

Are the Needs of Adult Offenders with Mental Health Difficulties being met in Prisons and on Probation?

Laura Cotter¹

Summary:

‘Fact: If you’ve a mental illness you’re far more likely to go to prison’
(The Prison Trap, Irish Times, 2013, p. 1).

People with mental illness are significantly overrepresented in the criminal justice system. Many policy makers and practitioners have labelled this phenomenon the ‘criminalisation of the mentally-ill’ (Ringhoff *et al.*, 2012). This article reports on a study exploring the prevalence of mental illness amongst offenders in the prison and probation populations in the Republic of Ireland. It examines the treatment of mentally ill offenders in prison and under community supervision. Recent policy and practice developments in this area are critically explored. Drawing on international literature a number of proposals are made for the development of probation policy and practice in this area.

Keywords: offenders, mental illness, mentally ill offenders, mental health difficulties, mental disorder, diversion programmes, probation, prison, criminal justice system, criminal behaviour, treatment needs, punishment of mentally ill offenders, human rights, mental illness and penal reform.

Introduction

My interest in the treatment of mentally ill offenders stemmed from growing up in Monaghan, a small Irish town where I lived opposite a psychiatric hospital. I was always intrigued by the red brick building and wondered if it was humane for people to spend their entire lives as in-patients. As an undergraduate Social Science student I was given the task of completing a research project and conducted a random sample survey of the characteristics of the patients admitted to the ‘Monaghan District

¹ Laura Cotter is a Probation Officer with the Probation Service based in Dublin. Email: ldcotter@probation.ie

Lunatic Asylum' at the turn of the twentieth century, their diagnoses, the perceived cause of their 'madness' and their treatments. This data was gathered from the census forms in the National Archives entitled 'Return of Idiots and Lunatics in Institutions' in 1901 and 1911.² The primary reasons for being admitted ranged from masturbation and religious excitement to loss of property or cattle.

In my own practice as a Probation Officer on Dublin's Circuit Court Assessment Team, I prepare reports for the Court. Offenders' mental health difficulties are often cited as a contributing factor in their offending. I often struggle with the 'criminalisation hypothesis' and wonder if in fact I am helping or hindering clients in the long run by recommending probation as a disposal for their case, questioning whether interaction with the criminal justice system can damage a mentally disordered offender further.

Research rationale, aim of the study, policy context and methodology

The law in Ireland regarding mental disorder and criminal insanity was radically reformed in 2006 with the full implementation of the Mental Health Act 2001 and the enactment of the Criminal Law (Insanity) Act 2006. The latter defines 'mental disorder' as 'mental illness, mental disability, dementia or any decrease of the mind but does not include intoxication'. A mentally disordered offender convicted of a criminal offence and detained in a mental institution will be detained under both the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2006. The Report from the Expert Group on Mental Health Policy, '*A Vision for Change*' (2006) sets out a blueprint for mental health service provision in Ireland and recommends that 'every person with serious mental health problems coming into contact with the forensic system should be afforded the right of mental healthcare in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done' (Department of Health, 2006, p. 137).

Set against the backdrop of changes in the law regarding mental disorder, this study is driven by two needs. The first is to examine the treatment of offenders with mental health difficulties in Irish prisons following a long period of what Mulcahy (2013, p. 141) characterises as

² www.nationalarchives.ie

‘neglect and inaction by the Irish state’. The second is to explore alternatives to custody for this client group. Three approaches have been used. While it is primarily a literature review, data is also drawn from the Probation Service’s collated *Level of Service Inventory Revised Assessments* (LSI-R)³ conducted in 2012. *LSI-R* is a risk and needs assessment instrument used nationally. It aims to identify dynamic areas of risk/needs that may be addressed in order to reduce risk (Andrews and Bonta, 2004). Permission was sought from the Probation Service and provided to use and examine the data for this study. The third approach involves consultation with key personnel within the mental health field. These consultations were not analysed and were conducted within the context of providing background to the literature.

A sociological perspective of mental illness

According to Foucault (1965) ‘madness’ in the Middle Ages was considered more a part of everyday life. With the Enlightenment a shift occurred which Foucault calls ‘the great confinement’, when the mad were no longer seen as citizens and were placed in asylums away from society lying outside the boundaries of ‘truth’. Walker (2006) states that the powerful in society promote a dominant discourse of ideas and practices that often pathologises and devalues practices of non-dominant cultures and marginalised groups, and often mental health practice and the profession itself acts as an agent of society in this way. This is of particular interest when the powerhouse of control within prison and probation populations is added to the picture.

The last couple of decades have witnessed the closure and downsizing of institutionally based care arrangements in Ireland. Deinstitutionalisation shifted the focus of care for people with mental illness away from psychiatric hospitals to local community mental health centres. It is argued that deinstitutionalisation became the single largest contributing factor to the criminalisation of the mentally ill as this process resulted in a significant number of individuals with mental illness being directed towards the criminal justice system (Teplin, 1984; Lurigio and Swartz,

³ The Level of Service Inventory–Revised™ (LSI-R™) is a quantitative survey of offender attributes and their situations relevant to level of supervision and treatment decisions. It was developed by Don Andrews, Ph.D. and James Bonta, Ph.D and is published by Multi-Health Systems Inc. (MHS) www.mhs.com

2000). Writing in the US context, Ringhoff *et al.* (2013) argue that the policy of deinstitutionalisation was never properly implemented. While it achieved the goal of reducing bed numbers in state hospitals, it never succeeded in providing adequate, appropriate or co-ordinated treatment in the community for those suffering with mental disorders.

Gunn (2004) reports a steady reduction in psychiatric beds over the past twenty years in Ireland with a continuing increase in the number of mentally ill offenders in the prison population with major mental illness. Penrose's Law (1939) is a theory demonstrating an inverse relationship whereby if the population of one institution of control (e.g. the mental hospital) decreases the population of another (such as the prison) rises. Penrose's theory proposes that a constant number of people with psychiatric disorders will always require institutional care. As a result, if the psychiatric hospitals are unavailable or unwilling to treat patients, they are housed elsewhere, such as prisons, and become criminalised (Teplin, 1984).

In their discussion of 'coercive confinement' in Ireland, O'Donnell and O'Sullivan (2012) documented the plight of tens of thousands of men, women and children detained in Ireland in a network of institutions including: psychiatric hospitals, mother and baby homes, Magdalen homes, reformatory schools, industrial schools, prisons and borstals. This account takes on a special importance as Irish society continues to grapple with the legacy of its extensive use of institutionalisation. This raises the question of how offenders with mental illness in Ireland are being 'managed' today. In line with Penrose's theory, has there been a displacement from one form of institutionalisation to another?

The relationship between mental illness and offending

A wide range of research documents the link between mental illness and offending. Woodward *et al.* (1999) document the category of 'offenders with mental disorders' covering a wide range of persons with criminal behaviour, from those who have committed violent crimes to petty offenders. There is an extensive body of research on the predictors of mental health problems and antisocial behaviour. However the interface between the two becomes more complicated as much of the literature concentrates on violence which is neither the only, nor the most prevalent offence committed by offenders with mental health difficulties (Hagell and Dowling, 1999).

Assessing the causal link between mental illness and crime is complex (Frank and McGuire, 2010). Some research indicates connections between mental illness and criminal behaviour (e.g. Ringhoff *et al.*, 2013), while some argue that ‘no pathogenesis between mental illness and crime has ever actually been established’ (Lurgio, 2011, p. 15). Much of the research exploring the relationship between mental illness and offending highlights a number of other relevant factors. Many studies focus on the relationship between mental illness and social problems such as unemployment and financial difficulties (Mocan and Tekin, 2006). A higher prevalence of intellectual disabilities, health and social care needs are also highlighted (Ringhoff *et al.*, 2013). Keene (2001) notes as many as 90 per cent of adult prisoners in the United States have a diagnosed substance misuse problem, mental illness or both.

The basic challenges are what one might expect in working with a population with serious mental illness. These include low levels of education, limited or absent social and/or family network and poor access to care (Trestman, 2013). However, one of the biggest issues highlighted in a range of international research concerns the association between mental illness and housing, as homelessness has been strongly linked to the elevated risk of re-incarceration of the mentally ill (Constantine *et al.*, 2010; Serowik and Yanos, 2013). Further challenges faced by this client group include substantial levels of stigma, both in relation to mental illness and as a result of contact with the criminal justice system. In some instances this can be further compounded by substance misuse (Trestman, 2013).

Prevalence of mental illness among prisoners

A landmark study on admissions to Sing Sing prison in New York in 1918 highlighted, for the first time, the large number of mentally ill people in custody (Fazel and Baillargeon, 2011). Since then a vast body of evidence worldwide has shown high rates of psychiatric morbidity among prisoners indicating approximately one in seven prisoners has a treatable mental illness (Fazel and Danesh, 2002; Coid *et al.* 2003; WHO, 2007). A more recent study indicates that of the 10 million people currently incarcerated worldwide approximately one million suffer from a significant mental disorder with an even higher proportion experiencing more common mental health problems such as depression and anxiety (Fazel and Baillargeon, 2011, p. 956).

A worldwide systematic review of serious mental disorders in prisoners showed the pooled prevalence of psychosis was 4 per cent and major depression was indicated at 10.2 per cent (Fazel and Danesh, 2002, p. 359). A more recent review covering 33,588 prisoners in 24 countries found a pooled prevalence of psychosis of 3.6 per cent in male and 3.9 per cent in female prisoners. The pooled prevalence of major depression was 10.2 per cent in male and 14.1 per cent in female prisoners (Fazel and Seewald, 2012, p. 365). Both reviews corroborated widely reported findings that prisoners have elevated rates of psychiatric disorders (including psychosis, depression and schizophrenia), compared with the general population.

Similar findings have been confirmed in studies on the Irish prison population (Duffy *et al.*, 2003; Linehan *et al.*, 2006). Research conducted in 2009 on psychiatric morbidity within the male prison population indicated prevalence rates for psychosis of 5.1 per cent for remand prisoners and 2.6 per cent amongst the sentenced population. The prevalence rates for major depressive disorders was found to be similar for both the remand and sentenced populations (4.5 per cent and 4.6 per cent respectively). Schizophrenia and organic psychoses were the most common psychoses and the findings of the study overall indicate there is significant psychiatric morbidity in Irish committal prisoners (Kennedy *et al.*, 2009, p.169).

Prevalence of mental illness among probationers

While research has demonstrated the high prevalence of mental illness in the prison population, relatively little is known about those serving community sentences. In the United States each year approximately five million offenders are subject to community supervision and approximately 16 per cent of this population are estimated to have a serious mental illness (Wolff *et al.*, 2013). In the United Kingdom a survey of the population subject to probation supervision in Lincolnshire, estimated that approximately 39 per cent of individuals in the probation population had a current mental illness with anxiety disorders being the most common diagnosis (Brooker, 2012).

To date no research exists on mental illness within the probation population in the Republic of Ireland, highlighting a major knowledge gap in this area. To address this gap, statistical data was obtained from the Irish Probation Service on the prevalence of mental health difficulties

among offenders on probation. This data is drawn from collated Level of Service Inventory – Revised (LSI-R) Assessments,⁴ conducted in 2012. The unpublished data on the population of offenders under supervision in 2012 suggests the prevalence of mental illness among offenders on probation in Ireland is high.

Probation Officers conducted a total of 6,018 LSI-R assessments in 2012 on 4,884 clients nationally. Analysing the responses to five questions⁵ specifically targeting psychological or psychiatric functioning, it emerged that 33.7 per cent of clients assessed in 2012 responded as having had ‘mental health treatment in the past’. 15.8 per cent were engaged in some form of psychiatric treatment at the time of the assessment. 12.6 per cent identified as requiring a psychological assessment, while 3 per cent were identified as having an active psychosis. Finally, 30.8 per cent were classified as experiencing ‘moderate interference’, meaning they were assessed as exhibiting some signs of distress, mild anxiety, or mild depression.⁶

In offering an interpretation of these figures, it is important to point out that scoring of questions relating to ‘moderate interference’, ‘severe interference’, ‘active psychosis’ and ‘psychological assessment indicated’ are at the discretion of the interviewer (Andrews and Bonta, 2004). It may be that the incidence of mental health needs is under-estimated or over-estimated as a result. Although Probation Officers are trained in using the LSI-R risk assessment instrument, there is no specific mental health awareness training provided. Notwithstanding these limitations, the overall data indicates that Probation Officers have assessed a high proportion of people on probation caseloads with mental health needs. However there are no practice guidelines, protocols or a specific mental health policy within the Probation Service in Ireland currently for working with this client group. This is an area that clearly requires attention.

How offenders with mental health difficulties are treated in prisons

Jails and prisons have become the largest de facto treatment settings for the mentally ill (Lurigio, 2011). The contribution of prisons to illness is

⁴ See Appendix (i) for further information on the LSI-R.

⁵ See Appendix (ii) for description, from the LSI-R User Training Manual, of the five questions relating to the ‘Emotional/Personal’ sub-component of the LSI-R assessment instrument.

⁶ See Appendix (iii) for responses and analysis of the data from the LSI-R Assessments, 2012.

unknown. However, according to Fazel and Baillargeon (2011) their shortcomings in treatment and aftercare provision contribute to adverse outcomes. The challenges mentally ill offenders face in prison are exacerbated by a lack of adequate funding, hazards and inadequacies in facilities, healthcare and psychiatric care. These challenges are documented in a report to the Government of Ireland by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT, 2011).

Lord Bradley's review of people with mental health difficulties in the criminal justice system in the United Kingdom documents the growing consensus that prison is not an appropriate environment for those with severe mental illness and that custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide (Bradley Report, 2009). These sentiments are echoed in the *Report of the Thornton Hall Project Review Group* (2011) regarding the Irish situation. The World Health Organisation highlights specific factors in prisons which contribute to mental ill-health such as overcrowding, violence, enforced solitude or lack of privacy, lack of activity, isolation from social contact, insecurity about the future and inadequate health services (in particular mental health services) (WHO, 2001).

The European Committee for the Prevention of Torture and Degrading Treatment have carried out five visits to Irish prisons and the fifth report in 2011 is the most critical yet (Brennan, 2012). It reports the prison system is failing to meet the most basic human rights standards of safe and humane custody. Other research into the specific needs of mentally ill prisoners highlights a lack of treatment programmes, lack of beds for psychiatric treatment, lack of appropriately trained staff, deficiencies in mental state screening, absent psychiatric aftercare, underfunding and insufficient co-operation with the general health systems (Dressling and Salize, 2009; IPRT, 2011).

Overcrowding and in-cell sanitation

The use of imprisonment has been on the rise in recent years. The prison population more than doubled between 1995 and 2013. A report on deaths in prisons conducted by the Department of Justice, Equality and Law Reform (1999) and the report from the CPT (2011, p. 21) both suggest that 'forced integration of mentally ill offenders with regular offenders as a result of overcrowding may be a contributing factor to the

increased rates of mental ill-health, suicide and violence within the prison system'. The management of vulnerable prisoners, in particular those with mental health difficulties within prison has been the subject of concern and criticism over a number of years. Mountjoy Prison has come in for particular criticism. It has consistently experienced high prison numbers, overcrowding, high turnover and inadequate infrastructure that greatly impacts on offenders with mental illness (Pilon, 2012; Williamson, 2012).

As far back as 1998 the CPT stated that overcrowding in Irish prisons was 'endemic' (CPT, 1999, p. 30). A subsequent report in 2011 highlighted the fact that the situation had deteriorated further, as many prison cells originally designed for single occupancy had three prisoners per cell in Cork, and in Limerick prison many inmates were sleeping two to a bed. Pilon (2012) stressed that both overcrowding and the presence of bio-hazardous waste is not only dehumanising but is particularly harmful to mentally ill prisoners. The Irish Prison Service (IPS) published its census of 2013 relating to cell occupancy and in-cell sanitation. At this time out of 3,090 usable cells in Irish prisons, 1,799 prisoners were in single cells, 1011 held two or three prisoners and thirty held four or more. Regarding in-cell sanitation, 504 prisoners (12.3 per cent) were required to slop out. Furthermore a large number, 1,606 (39.3 per cent), were required to use the toilet in the presence of another prisoner (IPRT, 2013).

However, some positive developments have begun to emerge. According to the IPS, the numbers 'slopping out' will eventually fall to approximately 300 prisoners as a result of the Forty Month Capital Plan of expenditure for refurbishment which was announced in 2012 (IPS, 2012). This, as described by Mulcahy (2013, p. 142), is ironic 'as Ireland is currently on its knees financially, plans for the "super prisons" have now been shelved, yet resources have had to be made available to refurbish Mountjoy, a prison which in the past was described as beyond redemption'.

Use of isolation

Studies in the United States indicate that prisoners with mental illness are at increased risk of being placed in solitary confinement (Haney, 2006). Behaviour stemming from psychiatric morbidity may be perceived and dealt with by the prison system as a disciplinary problem rather than

treated as illness-related behaviour (Coid *et al.*, 2003). A report commissioned by the Irish Penal Reform Trust exploring the use of solitary confinement amongst mentally ill prisoners reports similar findings in the Irish context. Bresnihan (2001), in the 'Out of Sight, Out of Mind' Report, highlighted the concern for the first time that mentally ill prisoners were being put into solitary confinement without receiving proper treatment. The report found that 78 per cent of those in isolation were mentally ill, that solitary confinement makes sick people sicker, yet those certified as insane were regularly confined. The report also found that most prisoners were kept naked, were not permitted books, radios or personal belongings, had no means of calling for help and were left in cells with smelly slopping out buckets, a dirty mattress and blanket (IPRT, 2001, p. 5).

At this time, the IPRT called for some immediate recommendations to be put in place including the ratification of the United Nations Covenant against Torture, Degrading and Inhumane Treatment, the implementation of all recommendations from the European Committee for the Prevention of Torture and a radical overhaul of the entire prison health system. To date the former recommendations have failed to be implemented in Ireland (IPRT, 2013). However, some progress is emerging regarding the overhaul of the prison health system.

A policy move in the right direction

'*A Vision for Change*' (2006) set out a comprehensive framework for mental health policy proposing that the delivery of prison based mental health services should reflect those in the community. A major objective of this policy framework was to see forensic psychiatric patients treated in full compliance with the standard set by the Mental Health Act 2001.

The establishment of a ten bed high support unit (HSU) in Mountjoy Prison has been a welcome development. However according to Giblin (2012) capacity remains an issue. Despite some improvements the reality remains that 'In many cases jails and prisons are the final stop on the institutional circuit that includes homeless shelters, psychiatric institutions and substance abuse residences' (Lurigio, 2011, p. 75). Poor prison policy and practice have existed for decades regarding the treatment of offenders with mental illness and while recent initiatives are welcome concerns will remain in relation to prisoners with serious mental illness being incarcerated in the first place.

Diversion services

A significant policy development over the past number of decades has been the shift in emphasis for diverting mentally ill patients away from in-patient treatment or incarceration to care in the community. As O'Neill (2013, p. 3) notes 'the majority of crimes committed by the mentally ill are minor and non violent.' Ireland's first Diversion and Liaison Service was established at Cloverhill remand prison (McInerney *et al.*, 2013). The aim of this service is to identify offenders with mental health needs, facilitate treatment in healthcare settings in the least restrictive environment in the community, for the process to take place as rapidly as possible and to broker 'joined up' care for these offenders/patients by liaising between the patient, community psychiatric services, the judiciary and correctional staff (McInerney *et al.*, 2013).

Over a six year period (2006– 2011) the programme diverted 572 prisoners with severe mental illness to varying levels of care. Eighty-nine to the CMH ,164 to community mental health hospitals and 319 to community mental health services. The achievements of this service have received positive commentary and support (IPS, 2011). However, one must consider this service is limited as it is confined to only one prison in the state. Diversion services ideally should be delivered at the earliest point of contact with the criminal justice system and one must be reminded that any period of incarceration exacerbates mental ill-health.

The Probation Service and mental health

The Probation Service has four main roles: to support offenders in prison, to supervise and support offenders in the community, to supervise offenders who have been released from prison and to write reports for courts to assist in decisions about sentencing (The Probation Service, 2014). Recent changes within the Irish Probation Service due to budgetary constraints and increasing numbers of prisoners being released, have seen a significant shift in priorities (Martynowicz and Quigley, 2010). Increased responsibility for post-release supervision orders and risk assessments means that the Probation Service now focuses largely on risk management.

Through consultation with the Probation Service the researcher has been informed of a commitment to develop a Probation Service mental health policy on working with offenders with mental illness as, to date, no such policy exists. It would appear the Irish Probation Service is

currently at a crossroads in relation to which policy model to follow in offering best practice and improved service and treatment delivery for offenders with mental illness.

Mental health models being implemented by Probation Services in the US

Wolff *et al.* (2014) examine specialised mental health caseloads (SMHC), as an effective means of addressing the treatment needs of offenders with mental illness on probation in the community. This study points to the fact that a large and growing number of persons with mental illness are under probation supervision and examines the inter-relationship between mental health symptoms, compliance with mental health treatment, probation supervision and recidivism. SMHC is a relatively new intervention designed to effectively engage probation clients with mental illnesses in successful completion of probation supervision.

Wolff *et al.* (2013) discuss the SMHC model which operates in New Jersey. The specialised mental health Probation Officers receive training on psychopathology, co-occurring disorders, criminal thinking styles, case management, problem-solving skills, motivational interviewing and stress management. Smaller, more specialised, caseloads are managed by expert officers and are expected to be more effective in securing much needed resources in treatment as well as social housing and public benefits through advocacy and collaboration with mental health service providers and community agencies (Babchuk and Lurigio, 2012). This is to be achieved by working with clients towards goals of treatment compliance and by engaging clients in styles and patterns of interpersonal interactions to increase compliance with general and special conditions of supervision. Wolff *et al.*'s (2013) findings generally support the effectiveness of the SMHC model. Crucial to its effectiveness is on-going specialist training and support for Probation Officers in recognising, understanding and responding to mental illness.

Mental health awareness training for Probation Officers

While probation staff in the United Kingdom receives some mental health training, it is not specialised (Brooker, 2012). In 2009 the Confederation of European Probation (CEP) held a conference centring on the concept of a Pan-European Probation Training Curriculum which

considered mental health training. Sirdifield *et al.* (2010) draw on results from an evaluation of a specialised training model developed and piloted in the UK. Results from this pilot create a strong case for mental health specialised training to form part of a common training programme across Europe. Fundamental aspects of the training included factors impacting on mental health, stigma and stereotypes, relevant legislation, bi-polar affective disorder, schizophrenia, self-harm and suicide, post-traumatic stress disorder, learning disability, depression, eating disorders, mental health and probation practice, local mental health service provision and referral procedures.

The need for a treatment philosophy: perspectives from mental health clinicians

Whether or not the criminal justice system is the proper place for the mentally ill, their presence creates a number of treatment challenges (Lindhorst and Lindhorst, 2013). The lack of alternatives and funding for appropriate service provision is highlighted time and time again throughout the literature (Bewley and Morgan, 2011; O'Keefe and Schnell, 2007). Lamb (1999, 2004) calls for a treatment philosophy that strikes a balance between individual rights and public safety, clear treatment goals, a close liaison between psychiatric treatment staff and Probation Officers, incorporation of the principles of case management, understanding of the need for structure, appropriate and supportive living arrangements and the inclusion of family members when possible. Trestman (2013) calls for mental health clinicians to extend their notions of inter-disciplinary teams to include Probation Officers as joint working provides opportunities not otherwise available to support this client group.

Proposals and implications for probation/social work practice

For some individuals, a custodial sentence will be necessary. Where this is the case, prisoners should have access to appropriate treatment, rehabilitation and resettlement services (Bradley Report, 2009). While recent efforts from the Irish Prison Service have been acknowledged in improving and safeguarding basic human rights, it is important, as Probation Officers and social workers, to maintain a focus on those experiencing deprivation of any kind. Isolation should not be used for prisoners with pre-existing mental illness. Meaningful rehabilitation is

simply impossible in such conditions. This practice should be eradicated to alleviate the long-term negative consequences for the prisoner and for society (IPRT, 2013).

Evidence based practice calls for a ‘whole systems’ approach and stresses the importance of joint working. Consultation for this study with key personnel in the Diversion Programme at Cloverhill Prison and the Central Mental Hospital resulted in a recommendation for a pilot programme involving the Probation Service, the Diversion Programme and community mental health clinics to improve service delivery for this client group.

Based on the findings from the Probation Service 2012 unpublished LSI-R data suggesting a high rate of mental health difficulties for offenders engaged with the Probation Service, I propose that a specific national study should be undertaken on the prevalence of mental health disorder among persons subject to Probation Service supervision in Ireland. It is likely that without such data, access to community based mental health services for offenders on probation supervision will remain restricted and inconsistent. It is of concern that high levels of mental disorder are not recognised or addressed by probation policy or practice currently. The complex needs of this neglected client group require urgent prioritisation by the Probation Service. A specific mental health policy needs to be implemented by the Probation Service as a matter of urgency.

In conjunction with a policy, provision of mental health awareness training would enable Probation Service staff to better recognise the signs and symptoms of mental health disorder, would increase their knowledge of local mental health services and legislation and improve their confidence in working effectively with the many individuals with mental health disorders on their caseloads (Sirdifield *et al.*, 2010). The provision of such training could influence future probation practice.

Given that the Probation Service has experience in working with offenders with mental illness, particularly on the Homeless Offender’s Team, staff should be supported by specialised training. This model should be developed further by implementing reduced specialised mental health caseloads. Protocols urgently need to be developed between the Probation Service and community mental health clinics and public funds should be invested in mental health services. While economic pressures are acknowledged, it would appear that an initial investment has the potential to offset the much higher costs of in-patient psychiatric care and imprisonment (WHO, 2007).

Concluding comments

Mentally ill offenders are often placed in a hopeless situation. While incarcerated, their mental health deteriorates. Upon release, they are often unable to access available community treatment because of a lack of adequate services or because of mental health service providers' reluctance to treat them. As a result many offenders with mental illness repeatedly churn through the criminal justice system, going from street to Court to cell and back again without ever receiving the assistance needed (Dencla and Berman, 2001). As economic realities force administrators of the mental health and criminal justice systems to reduce the number of facility beds and address overcrowded conditions, the importance of effective community supervision of offenders with mental illness exponentially increases (Dressing and Salize, 2009). A consistent application of best practices and therapeutic intervention is required to assist in providing effective treatment to offenders with mental illness in prison and on probation which will also contribute towards community safety.

Appendix (i)

The Level of Service Inventory-Revised (LSI-R) Assessment Instrument

The Level of Service Inventory-Revised (LSI-R) is an assessment instrument based on the general principles of cognitive psychology, social learning theory and the risk-needs-responsivity model. The LSI-R is a quantitative survey of attributes of offenders and their situation relevant to level of service decisions. The LSI-R is composed of 54 items. Each item is answered 'Yes or No,' or a '0 to 3' rating. The items are grouped into the following subcomponents (with number of items in parentheses):

- Criminal History (10)
- Education/Employment (10)
- Financial (2)
- Family/marital (4)
- Accommodation (3)
- Leisure/Recreation (2)
- Companions (5)
- Alcohol/Drug Problems (9)
- Emotional/Personal (5)
- Attitudes/Orientation (4)

Many of the subcomponents consist of items that are changeable or 'dynamic'. These dynamic factors are risk factors and by reducing the number of dynamic risk

variables, it is likely a reduction in the probability of future criminal activity will occur. In this way many of the LSI-R items and subcomponents act as treatment targets.

When complete the ten subcomponent scores are added together to give a total score. This score is translated into a low, medium or high-risk score that predicts the likelihood of future offending over the following twelve-month period. There is a facility in the assessment for the practitioner to document features of an offender's situation that may require special consideration or may override the final assessment.

Of particular relevance to this piece of work is the subcomponent 'Emotional/Personal'.

'Interference' refers to an individual's ability to respond to life's stressors and to the quality of that person's functioning in the real world. The instrument assists in determining if the individual's ability and functioning are affected by psychological or psychiatric problems. Client's level of adaptive functioning with regard to the past year is assessed (Andrews and Bonta, 2001).

Appendix (ii)

Selected Responses (Q46–50) from LSI-R Assessments (2012)

Total LSI-R assessments	6,018
Total individuals	4,884
Q – 46	#
No Response	9
Response = No	4,150
Response = Yes	1,845
Response = omit	14
% Response = Yes	30.8%
Q – 47	#
No Response	14
Response = No	5,815
Response = Yes	179
Response = omit	10
% Response = Yes	3.0%
Q – 48	#
No Response	18
Response = No	3,959
Response = Yes	2,014
Response = omit	27
% Response = Yes	33.7%

Q – 49	#
No Response	14
Response = No	5,048
Response = Yes	949
Response = omit	7
% Response = Yes	15.8%
Q – 50	#
No Response	82
Response = No	5,112
Response = Yes	739
Response = omit	85
% Response = Yes	12.6%

(Probation Service Data unpublished)

Appendix (iii)

Extract from The Level of Service Inventory-Revised (LSI-R) Manual Emotional/Personal subcomponent (Q46–50)

Emotional/Personal

“Interference” refers to an individual’s ability to respond to life’s stressors and to the quality of that person’s functioning in the real world. Is his or her ability and functioning affected by psychological or psychiatric problems? Assess client’s level of adaptive functioning with regard to the past year

46. Moderate interference.

The scoring of this item is left to the discretion of the interviewer. However, if item 47 is answered “Yes”, this item must also be answered “Yes”. Examples of moderate interference or emotional distress: signs of mild anxiety (insomnia, worrying); signs of mild depression (quiet, under-assertive). Consider also the client whose emotional and cognitive functioning seems stabilised through mental health intervention.

47. Severe interference, active psychosis.

This item should be answered “Yes” based on any indicator(s) of client’s mental health problems. The intent of the item is to detect active psychosis in a client. Severe emotional and cognitive interference may also be detected by observing the following types of indicators during the interview:

- excessive sweating
- extreme passivity or aggression
- verbal abusiveness

- odd or strange verbalisations
- very slow or very fast speech
- rambling conversation
- reports of auditory and/or visual hallucinations
- delusional thinking

48. Mental-health treatment past.

50. Psychological assessment indicated.

If the client has been assessed within the past year and the interviewer has knowledge of the problems and the assessment indicated they were present, then answer “Yes” for this item and note what that assessment indicated.

If the client has never been assessed, or if it is unknown whether the client has ever been assessed, but there are indicators of problems with the following, answer “yes” for this item. Note the problems that the client’s behaviours indicate, for example:

- intellectual functioning
- academic/vocational potential
- academic/vocational interests
- excessive fears; negative attitudes toward self; depression; tension
- hostility; anger; potential for assaultive behaviour; over-assertion/aggression
- impulse control; self-management skills
- interpersonal skills; under-assertive
- contact with reality; severe withdrawal; over-activity; possibility of delusion/hallucination
- disregard for feelings of others; possibility of reduced ability or inability to feel guilt/shame; may be superficially “charming”, but seems to repeatedly disregard rules and feelings of others
- criminal acts that don’t make sense or appear irrational
- other (specify)

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