Confederation of European Probation

THE EUROPEAN SURVEY OF PROBATION STAFF'S KNOWLEDGE OF, AND ATTITUDES TO, MENTAL ILLNESS

Funded by CEP

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1. Abstract

There is a high prevalence of mental illness in probation including suicide. It is important for probation staff to recognise mental illness and to refer on to an appropriate agency once it is detected. Probation's staff knowledge about mental illness was therefore examined across Europe in this study using a well validated measure – the Mental Health Literacy Scale (MHLS). Response rates within services and countries varied widely from 0-74%. Scores on the MHLS also varied considerably from 113-138 with an average score of 128. This overall average score is similar other groups of the population such as university students and the clergy. There was a strong association between knowledge and confidence in working with people with a mental illness. The policy implications of these findings are discussed. It is clear there is a continuing role for CEP in this arena especially in the light of the Council of Europe's recent White Paper on mental health in probation and in prisons.

2. Background

The prevalence of mental health disorders in probation is high much higher than in the general population. Indeed, two robust studies have estimated that mental health disorders affect 40% of the probation population (Brooker et al, 2012; Lurigio et al, 2003). Suicide is also more prevalent within probation populations than both prisons and the general population (Philips et al, 2018). This study in England showed that suicide rates also vary by gender. The rate per 100,000 of the population for men 105 and for women 145 compares respectively 5.6/100,000 and 29.2/100,000 for men and women in the general population. There are, therefore, compelling reasons why probation staff should be able to recognise mental health disorders and refer on appropriately to community-based mental health services or even refer to acute psychiatric care. In one of the prevalence studies cited above (Brooker et al, 2012) the probation records of those identified with a mental health disorder were examined. The research showed that probation staff recognised 64% of mood disorders; 37% of anxiety disorders; 36% of psychotic disorders and 10% of likely personality disorders. Staff, however, were much better at recognising alcohol and drug use (identifying 88% and 77% of these respectively). Perhaps the especially worrying aspect of these findings is that only one-third of psychosis cases were recognised. It is difficult to know whether these findings would be replicated across the 47 Countries/ Jurisdictions of Europe although a recent European survey for the Council of Europe established that just 37% of probation services across Europe prepared staff for the mental health issues they might come across in practice compared to 74% of prisons (Brooker and Monteiro, 2021). There was a caveat to these findings. A number of countries indicated that mental health awareness training was not required, as training for core discipline required to be a probation officer, included mental health. One example of this was in Berlin (Germany) which stated that:

'….only state-certified social workers, special educators and psychologists are employed in the probation service, who already have the necessary knowledge and appropriate awareness of the topic of mental health due to their training. Routine training for employees is therefore not required'

Another theme arising from the qualitative data in this section was the 'non-mandatory' nature of training that was on offer after qualifying as a probation officer (this included: Denmark, Brandenburg (G), Hesse (G), Nordrhein-Westfalen (G), Schelswig-Holstein (G), Scotland and France. In other countries training is either mandatory or part of the initial probation officer training (Austria, England, Malta, Northern Ireland, Romania, and Spain). Some countries described the content of training but only England and France cited 'the prevention of suicide' as an important area to cover. In the Czech Republic the main focus was on drug addiction. Most countries used external training providers apart from Baden-Wurttemberg (G) who used their specialist mental health trained probation staff:

'Probation staff can receive intern or extern trainings. Intern we provide further training on the topic "Clients with mental disorders". Probation officers have also the possibility to take individual supervision. Every of our 9 facilities has a probation officer with special skills in this subject. This specialized probation officer can advise colleagues or organizes trainings.'

Finally, several countries mentioned the importance of teaching about commonly prescribed psychotropic drugs and their side effects (Belgium and Northern Ireland).

Recent research in Ireland (Power, 2020) has shown that when asked to make estimates of those people on probation caseloads with a mental health disorder, staff struggled:

'Based on the significant gaps in the data gathered, assessing mental health functioning and asking relevant questions, making appropriate referrals and working effectively with mental health professionals require additional skills training and guidance for Probation Officers. It is unlikely that general Probation Officer training provides enough assessment skills or information for Probation Officers to be confident when making referrals'

Some examples of evaluated training initiatives exist, for example, Sirdifield et al (2010) reported a train-the train-trainers scheme run on one region of England. In this paper, the nature of the training is well described and included *inter alia*: mental health myths and stereotypes; relevant legislation; factors impacting on mental health; PTSD, bi-polar disorder, depression, suicide and self-harm and personality disorder; local mental health service provision and

finally, factors impacting on probation practice affecting mental health. There were 15 trainers who attended a two-day course and the evaluation consisted of measurement of knowledge, attitudes and confidence before and after training. In effect, a modified version of Kirkpatrick's framework used previously by Barr et al, (1999). The evaluation was short-term and it was thus impossible to understand the impact training had longer-term on probation practice and outcomes. Nonetheless attendees felt significantly more positive about working with probationers with a mental illness. This paper will be referred to again in the discussion as it was a response to discussions at the time, led by CEP, about a pan-European probation training curriculum.

There have been other reports of probation staff being trained over five days to make formulations of people with personality disorder (Brown et al, 2018). In the United States a variety of training programmes have been delivered to equip staff for the role of the specialist mental health probation role (Deinse et al, 2021). In a recent systematic review Sirdifield and her colleagues conclude that there should be an imperative to consider training in suicide prevention (Sirdifield et al, 2021):

> *'We have argued elsewhere that the lack of training for probation officers in either mental illness or substance misuse means that mental health issues are often missed by offender managers. We strongly suspect that suicidal ideation is hard to identify without specific education in this aspect of mental health We identified that offender managers only recognised 64% of cases with depression and 36% of those with psychotic disorders in a large community random sample of probationers formally identified with a mental health disorder (Sirdifield et al., 2012).*

To conclude, there is strong evidence for high levels of the prevalence of mental health disorders amongst probation populations. This is not usually an area that is addressed sufficiently in probation staff's preparatory training. Thus, cases of mental health disorder are frequently missed and referral to the appropriate agency does not occur. This project seeks to improve this situation in this study which involves different countries in Europe. In the study assessments will be made of probation staff's knowledge of mental illness and their attitudes to mental illness. This baseline exercise is an essential first step to take in efforts to improve knowledge about mental health disorders in probation services.

3. Method

a) Plan of investigation

Probation staff, in CEP Member countries, were asked to complete a 'knowledge' and attitudes' questionnaire. The study ran from September/ November, 2022 (10 weeks for data collection). Each of the participating 'CEP-member' probation services were asked to share an online survey prepared by the research team to all staff for completion. The survey was anonymous and asked questions about the individual, including length of employment in the service and training, followed by the full set of questions from the mental health literacy scale (O'Connor and Casey, 2015). All data were held securely on the UK Universities online survey website (www.onlinesurveys.ac.uk) until the research end date and then downloaded for analysis.

b) The measure of knowledge employed

Knowledge of, and attitudes to, mental illness was assessed using the Mental Health Literacy Scale (MHLS) developed by O'Connor and Casey (2015). The scale includes 15 'knowledge' items and 20 'attitude' items (see Appendix I to see the scale in full). The MHLS was included in a systematic review of mental health literacy scales world-wide. It outperformed most of the 16 other measures that were included in the final review. It was independently assessed to have strong evidence for internal consistency and content validity and moderate evidence for reliability (Wei et al, 2016).

e) Analysis

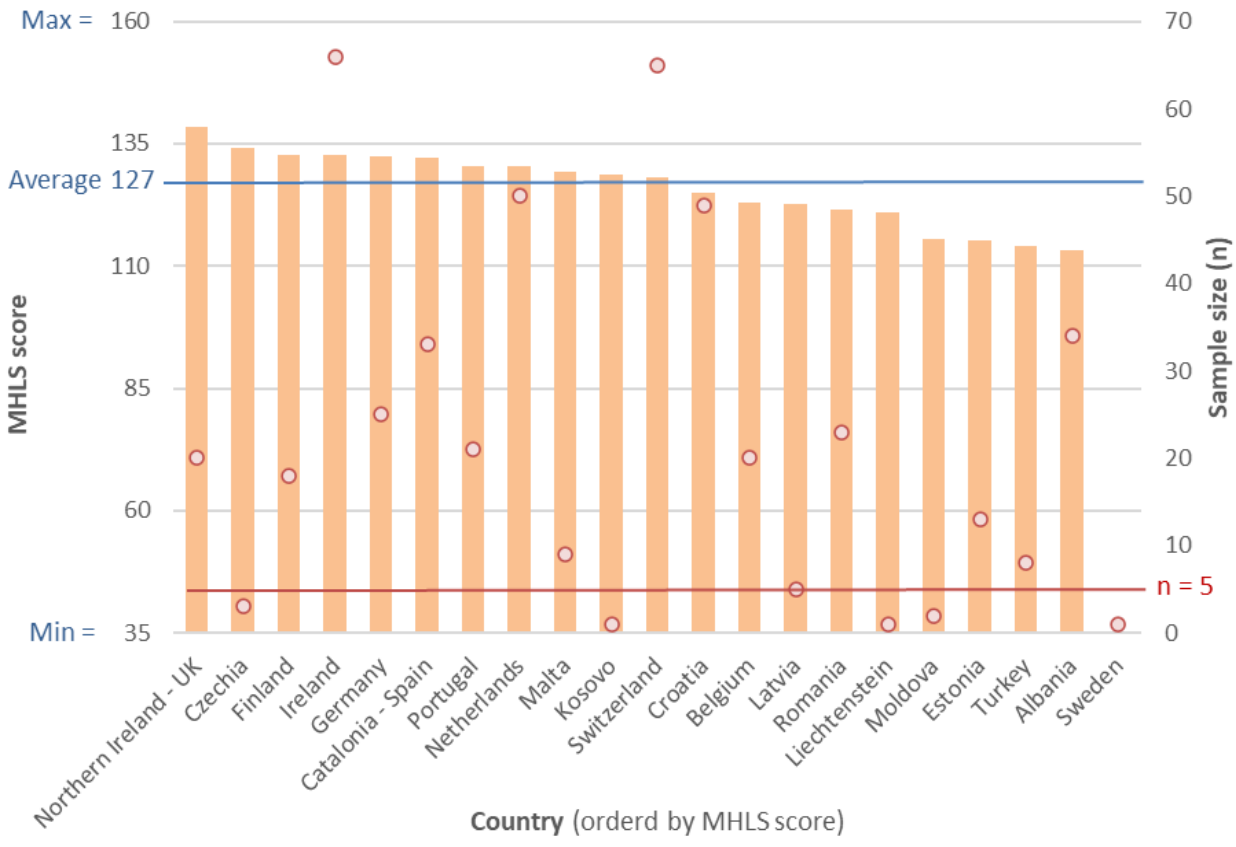
The attitude and knowledge data were analysed using IBM SPSS v26. A total score was calculated for each respondent, with reverse items scored accordingly. Mean total scores were calculated for each service and for the whole sample. These summary statistics has been compared descriptively with the normative data from other populations. In addition, we examined the individual knowledge and/or attitude items that performed badly or well. Multivariate analysis was used to investigate predictive factors for mental health literacy.

4. Results

a) Response

Response rates were variable with four countries contributing 51% of participants – Ireland n= 66, Switzerland n=65, Netherlands n=50 and Croatia n=49 (see Figure 1). Overall, 16 of 21 countries provide 5 or more responses to the survey (only 4 participants (0.9%) failed to answer the mental health literacy questions). A response was received from the majority of countries that are full members of CEP (60%). There were a number of reasons for non-response: the conflict in Ukraine; service re-organisation with little capacity (Austria); and finally, the requirement to obtain ethical approval which did not fit with the study timetable (England and Wales). Nonetheless, it was disappointing that several large countries did not take part such as France and Italy. We address the variations in response in the discussion section.

Figure 1 Response rate by Country and MHLS Score



b) MHLS Scores by Country

It is noteworthy that three countries with 5+ responses (Northern Ireland, Ireland and Netherlands) scored significantly higher than the overall average (Table 1) and five countries scored significantly lower than the average MHLS score (Belgium, Estonia, Romania, Turkey and Albania). The overall mean score for the MHLS was 128.

Table 1. Statistical comparison on the MHLS scores for countries where response rates were 5 or more.

				95% CI			Range	
Country	N	Mean	Std. Error	Lower	Upper	*p* [(a)]	Min	Max
Northern Ireland	20	138	1.8	135	142	****	121	154
Finland	18	133	2.9	127	139	*0.126*	105	150
Ireland	66	133	1.4	130	135	**	103	151
Netherlands	49	132	1.4	130	135	***	115	152
Germany	25	132	2.3	127	137	*0.117*	101	151
Catalonia - Spain	33	130	2.1	126	135	*0.264*	100	150
Portugal	21	130	3.4	123	137	*0.404*	97	152
Malta	9	129	3.8	120	138	*0.745*	112	153
Switzerland	64	129	1.7	125	132	*0.624*	90	149
Croatia	49	125	1.8	121	128	*0.157*	80	145
Belgium	20	123	1.7	119	126	*	111	138
Latvia	5	123	7.9	101	144	*0.401*	101	150
Romania	23	121	1.9	118	125	***	104	139
Estonia	13	115	4.0	106	124	****	92	138
Turkey	8	114	5.1	102	126	**	102	147
Albania	33	113	2.8	108	119	****	83	150
Total	**463**	**128**	**0.6**	**127**	**129**		**80**	**154**

significantly above the overall average

significantly below the overall average

*(a) t-test * <0.05; ** <0.01; *** <0.005; **** <0.001*

Respondents from six countries had listed various organisations and there were sufficient responses to be able to analyse the MHLS by either different locations (national v. territorial, where territorial is defined when a sub-national

geographic area was stated under "Organisation name") or by service type (Table 2). The only significant difference in responses by locality was for Switzerland, where territorial services had a significantly higher MHLS than national services. For Germany, only 4 responses (classified as national) were NOT from Baden-Württemberg and although these had a lower average MHLS, it was not statistically significant.

Table 2. Countries where responses could be broken down by different services based on either locality (national v. territorial[#]) or by service type.

[#] territorial is defined when a sub-national geographic area was stated under "Organisation name".

Country	N	No of services	National	Territorial	Addiction Rehab	Salvation Army	*p* [(a)]
Switzerland	62	5	120	133			****
Germany	24	2	126	133 [(b)]			0.241
Croatia	49	2	125	124			0.642
Albania	32	2	119	110			0.293
Netherlands	49	2			138	131	0.097
Romania	23	2	122	120			0.621

*(a) t-test * <0.05; ** <0.01; *** <0.005; **** <0.001*

[(b)] all Baden- Württemberg

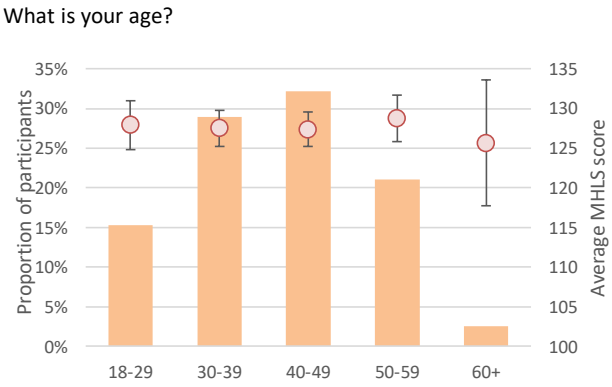
c) Socio-demographic variables and MHLS Scores

Most respondents were aged 30 to 49 (61%) and the majority were female (73%). Age did not influence MHLS score but females (128) scored significantly higher than males (123).

Please see Figures 2 and 3 below.

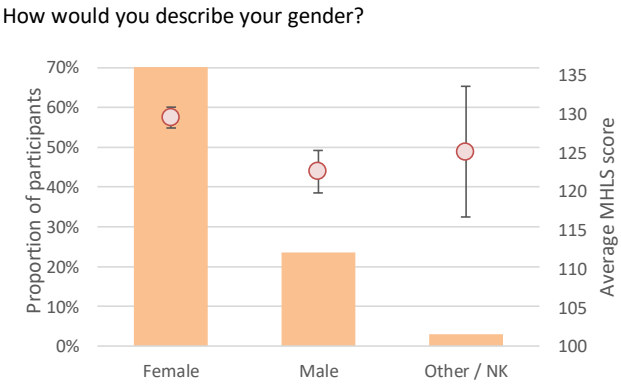
Figure 2 Respondent's Age

Response rate (bars) and average MHLS (circles with 95% CI)



ANOVA: F = 1.242; *p = 0.914*

Figure 3 Respondent's gender

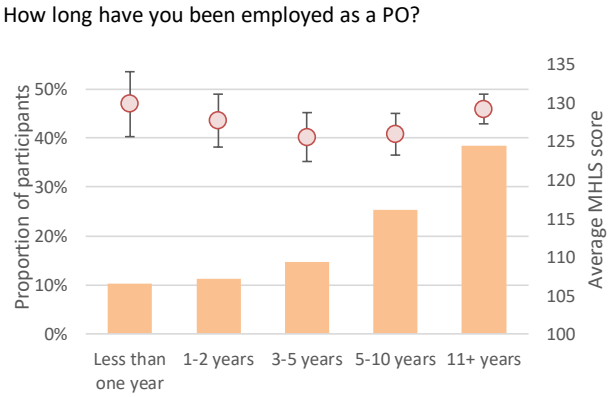


ANOVA: F = 11.847; *p <0.001*

Two thirds (64%) of respondents have been employed as a PO for 5+ years and less than one third (30%) remembered mental illness being part of their training. Neither of these factors influenced the average MHLS score (see Figures 3 and 4 below).

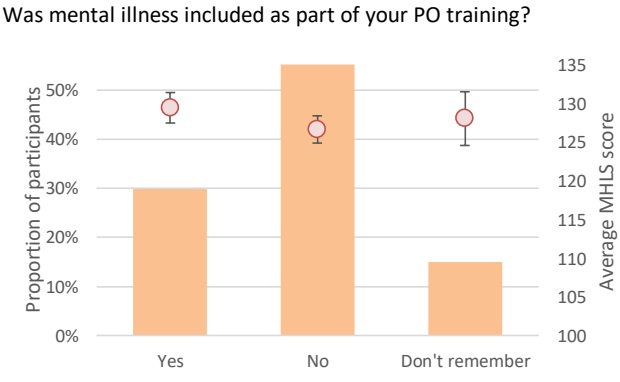
Figure 3 Length of Employment

Response rate (bars) and average MHLS (circles with 95% CI)



ANOVA: F = 1.769; *p = 0.134*

Figure 4 Was 'mental illness' part of your basic training?

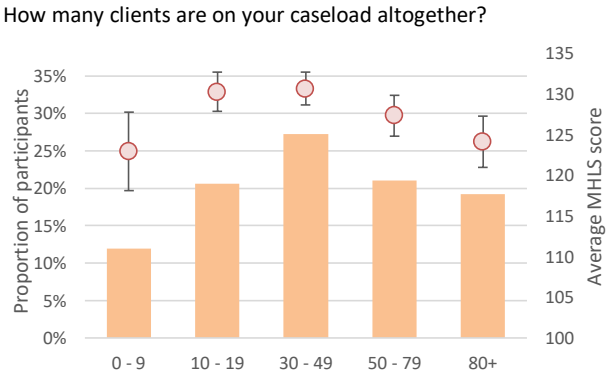


ANOVA: F = 1.985; *p = 0.139*

Most respondents (27%) had 30 - 49 clients on their caseload but around a fifth had either 50 - 79 (21%) or 80+ (19%) clients. Around a third of respondents had 10 - 19 hours (31%) or 20 - 29 hours (33%) of direct contact in a week with 13% having 30 - 49hrs and 1% stating that they had 50+hrs of direct contact in a week. Respondents with 10 - 19 (130) and 30 - 49 (131) clients has statistically greater MHLS scores than those with 0 - 9 (123) or 80+ (124) clients but hours of direct contact did not influence the MHLS score.

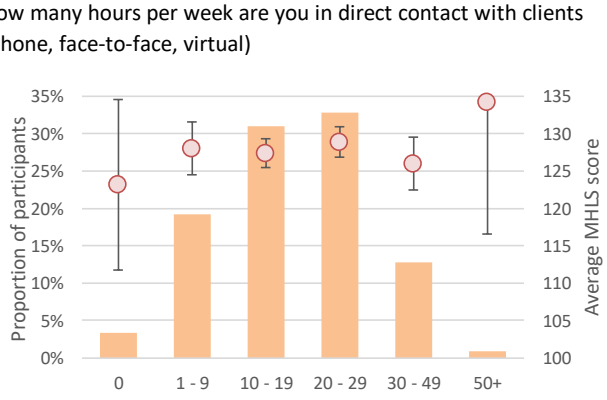
Figure 5 Caseload Size

Response rate (bars) and average MHLS (circles with 95% CI)



ANOVA: F = 5.845; *p < 0.001*

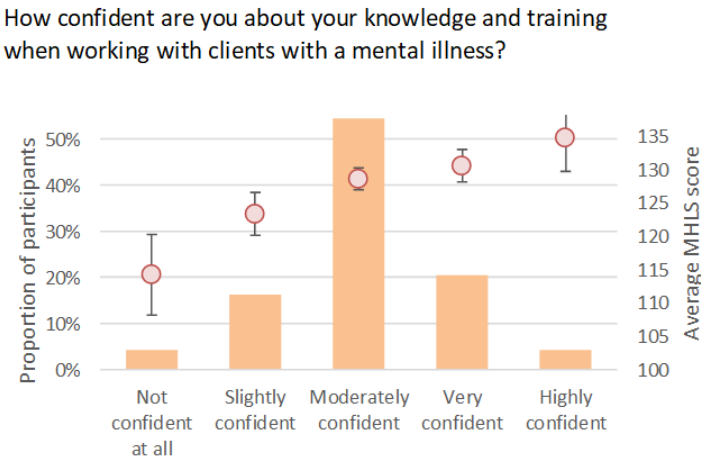
Figure 6 Client contact hours



ANOVA: F = 0.958; *p = 0.443*

Just over half (55%) of respondents said they were moderately confident in their knowledge and training when working with clients with a mental illness and a further one quarter (25%) were very or highly confident. This confidence in knowledge and training was strongly correlated with the MHLS score – those highly confident scored 137 compared with those not confident at all scoring only 105. However, only the 20% stating they were not confident at all or slightly confident were significantly lower than the 80% with moderate to high confidence (see Figure 7 below).

Figure 7 Confidence and knowledge when working with clients with a mental illness. [Response rate (bars) and average MHLS (circles, with 95% CI)]



ANOVA: F = 10.160; $p < 0.001$

d) Multivariate analysis

A generalised linear model (SPSS v 26) was applied to the MHLS scores initially with each of the above variables included. The only significant variables which remained in the final model were: country, gender, number of clients and confidence, which confirms the univariate analysis and suggests that these factors are combined predictors of the MHLS score.

e) Best and worst performing items on the MHLS

The 5 questions that respondents got mostly **correct** were:

- A mental illness is a sign of personal weakness
- A mental illness is not a real medical illness
- It is best to avoid people with a mental illness so that you don't develop this problem
- Seeing a mental health professional means you are not strong enough to manage your own difficulties
- I believe treatment for a mental illness, provided by a mental health professional, would not be effective

These items can best be described as 'attitudinal'. It is gratifying that probation staff display non-stigmatising positive attitudes to mental illness.

The 5 questions that respondents got mostly **incorrect** were:

- If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have Social Phobia
- If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have Major Depressive Disorder
- To what extent do you think it is likely that, in general, women are MORE likely to experience a mental illness of any kind compared to men
- To what extent do you think it is likely that, in general, men are MORE likely to experience an anxiety disorder compared to women
- To what extent do you think it would be helpful for someone to avoid all activities or situations that made them feel anxious if they were having difficulties managing their emotions

The five worst scoring items require technical and more in-depth knowledge of mental illness so perhaps it is not surprising, given overall MHLS scores, that these questions were found harder to answer.

e) Qualitative Findings

A semi-structured questionnaire was sent to five countries/jurisdictions (Ireland, Finland, Catalonia (Spain), Romania and Malta). The instrument is attached at Appendix II.

Was the fact the questionnaire was in English a major barrier to staff? Can you say how?

In countries/jurisdictions where English was the first or second spoken language few problems were reported. However, where this was not the case, response was reduced. Several respondents throughout this exercise asked if the MHLS could be translated (and at least one country/jurisdiction did translate the MHLS). The technical problem with translation was the lack of validity for what was a 'new' measure.

Did staff feel the completion of the questionnaire raised any issues for them? Did they generally feel positive about the exercise? If so, why? Or did they feel generally negative, again, if so, why?

Generally, most probation staff from all countries/jurisdictions felt positive about the exercise. Mental health was a key issue for them and many freely admitted their knowledge was lacking. However, in one country there was a concern that a demonstrable lack of knowledge would lead to staff losing their jobs.

As the manager of the probation service, did participation in the exercise make you feel you needed to address your staff's knowledge about mental illness? Do you have any plans to do this? If so, can you describe them

There was general consensus that more needed to be done to improve probation staff's knowledge of mental health issues. However, as a minimum, one manager reported, probation staff should be able to identify a mental illness and help the person obtain treatment. In one country, the survey was regarded as very helpful in providing a baseline of knowledge in that service. This, because, new training initiatives were planned. One manager made the point that it's wasn't only the mental health of clients that was a concern but the mental health of staff too.

If the general conclusion of the study shows that a European-wide mental health training curriculum is this something you would support?

There was widespread support for a common core of mental health training for staff across Europe. One caveat was that whilst there would be value in

determining a European-wide core curriculum each local course would have to take into account local circumstances within each countries/jurisdiction.

How might CEP assist with the question of training in mental health in the future?

Most of the respondents felt that CEP's role was to continue awareness-raising either on-line or face-to-face. One country felt that a CEP-endorsed core mental health curriculum would give them clout in arguing for resources to fund training locally. One respondent also felt that CEP should commission more research in mental health and probation.

5. Discussion

Response

Over half of all countries in CEP responded (60%) and there was enormous variation in overall response and response within countries. In total, 467 completed questionnaires were received. A significant proportion of these came from: Ireland (14%); Switzerland (14%); the Netherlands (11%) and Croatia (10%). In fact, these four countries provided 49% of all responses. It was perhaps surprising that France, Spain and Italy did not participate. Of course, the questionnaire, was in English, and this might have been a serious problem for some countries. 'English language Proficiency' will be discussed as a possible explanation for non-response.

We looked at response as a proportion of the total probation workforce within countries/jurisdictions. The best response by far was from Croatia (74%) followed by Catalonia (Spain) with 47%, then Malta with 45% and Switzerland (32.5%). There were disappointing responses from some countries with large workforces (Belgium 2%), Germany (1%), France (0) and Italy (0). However, this might be because of anticipated language problems with the MHLS questionnaire. We report an index of English language proficiency in Table 3 (Education First – EPI, 2022).

Table 3 Individual Response by country/jurisdiction as a proportion of the total probation workforce

CEP Country	Survey responses	%	MHLS score	Probation officers (qualified Probation staff)		% response	English proficiency
Ireland	66	14%	133	229		28.8%	700#
Switzerland	65	14%	128	200	*	32.5%	563
Netherlands	50	11%	130	2,193		2.3%	661
Croatia	49	10%	125	66		74.2%	612
Albania	34	7%	113	68	*	50.0%	523
Spain - Catalonia	33	7%	132	69		47.7%	545
Germany	25	5%	132	2,500	*	1.0%	613
Romania	23	5%	121	508		4.5%	595
Portugal	21	4.5%	130	449		4.7%	614
Belgium	20	4.3%	123	900		2.2%	620
Northern Ireland - UK	20	4.3%	138	106	**	18.9%	700#
Finland	18	3.9%	133	207		8.7%	615
Estonia	13	2.8%	115	116		11.2%	570
Malta	9	1.9%	129	20		45.0%	
Turkey	8	1.7%	114	963		0.8%	495
Latvia	5	1.1%	123	280		1.8%	571
Czechia	3	0.6%	134	352		0.9%	575
Moldova	2	0.4%	116	158		1.3%	528
Liechtenstein	1	0.2%	121	3		33.3%	
Kosovo	1	0.2%	129	73	*	1.4%	
Sweden	1	0.2%	not completed	657		0.2%	618
Austria	0	-		348		-	628
Norway	0	-		421		-	627
Denmark	0	-		274		-	625
Slovakia	0	-		85		-	597
Luxembourg	0	-		16		-	596
Hungary	0	-		344		-	590
Bulgaria	0	-		262		-	581
Italy	0	-		1,016		-	548
France	0	-		3,461		-	541
Georgia	0	-		175		-	524
Jersey	0	-		42	*	-	700#
Scotland	0	-		989	*	-	700#
United Kingdom (E&W	0	-		3,543		-	-
Lithuania	0	-		330		-	-
Slovenia	0	-		38		-	-
Macedonia	0	-		29		-	-
Montenegro	0	-		8		-	-
Total	**467**		**128**	**21,498**			
		Total for countries in survey		**10,117**		**4.6%**	

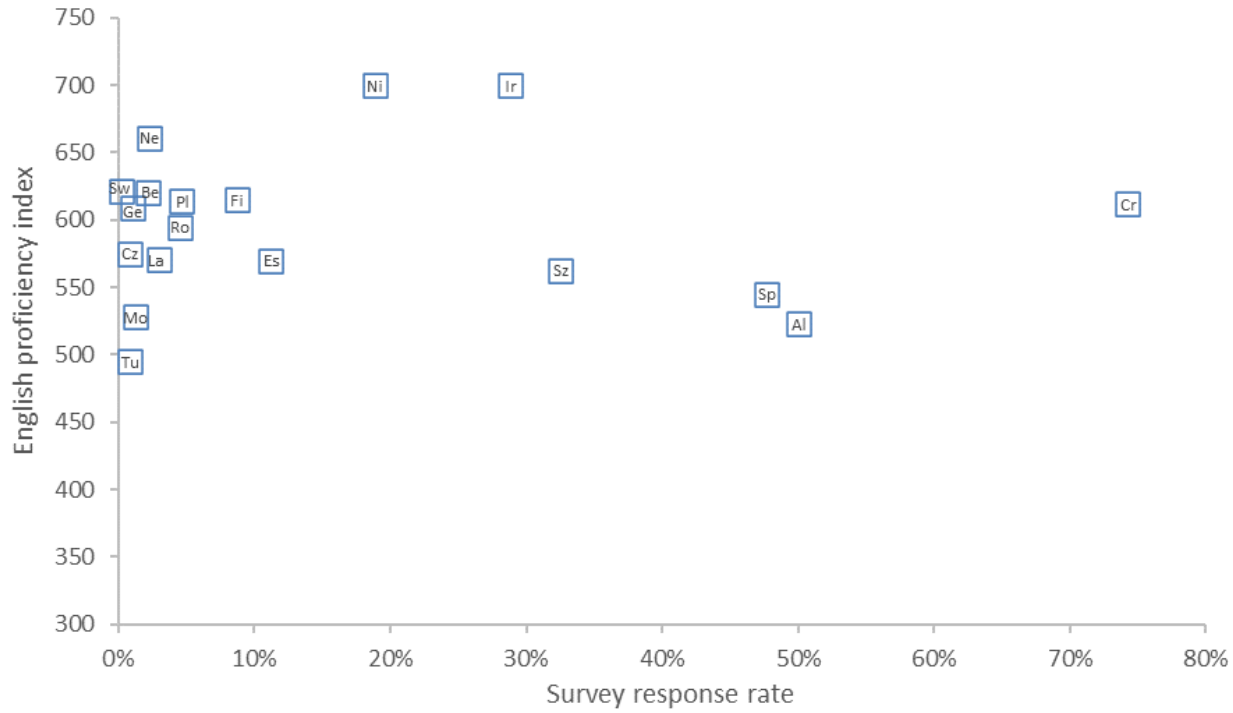
* Number taken from CEP website

** NI = 3% of UK population. 3% of 3,543 = 106

Estimated high index

Also, in Figure 8 below, we show response plotted against English language proficiency. There is no correlation between the ability to speak/understand English and response.

Figure 8 Response plotted against English language proficiency



Correlation between survey response rate and proficiency in the English language by country. Key: Ir - Ireland, Sz - Switzerland, Ne - Netherlands, Cr - Croatia, Al - Albania, Sp - Spain – Catalonia, Ge - Germany, Ro - Romania, Pl - Portugal, Be - Belgium, Ni - Northern Ireland – UK, Fi - Finland, Es - Estonia, Mt - Malta, Tu - Turkey, La - Latvia, Cz - Czechia, Mo - Moldova, Li - Liechtenstein, Ko - Kosovo, Sw - Sweden,

Despite a low response rate across Europe this survey, nonetheless, represents the largest sample of European probation staff ever reported.

What can say about European probation officer's knowledge of, and attitudes to, mental illness?

Each countries score is given above in Table 3 as is the overall score for the whole sample of probation staff (128). It will be remembered that the range of scores for the MHLS is 35-160. The literature was examined to see how the overall score of 128 for the probation sample equated with other samples and occupational groups (Table 4).

Table 4 MHLS scores from previous studies (2017-2021)

Study Author (year)	Type of Sample	Country	Score on MHLS overall
Vermaas et al (2017)	238 Christian clergy members – convenience / voluntary sampling	USA	Overall: Mean = 134.20 (SD = 10.83)
White & Casey (2017)	263 general population – convenience sample targeted older people but open to anyone over 17	Australia	Overall: Mean = 127.98 (SD = 13.92)
Clough et al (2019)	357 domestic and international students – convenience/voluntary sampling	Australia	Domestic students: Mean = 132.41 (SD = 13.12) International students: Mean = 113.12 (SD = 15.54)
Marwood & Hearn (2019)	251 medical students – voluntary sampling	UK	Mean = 127.69 (SD = 11.82)
Sullivan et al (2019)	80 athletic staff (57 coaches, 18 athletic therapists) – voluntary sampling	Canada	Overall: Mean = 131.48 (SD = 10.34)
Gorczynski et al (2020)	300 students – voluntary sampling	UK	Mean = 123.5 (SD = 15.5)
Scollione & Holdan (2020)	291 participants (255 criminal justice students; 47 police academy students) – convenience sampling	USA	Overall: Mean = 106.47 (SD = 9.05)
Argao et al (2021)	519 state and private university students – convenience sampling	Philippines	Mean = 118.15 (SD = 11.97)

Table 4 shows that probation staff in Europe score similarly to the general population in Australia (White and Casey, 2017); medical students (Marwood

and Hearn, 2019); and athletic staff (Sullivan et al, 2019). Probation staff in Europe score better than UK students (Gorczynski et al 2020); US criminal justice students (Scollione and Holdane, 2020) and a mixture of state and private university students in the Philippines (Argao et al, 2021). However, the scores for the European probation staff were worse than for US Christian clergy (Vermaas et al, 2017) and domestic students in Australia (Clough et al, 2019).

This, however, is to discuss just the average MHLS scores across Europe the individual country scores reveal much variation. There are a cluster of countries that score in excess of 128 which include: Ireland, The Netherlands, Catalonia (Spain), Germany, Northern Ireland, Finland and Czechia (although this was a very small sample of 3). There are then countries on or near the average such as Switzerland, Portugal and Malta. Finally, there are some countries with lower scores such as Albania, Romania, Belgium, Turkey and Latvia.

Finally, there is indeed, even variation within countries that can be teased out and Switzerland is a good example (See Table 2). Here, in the national service the mean score was 120, this is contrast to that part of Switzerland we have defined as 'territorial' where the mean score is 133. There is a similar pattern for Germany.

The highest score that was achieved was 138 by Northern Ireland, however, if the top scores for MHLS is 160, there is a question to be posed, is a score of 138 good enough? Or should probation services be aiming for a much higher score in order to be confident in their role of working with high numbers of people with a mental illness? We have shown earlier that there is a high correlation between confidence in working with people with a mental illness and MHLS score (see Figure 7).

A Pan-European curriculum or 'Horses for courses'?

It seems clear that there is much work to be done, across Europe, to meaningfully increase probation staff's knowledge of mental illness. Interestingly, CEP hosted an event[1] in 2009 that examined probation officer

[1] The argument for the development of a Pan-European probation training was explored at a conference held by CEP on the recruitment and training of probation officers

training and recruitment. Siridifield et al (2010) gave a paper at this conference on the mental health training component of such a course were it ever to come to fruition. She, and her colleague, Mark Gardner, presented an evaluation of a short mental health programme, run in one county in England, which significantly improved; knowledge, attitudes and confidence. Canton (2009) argued at this conference that 'exporting' criminal justice policy via training was impossible as it ignored the local context and culture. He stated that:

'While there are ideas and practices that can be plausibly offered as resources to other jurisdictions, it must always be borne in mind that that these have to find or make their place in a specific national context'

Canton noted that the development of any pan-European curriculum would need to consider a whole host of factors including: the existing legal system; the cost of training; the function and the organisation of probation services in each country. He suggested one possible solution might be to develop training with generic elements (Europe-wide) with other local (Region or country-wide) specific elements. These are helpful suggestions that might well apply to mental health. The generic elements of mental health training are relatively easy to identify and could include: mental health myths, stigma and stereotypes; factors that impact mental health; common diagnoses; the interaction between mental health and probation practice and local mental health services and their referral mechanisms. The local elements might involve the interaction between legislation and mental health and probation service organisation and what this means for the role of the probation officer.

6. Conclusion

Some findings are clear from this report. First, response by overall number of probation staff to the survey across Europe ranged from 0% - 74% within each country. However, 60% of all countries in Europe involved with CEP contributed to the survey. There were compelling reasons why some countries did not participate (including Ukraine, England and Austria). Overall, 467 probation staff took part, which is a high total sample for any probation study. Feedback was received that suggested that zero response from some countries was because the MHLS was written in English. We explored this using an English Language Proficiency measure which showed no relationship between 'English proficiency' and response.

Second, knowledge of, and attitudes, to mental health, are highly variable across Europe. This is true even within countries. The average score obtained by probation staff across Europe in this survey was lower than for Christian clergy and university students. Some countries had a much higher level of mental health knowledge than others. Notable examples included Northern Ireland, Finland and Ireland. Other countries scored significantly lower than the average score.

Third, we detected a statistically significant association between high knowledge scores and the extent to which probation staff felt confident in working with people with a mental illness. The higher the score the more confident staff were. This finding, alone, is very important and makes the case for mental health training to be available to all probation staff across Europe.

Finally, the question remains how should such training be delivered. It's likely that this question will be key in the future when the Council of Europe paper on mental health and probation/prisons is published in 2023 where training in mental health will be a recommendation. We would argue that a model that acknowledges the uniqueness of the criminal justice system in each country/jurisdiction combined with generic elements would be the place to start.

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Appendix I – The Mental Health Literacy Scale

The purpose of these questions is to gain an understanding of your knowledge of various aspects to do with mental health. When responding, we are interested in your degree of knowledge. Therefore when choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely

Unlikely = I think it is unlikely but am not certain

Likely = I think it is likely but am not certain

Very Likely = I am certain that it IS very likely

1

If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have **Social Phobia**

Very unlikely Unlikely Likely Very Likely

2

If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigued then to what extent do you think it is likely they have **Generalised Anxiety Disorder**

Very unlikely Unlikely Likely Very Likely

3

If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have **Major Depressive Disorder**

Very unlikely Unlikely Likely Very Likely

4

To what extent do you think it is likely that **Personality Disorders** are a category of mental illness

Very unlikely Unlikely Likely Very Likely

5

To what extent do you think it is likely that **Dysthymia** is a disorder

Very unlikely Unlikely Likely Very Likely

6

To what extent do you think it is likely that the diagnosis of **Agoraphobia** includes anxiety about situations where escape may be difficult or embarrassing

Very unlikely Unlikely Likely Very Likely

7

To what extent do you think it is likely that the diagnosis of **Bipolar Disorder** includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood

Very unlikely Unlikely Likely Very Likely

8

To what extent do you think it is likely that the diagnosis of **Drug Dependence** includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)

Very unlikely Unlikely Likely Very Likely

9

To what extent do you think it is likely that in general in Australia, **women are MORE likely to experience a mental illness of any kind compared to men**

Very unlikely Unlikely Likely Very Likely

10

To what extent do you think it is likely that in general, in Australia**, men are MORE likely to experience an anxiety disorder compared to women**

Very unlikely Unlikely Likely Very Likely

When choosing your response, consider that:

- Very Unhelpful = I am certain that it is NOT helpful
- Unhelpful = I think it is unhelpful but am not certain
- Helpful = I think it is helpful but am not certain
- Very Helpful = I am certain that it IS very helpful

11

To what extent do you think it would be helpful for someone to **improve their quality of sleep** if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)

Very unhelpful Unhelpful Helpful Very helpful

12

To what extent do you think it would be helpful for someone to **avoid all activities or situations that made them feel anxious** if they were having difficulties managing their emotions

Very unhelpful Unhelpful Helpful Very helpful

When choosing your response, consider that:

- Very unlikely = I am certain that it is NOT likely
- Unlikely = I think it is unlikely but am not certain
- Likely = I think it is likely but am not certain
- Very Likely = I am certain that it IS very likely

13

To what extent do you think it is likely that **Cognitive Behaviour Therapy (CBT)** is a therapy based on challenging negative thoughts and increasing helpful behaviours

Very unlikely Unlikely Likely Very Likely

14

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

If you are at immediate risk of harm to yourself or others

Very unlikely Unlikely Likely Very Likely

15

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

if your problem is not life-threatening and they want to assist others to better support you

Very unlikely Unlikely Likely Very Likely

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
16. I am confident that I know where to seek information about mental illness					
17. I am confident using the computer or telephone to seek information about mental illness					
18. I am confident attending face to face appointments to seek information about mental illness (e.g., seeing the GP)					
19. I am confident I have access to resources (e.g., GP, internet, friends) that I can use to seek information about mental illness					

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
20. People with a mental illness could snap out if it if they wanted					
21. A mental illness is a sign of personal weakness					
22. A mental illness is not a real medical illness					
23. People with a mental illness are dangerous					
24. It is best to avoid people with a mental illness so that you don't develop this problem					
25. If I had a mental illness I would not tell anyone					
26. Seeing a mental health professional means you are					

not strong enough to manage your own difficulties					
27. If I had a mental illness, I would not seek help from a mental health professional					
28. I believe treatment for a mental illness, provided by a mental health professional, would not be effective					

Please indicate to what extent you agree with the following statements:

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
29. How willing would you be to move next door to someone with a mental illness?					
30. How willing would you be to spend an evening socialising with someone with a mental illness?					
31. How willing would you be to make friends with someone with a mental illness?					

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
32. How willing would you be to have someone with a mental illness start working closely with you on a job?					
33. How willing would you be to have someone with a mental illness marry into your family?					

34. How willing would you be to vote for a politician if you knew they had suffered a mental illness?					
35. How willing would you be to employ someone if you knew they had a mental illness?					

Scoring

Total score is produced by summing all items (see reverse scored items below). Questions with a

4-point scale are rated 1- very unlikely/unhelpful, 4 – very likely/helpful and for 5-point scale 1

– strongly disagree/definitely unwilling, 5 – strongly agree/definitely willing

Reverse scored items: 10, 12, 15, 20-28

Maximum score – 160

Minimum score – 35

APPENDIX II – Semi-structured interview questions sent to five countries

The CEP-funded study to examine Probation Officer's knowledge of, and attitudes to mental health illness

Qualitative Phase

I am writing to you and as you agreed to take part in a qualitative interview following the distribution of the mental health literacy scale (MHLS) to your staff. I would be very grateful if you could look at the questions overleaf and give me your views? There are no 'right' or 'wrong' answers and please feel free to say as much or as little as you'd like to. Thank you again for agreeing to be part of this important research.

1. Was the fact the questionnaire was in English a major barrier to staff participation – can you say how?

2. Did staff feel the completion of the questionnaire raised any issues for them? Did they generally feel positive about the exercise? If so, why? Or did they feel generally negative, again, if so, why?

3. As the manager of the probation service, did participation in the exercise make you feel you needed to address your staff's knowledge about mental illness? Do you have any plans to do this? If so, can you describe them

4. If the general conclusion of the study shows that a European-wide mental health training curriculum is this something you would support?

5. How might CEP assist with the question of training in mental health in the future?

6. Are there any other comments you would like to make about any aspect of this exercise not mentioned above?