment for the offender and it is expected that risk will be reduced through an increased understanding of the offender's behaviour. Whilst risk is an important factor, this is not the primary focus of the work" (Ramsden et al., 2016, p. 66). At first there were concerns about the defensibility of this approach amongst probation staff, but these concerns were not present in later focus groups. The authors also provided some guiding principles for writing psychologically informed warning letters. Themes arising from the focus groups suggested that the new way of working may impact on Offender Managers' professional identity – the semi-specialist offender managers working on the project were gaining new skills but felt that at times this could isolate them or detract from their usual focus on risk management and public protection (Ramsden et al., 2016, p. 62). It also impacted on their thinking – potentially connecting more emotionally with the potential causes or triggers behind clients' offending behaviour. The authors also note that practitioners had been given reduced caseloads as part of the project to enable the new approach to be successful, but this was being threatened by changes resulting from *Transforming Rehabilitation.*

3.1.9. Approved Premises' residents' mental health needs and use of mental health services

We included two papers in the review that studied the mental health needs of Approved Premises residents, and their use of mental health services. Hatfield et al. (2004) investigated the prevalence of mental health problems amongst residents of seven Approved Premises in Greater Manchester (n = 533 of 608 residents admitted between 1st of May 2002 and 30th April 2003 and resident for at least seven nights), and their use of psychiatric services. Participants were aged 18–80 years, 475 were male and 58 were female, 494 were White, and they had committed a wide variety of types of offence. Just over a quarter of the residents in their sample had at least one known mental health diagnosis, and 41% of these had a second known diagnosis. Those with mental health needs had higher rates of psychological distress than those without. Whilst the majority of cases with psychotic illness were housed in an Approved Premises with mental health support, there were cases with both severe and common mental health disorders that were housed in Approved Premises without this specialist support.

Individuals with mental health needs that were housed either at the specialist Approved Premises with mental health support, or at the Approved Premises for women were significantly more likely to be receiving mental health services than those with mental health needs that were housed at the other Approved Premises (Hatfield et al., 2004, p. 108).

Ryan et al. (2005) conducted a follow-up study with the 113 residents that had been identified as having contact with mental health services in the above study and found that three-quarters of the sample had been referred to at least one mental health service when they left the Approved Premises, and two-thirds of those leaving the Approved Premises were in contact with at least one mental health service at follow-up. However, there were 26 individuals who were not in contact with mental health services at follow-up, and staff felt that 12 of these should either definitely or possibly be receiving mental health support. The authors also note that their sample is likely to under-represent the true prevalence of people with mental health needs housed in probation Approved Premises as some residents' mental health needs may not have been detected within the data collection period. Together, these two studies point to the high prevalence of mental illness amongst Approved Premises residents, and the value of both having good links between Approved Premises and primary care, and of having specialist Approved Premises for those with mental illness to improve access to care.

3.1.10. The impact of mental health courts on participants' use of mental health services

Herinckx et al. (2005) investigated the effectiveness of a mental health court in Clark County both in terms of criminal justice outcomes, and the impact of the programme on participants' use of mental health services. They conducted a secondary analysis of data comparing service use 12 months pre-enrolment with service use 12 months post-enrolment for those enrolled between April 2000 and April 2003 (n = 368, with data on service use being available for 320 of these). Those included in the sample had an age range of 18–61 years, a DSM-IV axis I diagnosis of major mental illness, did not have a developmental disability or an Axis II personality disorder, 56% were male and 44% were female, and 89% were Caucasian. The following types of service use were considered: case management, medication monitoring, intake and evaluation, individual therapy, group therapy, crisis intervention, inpatient treatment days, and outpatient treatment days. Findings suggested that those participating in the programme "received more hours of case management and medication management and more days of outpatient service after enrolment" (Herinckx et al., 2005, p. 855), and "also received fewer hours of crisis services and fewer days of inpatient treatment after enrolment" (Herinckx et al., 2005, p. 855). However, one must be cautious in interpreting these findings as individuals that enrol in the programme and stay in it for at least 12 months may already have higher levels of motivation to make life changes than those that choose not to engage with the programme or who drop out (Herinckx et al., 2005).

4. Discussion

It is clear from this review that there are very few published studies that have looked at the effectiveness of approaches to improving mental health outcomes for those serving probation orders world-wide. We discovered four such studies only one of which examined the effectiveness of mental health interventions using a randomised controlled trial methodology. Why might this be the case? It is possible that our search strategies did not identify all relevant papers on this topic. However, we did conduct a broad search, and we searched a wide range of databases, and hand-searched key journals and the grey literature.

The prevalence of mental health disorders in probation samples is high, as high, if not, higher than in prison populations (Geelan et al., 2000; Brooker et al., 2012; and; Sirdifield, 2012). However, the nature of disorders is similarly complex with high levels of co-morbidity including personality disorder, substance misuse and psychosis. A suite of interventions to deliver to these groups with this complicated set of problems might be hard to determine and undoubtedly expensive to deliver.

Despite the complexity of mental health disorders faced by this group, mental health services and probation working together have attempted to promote models that engage probationer and a number of these models have been evaluated. For example, in the United States, Lamberti et al. (2004) used assertive outreach programmes in an attempt to reduce re-offending and treat serious mental illness. Mitton et al. (2007) describe a diversion programme run in Canada to the same end: use of mental health services decreased as did visits to Accident & Emergency departments however at six-month follow-up 50% of the sample had been lost to attrition so little is known about the longer-term consequences. Clayton et al. (2013) in their 'citizenship' project allocated people at random with a serious mental illness who had been charged with a criminal offence in the last two years into an intervention that consisted of; individual peer mentor support, and 8-week citizenship course and an 8-week valued role component. Alcohol and drug use decreased for the experimental group and quality of life increased. There are two noteworthy aspects to this study. First, this is the only

randomised controlled trial in the whole of the literature. Second, a total of 114 people in total were recruited from just two community mental health centres – a high number of those with both a serious mental illness and a criminal conviction on the last two years. In a series of innovative programmes, Skeem and Louden, (2006) describe the use of 'speciality caseloads' in the United States. In this model of working, probation staff work with reduced mental health caseloads, receive training and on-going supervision in mental health and are also trained to use problem solving strategies. The authors conclude that working in this way is more effective than traditional models of probation service delivery: well-being improves; treatment services are better engaged; and the likelihood of probation violations is lower. Finally, Herinckx et al. (2005) has conducted research that has shown that the use of a variety of approaches such as crisis intervention and medication monitoring have a meaningful impact on the length of in-patient treatment in a mental health facility.

In the UK, treatment for substance misuse and/or mental health can be mandated by the courts so-called treatment orders. Whilst there is a strong uptake of treatment orders for alcohol and drug misuse the same cannot be said for orders relating to mental health. In England, it has been estimated that mental health treatment requirements (MHTRs) make up less than 1% of all probation orders made the courts.

The under-use of MHTRs in England is due to a number of factors, for example, a lack of practical guidance on their use, a lack of understanding about who they are suitable for and how to use them, delays in obtaining psychiatric reports and a lack of appropriate service provision (Bradley, 2009; Durcan, 2016; Khanom et al., 2009; NOMS, undated; Scott & Moffatt, 2012). In an ideal world MHTRs would be fully instigated and well-designed research would flow from their proper use.

Despite the high level and complexity of mental health needs in this group, people in contact with probation also face both system-level and personal-level barriers to accessing healthcare. Many people in contact with probation are not registered with a GP, and/or only access healthcare during crises (Revolving Doors Agency, 2017). Sometimes services simply do not exist to meet their needs, and sometimes services are difficult to access due to their location, problems with their opening hours, restrictive referral criteria and poorly understood access routes. Moreover, the health needs of people in contact with probation and how best to structure service provision to make health care accessible to and appropriate for this group are not always considered by healthcare commissioners especially in England (see Brooker and Ramsbotham [2014] for example).

Many people serving a probation order have at least one mental health disorder. Research that examines the effectiveness of interventions for this group is scant especially where a probationer might be experiencing a number of mental health disorders. A variety of different approaches have been undertaken to attempt to engage probationers in mental health service delivery often devised for a one-off study. Mainstream policy-makers do not seem to regard effective mental health interventions for probationers to be a priority - if they did would the uptake of MHTRs be less than 1%?

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Declaration of competing interest

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Appendix A. MEDLINE search strategy

S1	TI probation* OR AB probation*
S2	TI offend* OR AB offend*
S3	TI parole* OR AB parole*
S4	TI "community rehabilitation compan*" OR AB "community rehabilitation compan*"
S5	TI "community order*" OR AB "community order*"
S6	TI "community treatment order*"OR AB "community treatment order*"
S7	TI "community sentenc*"OR AB "community sentenc*"
S8	TI health OR AB health
S9	TI mental N6 health OR AB mental N6 health
S10	TI mental N6 illness* OR AB mental N6 illness*
S11	TI mental N6 disorder* OR AB mental N6 disorder*
S12	TI "physical health" OR AB "physical health"
S13	TI self-harm OR AB self-harm
S14	TI "self harm" OR AB "self harm"
S15	TI suicide OR AB suicide
S16	TI (substance* OR drug*) N6 misuse* OR AB (substance* OR drug*) N6 misuse*
S17	TI (substance* OR drug*) N6 abuse* OR AB (substance* OR drug*) N6 abuse*
S18	TI (substance* OR drug*) N6 use* OR AB (substance* OR drug*) N6 use*
S19	TI (substance* OR drug*) N6 depen* OR AB (substance* OR drug*) N6 depen*
S20	TI (substance* OR drug*) N6 disorder* OR AB (substance* OR drug*) N6 disorder*
S21	TI (substance* OR drug*) N6 addict* OR AB (substance* OR drug*) N6 addict*
S22	TI (substance* OR drug*) N6 treatment* OR AB (substance* OR drug*) N6 treatment*
S23	TI alcohol N6 treatment* OR AB alcohol N6 treatment*
S24	TI healthcare N6 access* OR AB healthcare N6 access*
S25	TI "health care" N6 access* OR AB "health care" N6 access*
S26	TI "smoking cessation" OR AB "smoking cessation"
S27	TI maternity OR AB maternity
S28	TI dental N6 health OR AB dental N6 health
S29	TI vaccinat* OR immunis* OR immuniz* OR AB vaccinat* OR immunis* OR immuniz*
S30	TI sexual N6 health OR AB sexual N6 health
S31	TI "primary care" OR AB "primary care"
S32	TI "general practi*" OR AB "general practi*"
S33	TI healthcare OR AB healthcare
S34	TI "health care" OR AB "health care"
S35	TI "social care" OR AB "social care"
S36	MH health+
S37	MH mental disorders+
S38	MH learning disorders+
S39	MH self-injurious behavior+
S40	MH smoking cessation
S41	MH health care quality, access, and evaluation+
S42	MH substance abuse treatment centres
S43	MH immunization+ (includes 'vaccination' on one tree – explode on this one)
S44	MH health services +
S45	TI "quality of life" OR AB "quality of life"
S46	TI QALY OR AB QALY
S47	TI patient N6 experience* OR AB patient N6 experience*
S48	TI patient N6 satisfaction OR AB patient N6 satisfaction

S49	TI admissions N6 avoidance OR AB admissions N6 avoidance
S50	TI self-management OR AB self-management
S51	TI "self management" OR AB "self management"
S52	TI self-care OR AB self-care
S53	TI "self care" OR AB "self care"
S54	TI healthcare N6 access* OR AB healthcare N6 access*
S55	TI "health care" N6 access* OR AB "health care" N6 access*
S56	TI cost-effective* OR AB cost-effective*
S57	TI "cost effective*" OR AB "cost effective*"
S58	TI (mortality OR "standardized mortality rat*") OR AB (mortality OR "standardized mortality rat*")
S59	TI morbidity OR AB morbidity
S60	TI death* OR AB death*
S61	TI early N6 diagnos* OR AB early N6 diagnos*
S62	TI late N6 diagnos* OR AB late N6 diagnos*
S63	TI delayed N6 diagnos* OR AB delayed N6 diagnos*
S64	MH health status+
S65	MH patient satisfaction
S66	MH hospitalization+ (includes 'length of stay' and 'patient admission')
S67	MH costs and cost analysis+
S68	MH quality-adjusted life years
S69	S1 OR S2 OR S3 OR S4 OR S5 OR S6
S70	S7 OR S8 ETC TO S42
S71	S43 OR S44 ETC TO S66
S72	S67 AND S68 AND S69
S73	Add limiters for year 2000 onwards

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