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Prisons and probation: a Council of Europe White Paper on the management of offenders with mental health disorders

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1.Introduction

The Council for Penological Co-operation (PC-CP), in accordance with its terms of reference for 2020-2021 (Doc. CM (2019) 131-addrev2), started examining the management of offenders with mental health disorders[1] by the prison and probation services, the problems which might be faced by their staff in relation to this and what possible solutions and standards might need to be developed at European level.

The Confederation of European Probation (CEP) and the European Organisation of Prison and Correctional Services (EuroPris) also contributed to the Council of Europe work in this area.

The PC-CP Working Group members and scientific experts agreed that the outcome of this work at this point should be a White Paper which takes stock of the situation in Europe, provides examples of existing challenges and good practices and a list of recommended steps to be taken by the Council of Europe member States to improve the management of such offenders. The White Paper is expected to be finalised and approved by the PC-CP by the end of 2022.

2. Background

All the data presented in this section which describes the probation and prison population across Europe is based on the work of Professor Marcelo Aebi and his team, at the University of Lausanne (Aebi et al, 2021), collecting the Council of Europe Annual Penal Statistics (SPACE).

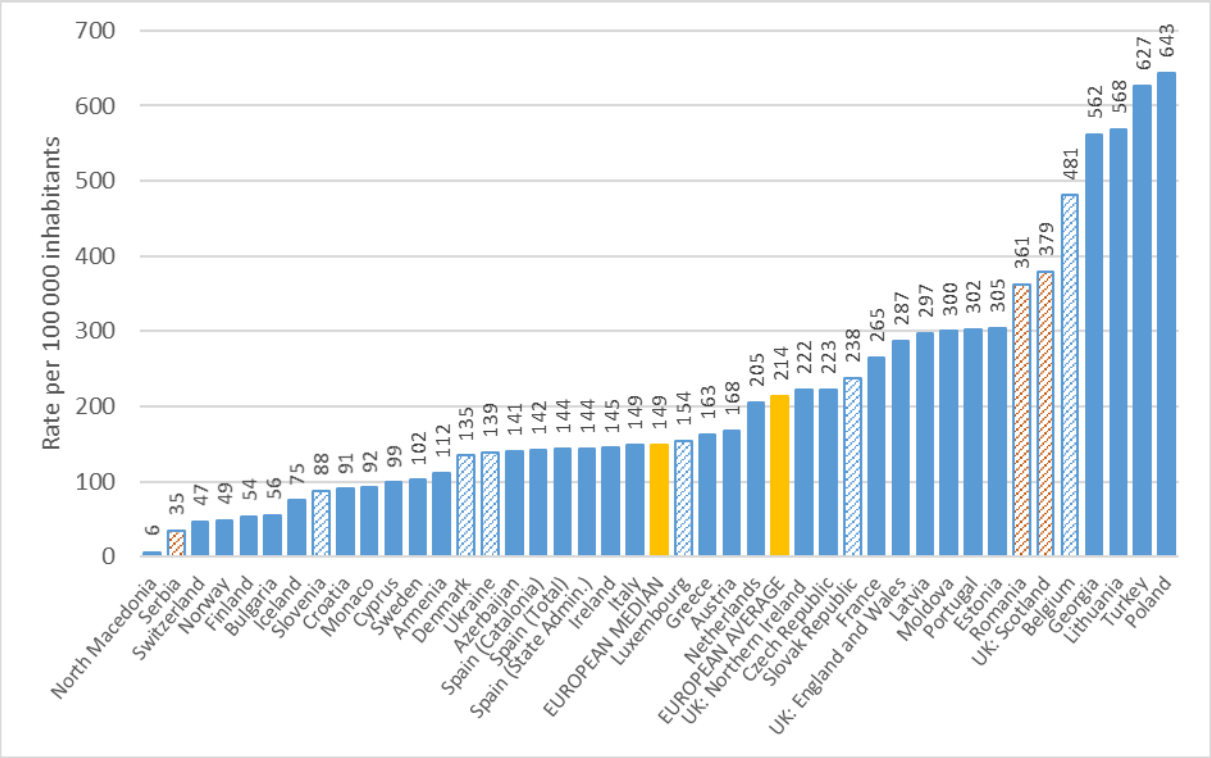
The population rate per 100,000 inhabitants of each country/jurisdiction is given in Figures 1 and 2 which show a wide variation between these.

The lowest rate of persons per 100,000 who are serving a probation order is North Macedonia (where a new service is being established and has not yet started its full-fledged functioning), the highest rate is 643/100,000 and this is found in Poland. The European median value is 149.

In terms of the rates in the prison population, we can find the highest rates in Turkey (357), Georgia (264), Lithuania (220) and Azerbaijan (209) inmates per 100,000 inhabitants, and the lowest rates can be found in Germany, The Netherlands, Iceland and in the Scandinavian countries and some countries in the Balkan region.

[1] In the survey questionnaire mental health disorders were defined, using the WHO definition, as 'depression, bipolar disorder, schizophrenia and other psychoses, dementia, and developmental disorders including autism."

Figure 1: Probation population rates (probationers per 100,000 inhabitants) on 31st January 2020 (N=40)[2]

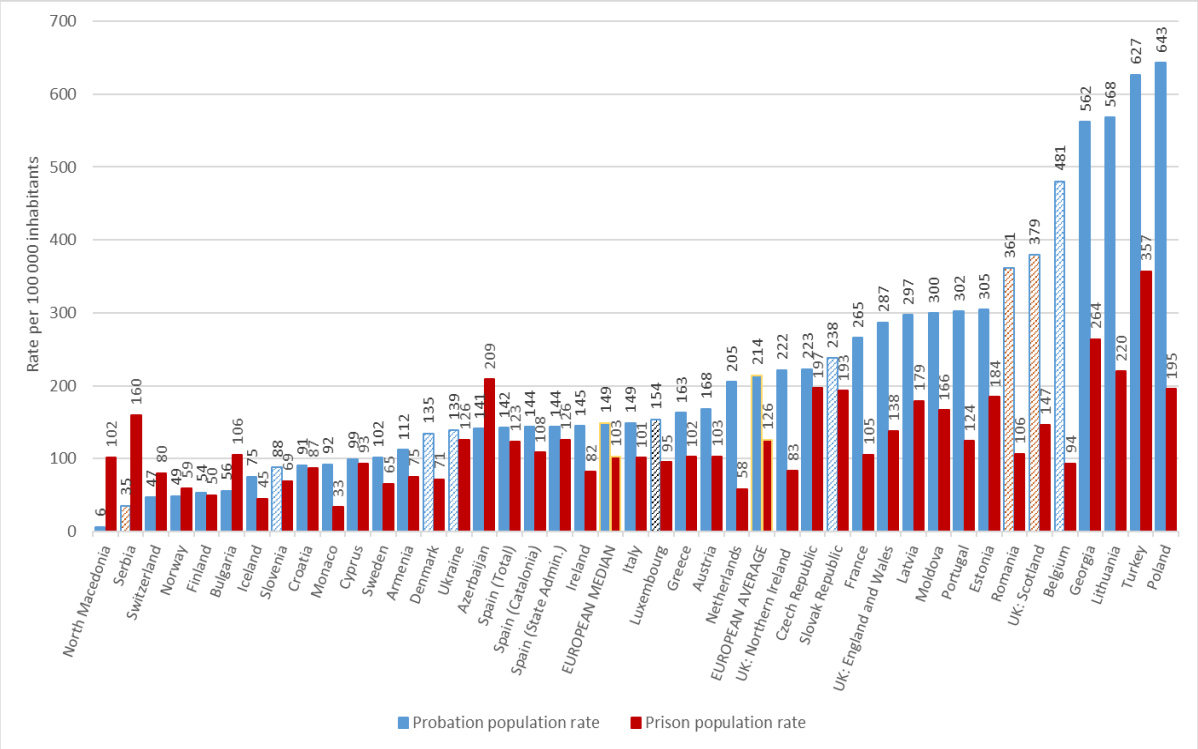


Note to Figure 1: Probation agencies not using the *person* as the counting unit of their statistics are presented in blue stripes, while those using it only *partially* are presented in orange stripes (Aebi et al, 2021)

In Figure 2 below the probation rates are presented alongside those same figures for prisons. One striking result of this comparison is that, in 34 out of the 40 prison services and probation agencies included in Figure 2, the probation population rate is higher than the prison population rate. The exceptions are (in order of magnitude) North Macedonia, Serbia, Switzerland, Norway, Bulgaria, and Azerbaijan, where the rates of inmates are higher than the rates of probationers per 100,000 inhabitants.

[2] The highest probation population rates are found in Lithuania, Turkey, and Poland, while the lowest are in North Macedonia, Serbia, and Switzerland. However, as noted earlier, comparisons across jurisdictions must be conducted carefully because the way in which data are collected varies. Data provided by the probation agencies that do not use the *person* as the counting unit for the total number of probationers are presented in a striped pattern. More specifically, Belgium, Denmark, the Slovak Republic, Slovenia and Ukraine reported that their counting unit is the *case* or the *file*. Luxembourg does not count *persons* but did not specify its counting unit. Romania, Serbia and Scotland indicated that they partially count the *person*; however, they specified that they count the *case*, the *verdict*, or the *order* for the probation stock. These different counting units could explain the high probation population rates observed in Belgium and Scotland.

Figure 2: Probation and Prison population rates (per 100,000 inhabitants) on 31st January 2020 (Aebi et al, 2021)



The data presented so far make it possible to categorise countries/jurisdictions on the basis of their prison and probation populations (with caveats about the way countries/jurisdictions occasionally count differently). This typology is given in Table 1 and has been extracted from the paper by Aebi et al (2021).

Table 1. Relationship between probation and prison population rates on 31st January 2020 (N=41, 8 categories)

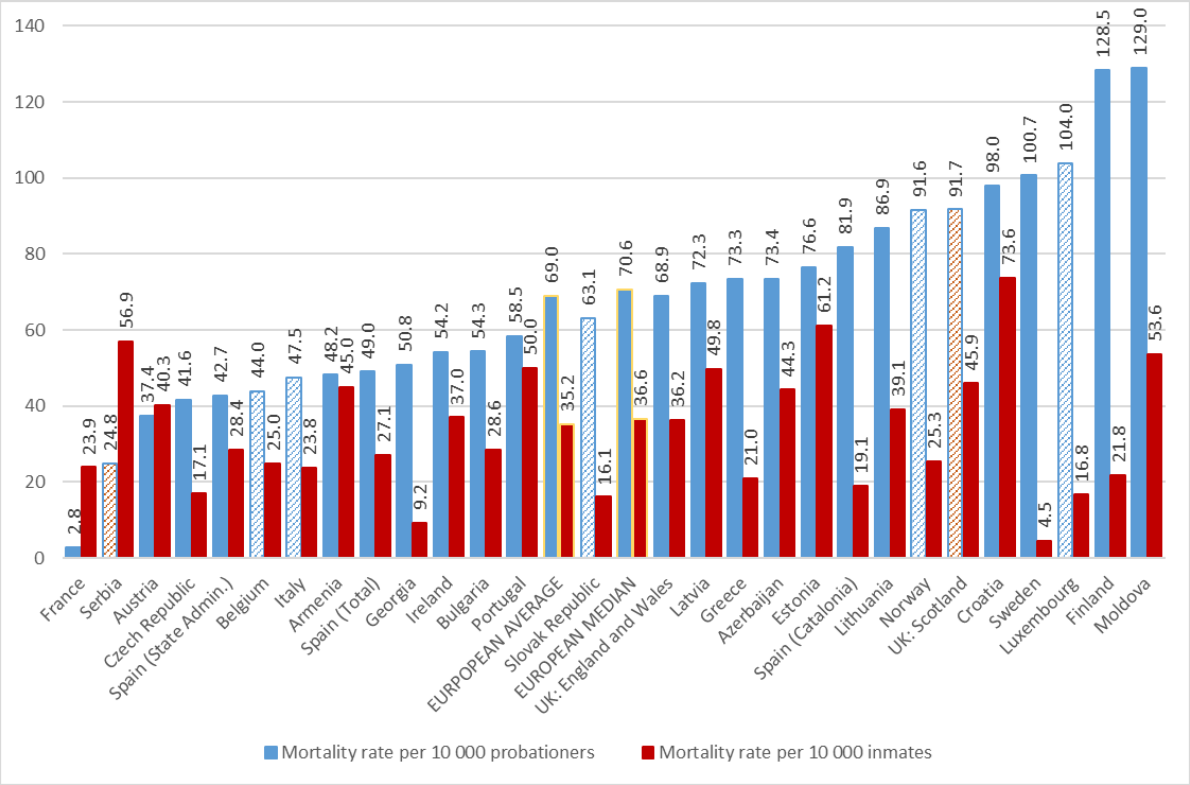
Jurisdiction	Probation population rate	Prison population rate
1. Jurisdictions with a low probation population rate (≤ 100 per 100,000 inhabitants) and a low prison population rate (≤ 100 per 100,000 inhabitants)		
Switzerland	46.8	80.2
Norway	48.8	58.8
Finland	53.5	49.9
Iceland	75.0	45.0
Slovenia	*87.8*	*69.1*
Croatia	90.6	87.1
Monaco	92.3	33.3
Cyprus	98.9	93.4

2. Jurisdictions with a low probation population rate (≤ 100 per 100,000 inhabitants) and a relatively high prison population rate (>100 to <200 per 100,000 inhabitants)		
North Macedonia	6.1	101.8
Serbia	*34.9*	*159.9*
Bulgaria	55.6	105.6
3. Jurisdictions with a relatively high probation population rate (>100 to <200 per 100,000 inhabitants) and a low prison population rate (≤ 100 per 100,000 inhabitants)		
Sweden	102.0	65.0
Armenia	112.2	75.0
Denmark	*134.6*	*71.1*
Ireland	144.9	81.6
Luxembourg	*153.6*	*94.9*
4. Jurisdictions with a relatively high probation population rate (>100 to <200 per 100,000 inhabitants) and a relatively high prison population rate (>100 to <200 per 100,000 inhabitants)		
Ukraine	*139.1*	*126.1*
Spain (Total)	142.3	123.3
Spain (Catalonia)	143.6	108.4
Spain (State Admin.)	143.8	126.2
Italy	149.0	101.2
Greece	163.0	102.4
Austria	168.1	103.2
5. Jurisdictions with a relatively high probation population rate (>100 to <200 per 100,000 inhabitants) and a high prison population rate (> 200 per 100,000 inhabitants)		
Azerbaijan	140.8	208.7
6. Jurisdictions with a high probation population rate (≥ 200 per 100,000 inhabitants) and a low prison population rate (≤100 per 100,000 inhabitants)		
Netherlands	204.9	58.5
UK: Northern Ireland	221.8	82.8
Belgium	*480.6*	*93.6*
7. Jurisdictions with a high probation population rate (≥ 200 per 100,000 inhabitants) and a relatively high prison population rate (>100 to <200 per 100,000 inhabitants)		
Czech Republic	222.6	196.8
Slovak Republic	*238.2*	*193.4*
France	265.5	105.3
UK: England and Wales	286.7	138.0
Latvia	297.4	179.0
Moldova	299.8	166.5
Portugal	302.3	124.3
Estonia	304.5	184.4
Romania	*361.4*	*106.5*

UK: Scotland	*379.1*	*146.6*
Poland	643.3	195.3
8. Jurisdictions with a high probation population rate (≥ 200 per 100,000 inhabitants) and a high prison population rate (≥ 200 per 100,000 inhabitants)		
Georgia	561.8	263.8
Lithuania	568.1	219.7
Turkey	626.7	357.2

Finally, given that suicide rates across probation and prisons are so high in comparison to the general population the data on 'all-cause' deaths in both settings is given below in Figure 4. Suicide thus only forms an element of these data.

Figure 4: Deaths of inmates per 10,000 inmates and deaths of probationers per 10,000 probationers during 2019 (N = 27)



Note to Figure 4: Probation agencies not using the *person* - or using it only *partially* - as the counting unit of their statistics are presented in stripes.

In seeking an explanation for the much higher mortality rates in probation, Aebi and his colleagues (2021) offer these explanations:

(a) the constraints of the prison environment reduce the risk of engaging in risky behaviour or suffering a fatal accident;

(b) inmates suffering terminal or serious illnesses are frequently released from prison

and placed on probation; and

(c) suicide is more common while on probation than while in prison.

This is certainly true of the UK (Philips et al, 2018) where the suicide rate in probation is 118 per 100,000, in prison it is 83 per 100,000 and for the general population it is 13.6 per 100,000. Thus, suicides in probation are nearly nine times more likely than the general population and in prisons there is a six-fold increase in risk.

3. Principles that should underpin mental health care in prisons and probation

There is a set of basic principles that should underpin mental health care both in probation and in prisons, as listed below:

a) Early detection of mental health disorders

The early detection of mental health disorders in either the prison or the probation service must be a key aim of both agencies. In probation as this might lead to timely diversion to an appropriate mental health service or it might indicate that a referral is required as soon as possible to an appropriate community-based mental health service. In prison, early detection of a mental health disorder could reduce the likelihood of suicide, mean a transfer to a locked specialist mental health service outside the prison, or treatment inside the prison by the mental health team.

b) Regular data collection

Both prisons and probation services should collect data routinely which focuses on the needs mentally disordered people being seen by either agency. We know from research that a particular problem can be the co-ordination of mental health care/treatment when people leave prison on a conditional discharge. We also know from research that many people in prison or serving a probation order have histories of serious childhood trauma. Trauma services are under-developed in most countries in the community but also in prisons. Promoting access to such services, on the back of routine data collection, would enable trauma services to be planned.

c) Information about suicidal thoughts/behaviour

Protocols and communication procedures should be agreed and adopted by all the respectively involved agencies, public or private in order to allow then to share relevant information regarding the risk of suicide or previous attempts, so that the probationer or inmate can be flagged right from the beginning and be referred to the mental health care department or service, depending on the context. We all are aware that in the majority of cases, before a suicide attempt, there are some sort of signs or symptoms that are present for a while before the incident, and if that information had been shared in due course a suicide attempt might have been prevented.

d) Focus on continuous professional development and workforce planning

In the recent survey (Brooker and Monteiro, 2021) there was significant variation in the skills that both custodial staff and probationers had acquired in relation to mental health. In some countries, such as the Republic of Ireland, a social work degree is required to become a probation officer. In such instances, one would expect more skills in mental health. Knowledge is also required of the local provision of mental health services and their pathways and referral criteria. Staff in prisons seemed more likely than probation officers to have such training, however, whether or not, mental health awareness is enough to help, for example, a highly suicidal client to be managed, is probably a separate issue. Very few services formally define the role of staff in relation to mental health and unless this is agreed at national level, it seems that specialized training is not usually designed and provided.

e) Clearly defined partnerships that include the voice of service

Prison and probation services and their interaction with healthcare services can be a very complicated exercise. There are complex partnerships that include: social care, mental health services, healthcare within prisons, community services in general (such as access to a general practitioner). These partnerships can cease easily at the prison gate when prisoners are released. Those that commission services clearly need to be involved in funding services and evaluating how effectively they work. Service users and their family members should also have a place at any discussion table.

At the ground level, local discussion on the ways in which national guidelines should be implemented, should be encouraged. Joint working groups, including multidisciplinary teams composed of prison and probation staff (prison officers, psychologists, case managers, social workers) health professionals (physicians, nurses, psychiatrists) and volunteers working in all sectors (prison, probation, mental health), should be created to share experiences and knowledge about their own context of work. The working groups should be encouraged to reflect and collect sufficient anonymised data and evidence in order to evaluate new approaches and innovative strategies. Regular debates and workshops should be organized in order to raise awareness and to inform the policy makers on how the situation is developing in their own countries and enable them to take actions to overcome the obstacles and to improve the practices. At a political/decision taking level, all relevant stakeholders should come to an agreement to declare as a priority the improvement of the level of service in the mental health area.

Increasingly, in some countries there are calls to involve those with 'lived experience' in all areas of healthcare provision: staff assessment, planning services, research and evaluation to name but a few. Although the survey did not contain any questions about the involvement of those with lived experience, we believe this is an important principle to pursue.

f) Continuous improvement through the use of accreditation and/or standards, quality indicators and health information systems

There are many models for accrediting the standards of mental healthcare received by prisoners or probationers. As far as we are aware no country/jurisdiction in Europe has a standards-based model in this area and there is an urgent need for such standards, especially in the probation area. National systems should be in place to allow all services to benchmark

themselves against each other (see, for example, prisons-standards-4th-edition.pdf (rcpsych.ac.uk).

The Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has its own set of standards for psychiatric care in prisons (see sections 41-44 here: https://rm.coe.int/16806ce943. These standards could be used as the basis for a set of basic standards across Europe. These standards could be regularly assessed where explicit indicators are audited on a regular basis. The level of service and the quality of care must be assured by all probation and prison services with standards equivalent to those provided for the public in general.

g) Investment in research and evaluation in order to align funding with care provision that is both evidence-based and accessible

There is little hard evidence of useful interventions for those with mental health disorders in prison or serving a probation order. Thus, it is crucial that interventions continue to be evaluated and researched to a high standard. We are well aware of the problems attached to this simple statement (see for example, Sirdifield and Denney, 2022, in press). Even allocation of any research funding for mental health in the criminal justice system is regarded as a low priority by many funding bodies. It would be extremely useful to consider a Europe-wide prison/probation research network and a long-term funding provision. One key weakness of the research in this field is the lack of large multi-centre randomised controlled trials. A new network for such activity would be a serious improvement and will ensure independence, continuity, and quality of data collection. This will allow health and justice departments to develop evidence-based policies in this area.

4. A mini-review of the effectiveness literature - where interventions have been shown to lead to mental health gain in probation and prisons

Probation

In the last two years were produced three systematic reviews in areas of mental health concern in probation: namely, mental health (Brooker et al, 2020); suicide (Sirdifield et al, 2020) and substance use (Sirdifield et al, 2021).

Mental Health - In this systematic review the methodology is briefly outlined, and the results considered in more detail. The major conclusion is that effective mental health interventions in probation have rarely been described. Just four studies that met inclusion criteria were elicited that examined: the offender personality disorder pathway in England; the mental health of residents in approved premises and their use of mental health services; the impact of mental health courts on participants' use of mental health services. Other useful research was identified that did not meet the criteria for effectiveness but nonetheless was useful, for example, studies that tried to understand why the take-up of mental health treatment orders in England was so low. The results of the review are discussed, and it is concluded that effectiveness research is hard to undertake in probation, but efforts must continue.

Suicide - Prevention of suicide is a priority area within the policies of most countries/jurisdictions. The study reviews what the research evidence tells us about the rates

of suicide amongst persons under probation supervision in comparison to the general population. Drawing on evidence from a recent systematic review, is considered what is known about risk factors associated with suicide, including probation-related factors; how probation can offer an important opportunity for intervention, and what is known about approaches to reducing suicide amongst persons under probation supervision. In particular, it is demonstrated the dearth of probation-specific evidence-based studies in this area and is offered some insight into how the current gaps in the literature could be addressed in the future.

Substance misuse - This narrative systematic review of the literature on substance misuse and community supervision. It includes an overview of what is known about the prevalence of substance misuse needs of people under probation supervision, and the effectiveness of different approaches to substance misuse treatment in terms of engagement with treatment, retention in treatment, and impact on health outcomes.

Prisons

A systematic review of the outcomes of 37 studies published between 1979 and 2015 from 7 different countries (China, India, Iran, Norway, Spain, US, and U.K.) on "Psychological Therapies for Prisoners with Mental Health Problems", conducted by Senna Fazel (2017), suggests that the Cognitive-Behavioural Therapies (CBT) and mindfulness-based therapies are modestly effective in prisoners in treating depression and anxiety symptoms. Furthermore, that there is no clear difference between group and individual-based treatments.

In fact, this review suggests that CBT and mindfulness-based therapies have shown moderate evidence that there are improvements in dimensions as depression and anxiety symptoms in prisoners where no pre-existing treatments were taken, with mindfulness-based therapies possibly demonstrating higher effect sizes, as well as trauma-based therapies demonstrating limited evidence of effect on trauma symptomology.

In conclusion, the authors found that psychological therapies for mental health have moderately effective outcomes on prisoners and suggest the investment and development of this type of interventions inside prisons.

In summary there are very few interventions that have been examined that are likely to provide an improvement in health outcomes. There are many reasons for the lack of evidence, but they include: the challenges that exist in relation to obtaining mental health research funding in probation and prisons and the methodological issues that arise when conducting randomised controlled trials in criminal justice settings. In contrast there is much research on the prevalence of mental health disorders in prison but little meaningful research on prevalence in probation.

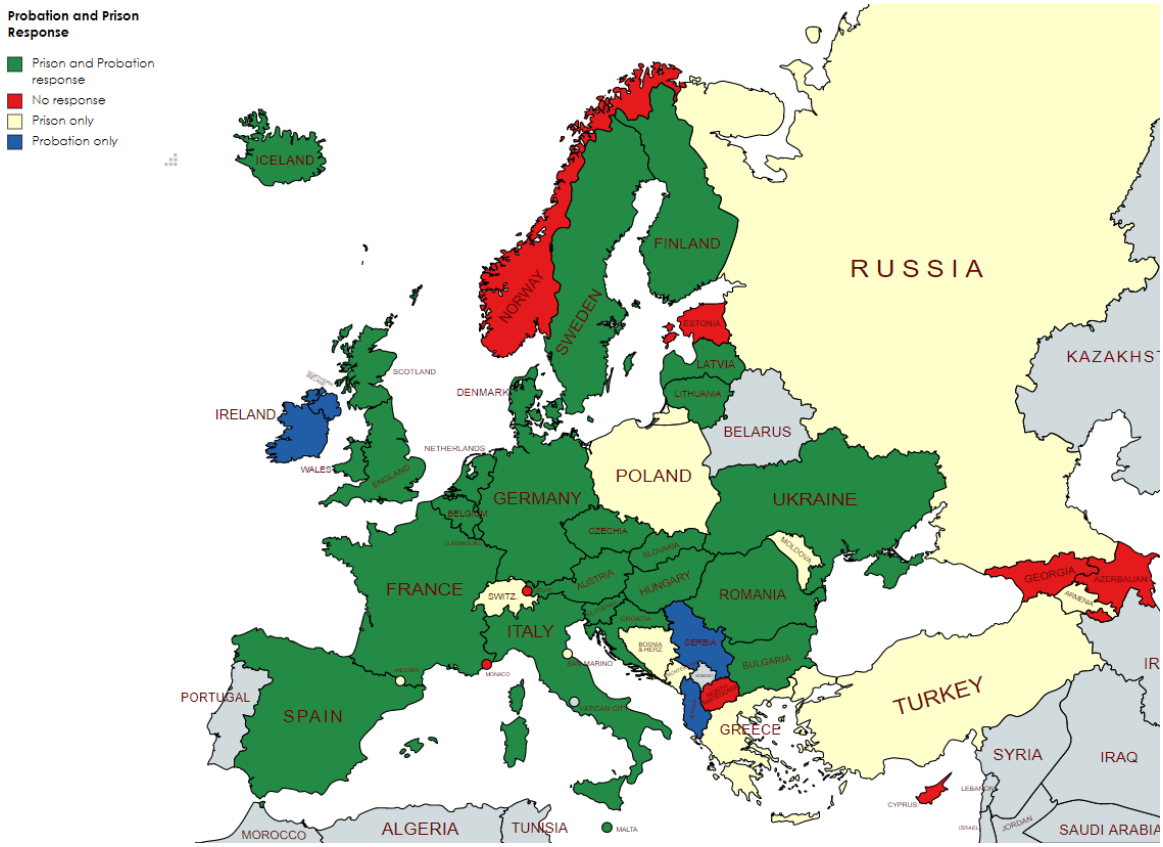
5. Summary of the Council of Europe survey

The whole survey undertaken earlier in 2021 will not be presented here. For those that would like to see the entire survey please access it here: Prisons and probation: Council of

Europe/CEP Mental Health Project (coe.int) or in Annex 2 of this report. The aim of this summary is to highlight the issues that should be taken forward by the Council of Europe.

First it should be stated that responses to both the prison and probation surveys were good. Below is the map of responses.

Figure 1: Map of Response to the prison and probation questionnaires.



First, there was national policy for probation and mental health in just over half of the countries/jurisdictions (53%). This contrasted sharply with prisons where policy existed in nearly all countries/jurisdictions (93%). Clearly for probation, this is action that needs to take place at a national level. A similar disparity was seen in relation to mental health awareness training with 74% of prison staff receiving training compared to only 37% of probation staff, that is 25 countries/jurisdictions do not ensure that probation staff are trained in mental health.

Estimates of the prevalence of mental health disorders in probation varied significantly with the estimates in prisons where the estimates ranged from 0-80% (median=18%) whilst in probation the estimates ranged from 2%-90% (median 15%). It is worth reiterating that all respondents were given the same definition to use in their answer as follows from the World Health Organisation:

'According to the World Health Organization, mental disorders are: depression, bipolar affective disorder, schizophrenia and other psychosis, dementia and developmental disorders, including autism'[3]

Only four jurisdictions collected prevalence data routinely in probation and these were: Northern Ireland (UK), Catalonia (Spain), the States of Berlin and Brandenburg (Germany).

In prison most clients were screened at intake/admission. Screening in probation took place mostly at the court stage and before leaving prison (for probation services which deal with released prisoners). In prison this was likely to occur at admission/intake and when leaving prison. The tools that are used are various. Two probation services that have in-house forensic mental health teams, Malta and Northern Ireland use: the BDI (Beck depression Inventory); the STAX (used to assess personality disorder); the GAD (Generalised anxiety and depression scale) and the PDE (the personality disorder examination). Other assessment tools used by other services include: the Hare Psychopathy Checklist (Bulgaria); the CAGE (Spain) in Iceland the mini-mental state is employed. Prisons tend to use data bases to record diagnoses that are made. So, for example, in Austria, the Integrated Execution Management System is used (IEXS). The person screening is usually the GP in both prisons and probation although the psychologists in the Forensic mental health services (Malta and N. Ireland) undertake the screening.

One-third of probation services have mental health treatment orders. The jurisdictions where this occurs are: Catalonia (Spain); England (UK), France; Berlin, Mecklenburg-Vorpommern and Schleswig-Holstein (Germany); Northern Ireland (UK); Scotland (UK) and Turkey. Whereas 70% of prisons have special orders or requirements for the treatment of mental health disorders within prisons and these include:

Armenia, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Greece, Italy, Lithuania, Latvia, Luxemburg, Malta, The Netherlands, Poland, Portugal, Romania, Russian Federation, Slovak Republic, Slovenia, Spain (including Catalonia) and Sweden. There is a large discrepancy in the monitoring of suicide depending on whether you are in prison or serving a community order. Monitoring occurs in most prisons (90%) but by very few probation services (13%).

We looked at gender issues in the survey as it is known that women constitute by far the smallest element of prison and probation populations. Nearly half (47%) of all prison related responses stated that they had gender-sensitive approaches in place. The figure for probation was much smaller at approximately one-quarter (24%) of all probation services. Three probation services described their approach as trauma-informed (UK: England, Scotland and Northern Ireland). In France research is being undertaken by SPCS, a team in Lille, one aspect of which focuses on women leaving detention. Other aspects of good practice will be elaborated upon in the next section.

6. Summary of Good Practice

[3] Please note that we have adhered to this definition throughout the paper so we have not discussed the complexity of mental health disorder (such as a dual diagnosis). Neither have we addressed the issue of personality disorder.

There are significant areas of good practice that exist or are being developed within most European countries/jurisdictions in both prisons and probation (see Appendix 3). In probation there are two interesting models described within the probation service itself where forensic psychologists are employed to address the needs of clients with a mental health disorder. Other countries are attempting to address the issues with mental health in the transition from prison to probation (England and Spain). Others are in the midst of strategy development such as Bulgaria. In German states there are also some useful initiatives, for example, in Baden-Wurttemberg, probation officers are trained to be mental health specialists and provide input to the nine probation offices. Also, Lower Saxony have developed standards for mental health in probation. Currently, these are only in German, but as a result of this project, they are currently being translated in English. It will be very interesting to see these standards when translated as obviously they might have wider applicability.

In prisons the same scenario is observed with an optimistic feeling for the future implementation of good practices in prison context, when dealing with mentally disordered inmates. It´s not only a matter of building new prisons with better physical conditions, which of course is a good sign of the investment and importance that each country/jurisdiction is paying to the living conditions of those who are deprived of liberty deserve, but above all the level of attention and priorities that have been growing in the European context, and that the questionnaire brought to our attention and highlighted.

Law orders, provisional procedures, internal guidelines and other written orientations are becoming standards in the majority of the European jurisdictions, as is the case in Austria, Belgium, Germany, Finland, Italy, Montenegro, Portugal, Romania, Russian Federation, Spain and Switzerland, among others.

The existence of these approved written guidelines can be the beginning of the mentioned above desired “National Minimum Standards for the Treatment of Inmates with Mental Disorders”. Other good practices seem to be the partnership of the prison authorities with academic experts in terms of assessment, evaluation and research about the mental health conditions of the inmates, as is the case in France, Italy and Switzerland, among others, which gives more credible scientific results of the evaluation, and provides the prison administration with stronger arguments to call for more investment and improvement of conditions, not only for these inmates, but in general for all who are incarcerated.

Finally, a trend that inspires us for a better future in terms of the level of care provided to the offenders with mental disorders is the shared responsibility between the justice and the health ministries to treat, rehabilitate and reintegrate these offenders, each of them contributing with their knowledge and experts in the respective field, in a complementary and collaborating platform of multidisciplinary work, thus contributing to a better and safer society for all citizens.

7. Recommendations

Probation

- There should be a national strategy for mental health within probation as part of a larger general mental health strategy
- The strategy should lead to agreeing on standards for mental health within the probation service in order to benchmark all such services in a given country/jurisdiction
- The strategy should operationalise the probation officer's role in the recognition and assessment of mental health disorders and in providing interventions and/or facilitating access to mental health care
- The strategy should address methods for collecting data within the probation service in conformity with the existing GDPR in Europe on mental health disorders and the extent to which persons experiencing mental health disorders are engaged with services. It might be that structured assessment tools should be employed as part of assessment.
- The strategy should also examine how best to collect monitoring data on suicide by probationers. The data should be collected routinely over a period of time (3-5 years) so that trends might be examined
- The strategy should be explicit about how continuity of care for mental health disorders can be achieved on transfer from prison to probation
- The involvement of service users should be considered in all initiatives
- National research funding should be made available to evaluate the implementation of the strategy and its impact on health and re-offending outcomes
- It is likely that once the probation officer's role in dealing with probationers with mental health disorders is understood and clearly articulated, training might be required
- There should be a network of mental health researchers and experts working in probation settings
- Every probation service should know and understand the pathways and access criteria to all local mental health services.

Prisons

- There should be an agreement among all Member States regarding the recognition and establishment of a baseline of standards regarding the mental health care in prison context, aligned and integrated in the National Heath Policy, with equivalence in terms of quality, number and level of expertise of the clinical staff that provides care inside prisons
- In accordance with the European Prison Rules (Rule 12) the national authorities should consider allocating persons in order to take the necessary measures that persons who are suffering from mental illness and whose state of mental health is incompatible with detention in a prison are sent to an establishment specially designed for the purpose. If such persons are nevertheless exceptionally held in prison, there shall be special regulations that take account of their status and needs.
- In accordance with the European Prison Rules (Rules 15.1.f, 16.a and 42) all prison services should screen new prisoners at admission, subject to the requirements of medical confidentiality and should register any relevant information regarding their

physical and mental well-being. This information should be supplemented promptly by a medical examination

- In accordance with the EPR (Rules 39-48) all prison services must ensure adequate access to treatment and care of all inmates in general in to mitigate the effects of imprisonment on their health, including their mental health
- As admission to prison can be a traumatic experience, especially for juveniles, women, foreign nationals and first-time offenders, prison administrations should be vigilant and should follow specific written procedures to detect early signs of mental disorder or distress, as well as suicide attempt risks and should collect suicide profiles that can be used to target high-risk groups and situations
- Conducting initial and ongoing comprehensive assessments to identify the individual needs of mentally disordered prisoners should be put in place to prevent, detect and treat signs and symptoms of mental disorder
- The development and implementation of integrated and tailored approaches for early referral, assessment, diagnosis, and treatment of prisoners with mental disorders, including assessment instruments and treatment programmes should be in place in all prisons, preferably with written guidelines and procedures that must be followed at the early stage of admission
- The standardisation of the use of assessment and referral instruments across the prison system must be a priority to all prison administrations
- A well-organized procedure should be in place in all prisons to help prisoners to have access to relevant information on what, by whom and how they can get help if needed, especially in the initial period of incarceration, reinforcing the information regarding all important topics of life inside prison (health department, schedule for visitation, telephone calls)
- The development of a unified mental health recording system integrating different instruments (screening, assessments), diagnostic results and treatment files, should be designed and developed, in collaboration with scientific experts, and their results should inform the decision makers about the trends and actions needed to be taken at a national level
- Prison staff should be trained with different aspects of knowledge and techniques of intervention. At a minimum, initial suicide prevention training should include but not be limited to the following: why correctional environments are conducive to suicidal behaviour, staff attitudes about suicide, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, recent suicides and/or serious suicide attempts within the facility/agency, and components of the facility/agency's suicide prevention policy4
- Basic mental health awareness training should be regularly provided to all prison staff, specifically oriented to the detection of early signs and symptoms of mental disorders and/or suicidal ideation or risk of suicide and how to recognize and deal with mental disorders, as well as to detect emotional distress and crisis, and should also include examples of lived experiences from the past and teach the "dos and don´ts" of each example
- Prisons should promote the contact between prisoners and their family and friends as they play an important role on the prisoners' mental health condition

[4] WHO, 2007

- Inmates should be provided with meaningful activities to make the best use of their time and reduce the negative impact of imprisonment on their mental health, especially cognitive therapies, and specific therapeutical activities should be available
- Planning of prison infrastructure to respond to the increasing care needs of vulnerable groups should include, whenever possible, specific units adapted to host prisoners with mental disorders, and they should have in place, on a regular basis, specific programmes for treatment, rehabilitation and for reducing risk factors of recidivism, especially regarding self-harm behaviours and suicide attempts.
- Joint development of work between prison hospitals (in particular forensic psychiatric clinics) and local hospitals or other external mental healthcare institutions is essential in order to promote the necessary collaboration and co-responsibility in the preparation for release of prisoners with mental disorders
- Referral of ill prisoners to external local or regional mental healthcare structures that can provide treatment after release or during probation measures should follow written protocols and partnership agreements should be established with such institutions

8. References

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Appendix I

Government policies

Albania: There is no policy regarding people under probation who experience mental disorders, mainly because they are sent for hospital treatment.

Austria: The rehabilitation assistance for offenders in Austria involves probation assistance as a judicial sanction instead of or after imprisonment, but also as an assistance for the release without any judicial order (optional choice of inmates during the release management). On behalf of the Ministry of Justice, the organization NEUSTART offers these kinds of care and support throughout Austria. In addition to helping perpetrators and victims, the services of NEUSTART also include preventive measures.

Probation service: Probation can be a judicial order instead of a prison sentence or in case of an early release. The responsibility of probation is to support a future lifestyle without committing new crimes. Probation officers helps the people concerned in coping different individual problems and/or everyday difficulties. At the center of the work is the effort to cover the main needs, such as finding a home or a place to live and finding a job. The probation service provides a solid foundation from which to begin a new life.

Further care offers: In addition to the offers of probation assistance, the follow-up care of those released from prison is an important pillar of the rehabilitation assistance. All inmates are informed by the prison social service that they can use the support of NEUSTART for preparing their release. In addition to the support of social needs, such as looking for a home and job, questions of employment and pursuant to insurance law and debt settlement, the development of finding individual solution strategies for the risk of relapse is another main part of the advisory service.

Inmates who have not received probation assistance as a judicial order can take advantage of the care and support offered by the assistance for the release or they can ask for probation assistance on a voluntary basis.

The organization NEUSTART is available in all federal states in Austria. Beside the mentioned release support, they also offer communication and work training, the mediation of charitable activities, the drug advice, the family care, the school social work, the youth welfare and the crime victim assistance.

Inmates with mental disorders or disabilities: If a person with mental disorders or disabilities has probation service supervision as a judicial sanction instead of or after imprisonment as well as using the optional choice of this support during the release management, generally all involved professionals (e.g. prison staff, relevant institutions, probation service, …) cooperate with each other in form of collecting the personal data as well as the individual needs and risks. In course of that - if necessary - the connection to stationary and/or ambulant institutions are made such as psychiatry, out-patient treatments, other institutions for care and treatment, psychologists, psychiatrists … The main aim is to give the person the support of a stable and self-determined life and give general and individual information of institutions and addresses for contacting when needed.

Involuntary detention ("Maßnahmenvollzug gem. § 21 StGB"): Basically, a distinction can be made between the executions of measures against *insane*, mentally abnormal lawbreakers (§ 21/1 StGB) and the execution of measures against *sane*, mentally abnormal lawbreakers (§ 21/2 StGB).

The placement in an institution for mentally abnormal lawbreakers is intended to prevent the detainees from committing criminal offenses under the influence of their mental or emotional "abnormity". The placement is intended to improve the condition of the detainees to such an extent that they can no longer be expected to commit acts threatened by a penalty, and to help the detainees to adopt a righteous attitude towards life that is adapted to the requirements of community life.

In Austria, generally *all* mentally abnormal lawbreakers have in case of their release the judicial order of probation. For the (optional) release management of mentally abnormal lawbreakers before the release, a very strict and interface management regulation was worked out by the Ministry of Justice and NEUSTART. The main goal is the ensurance of a timely and individual risk management and the widespread care and support in the finale phase of prison in preparation of the release between the prison and the probation service (the further probation officer). For a demand-oriented return in a social environment, a very

close and coordinated teamwork between all involved persons (Case Manager, other prison staff, probation service/further probation officer, judge and other institutions) is necessary. In form of case-conferences and different forms of risk assessments, the individual needs and required supports are identified, so that when being release the gap between time inside the prison and the release is as small as possible.

Belgium:

French speaking: We do not have any reports on the issue. There are no statistical links between persons on probation and mental disorders/disabilities because the matters are dealt with by two separate entities and there is no specific documentation in either of them. Probation is managed by the justice system (as regards court rulings) and the Communities (as regards monitoring and supervision), while the public health system is responsible for care for mental disorders and disabilities. The Ministry of Justice has more detailed information on persons confined to mental hospitals, but they are not within the scope of this questionnaire.

Flemish speaking: The Flemish concertation platform for Mental Health (Vlaams Overlegplatform Geestelijke Gezondheid - VLOGG) has made a report addressing the description, the evaluation and the shared vision regarding the guidance and treatment of non-detained probation clientele who have a psychological vulnerability.

Shared vision = cooperating partners are Mental health services, general social work services and the houses of justice (probation services).

Non-detained probation clientele = in Belgium that means every form of criminal execution outside of prison for adults (over 18): community service, conditional sentences, early release from prison, electronic monitoring, …

The report serves as a starting point to take actions to facilitate the accessibility to and to improve the continuity of the aid and care that is provided. Special attention goes to the collaboration between the social worker / mental health provider and the probation officer (cooperation protocols and consultation structures are needed).

The Flemish Agency Care and Health (Vlaams Agentschap Zorg en Gezondheid) developed a framework for forensic mental health care. Through this instrument the government wants to improve the quality of mental health care for non-detained probation clientele. The framework provides specific and additional quality standards for this specific group of clients. The framework must be evaluated (refined and adjusted if necessary) in cooperation with the partners concerned.

Czech Republic: MANUAL FOR WORKING WITH DEPENDENT PERSONS (topics)

Theoretical part (Dependency phase, change cycle stage, available services for dependents)

Practical part (Safety of worker working with drug addicts, security at the Centre PMS, tester manipulation, field work safety, working with addictive or alcohol-dependent offenders, mapping the offenders situation, communication with dependent offenders

Finland: Supervisors are obligated to guide a person to social services if he/she assess the need for support and services. Supervisors are also obligated to inform social services if a person is incapable to take care of himself or if interests of the child are involved. (Social Welfare Act 35)

➔ Referring to social services
https://stm.fi/en/social-services

OR

➔ Referring to general practitioner / psychiatric nurse at public health care
https://stm.fi/en/mental-health-services

France: Persons in semi-liberty (on day release) are covered by ordinary law and therefore have access to ordinary healthcare. The same applies to all those under the supervision of prison rehabilitation and probation services in community settings. In addition, strand 5 of the 2019-2022 health roadmap for persons under judicial supervision ("Ensuring continuity of care in the case of prison release and ending of judicial measures") is intended to ensure continued care and treatment for detained persons, in particular between secure and community settings.

Germany:

BW: The Bewährungs- und Gerichtshilfe Baden-Württemberg /BGBW) has established a specialist concept. In each of our 9 facilities, we have a specialist for different topics, such as the topic "persons under probation with mental disorders". Theses specialists have up-to-date expertise as well as methodical and didactical skills. Core tasks of the specialists include training and counselling of the probation officers, if needed case analysis, crisis intervention and tandem support for difficult cases. They also organize specialist days, training courses and lectures as well as networking meetings. The specialists offer case discussions and consultation hours for their colleagues. In order to enable continuous knowledge building, the specialists have 5 training days per year at their disposal. For quality assurance purposes, the central social work department of the BGBW, holds an annual meeting with all specialists.

BY: In Bavaria, there are no special (political) programs, recommendations or similar. The binding quality standards of the Bavarian probation service apply to the work of the probation service in Bavaria. These are available on the homepage of the Bavarian State Ministry of Justice under the following link:

www.justiz.bayern.de/gerichte-und-behoerden/oberlandesgerichte/muenchen/bewaehrungshilfe.php

NI: There are quality standards in the ambulant judicial social services in Lower Saxony. The corresponding manual in English is attached as an appendix ambulant.

SH: In Schleswig-Holstein, there are no known special programs or procedures for the treatment of probationers with mental illness in the sense of health care. In order to counteract stigmatization and promote participation in the health care spectrum, the support of mentally ill or conspicuous probationers is aimed at enabling access to general medical and therapeutic services.

In general, health care for mental illness/psychiatric disorders is organized as decentralized and community-based as possible. In Schleswig-Holstein, outpatient services as well as inpatient or day-care services are available for persons with mental illnesses, which are also open to offenders. Probation officers have knowledge of the regional support services and cooperate with/provide access to:

- Low-threshold regional counselling services provided by governmental and non-governmental organizations
- Psychotherapists in private practice, who are required by the Psychotherapy Guidelines to offer timely consultation hours and acute treatment.
- Specialists in private practice (neurology/psychiatry, addiction medicine)
- The emergency rooms of psychiatric clinics/departments (in the event of acute psychiatric or psychotic crises), as well as day clinics and outpatient follow-up care
- Specialist and rehabilitation clinics
- Social psychiatric services of the health authorities
- Offers of addiction support for probationers with ICD10 F10-F19 disorders;
- Offense-specific services for sex offenders and violent offenders, which are also open to probationers with mental disorders.

The following programs are available for probationers with crime-relevant disturbance patterns:

- "Don't become an offender" - low-threshold counselling and treatment offer for persons with sexual preference disorder directed at minors
- Forensic specialist outpatient clinics - for treatment for persons with sexual preference disorder, usually in accordance with a directive under the Criminal Code
- Suspension of execution of sentence according to § 35, 36 des Betäubungsmittelgesetzes (Narcotics Act) in favour of a mostly inpatient addiction therapy measure.

BE, BB, HE, MV, NW; SL, TH: Specific political programs, recommendations, reports or similar documents as mentioned above do not exist.

Iceland: A mental health interdisciplinary mental health team has been established for the prison system, starting in 2020. The team includes psychologists, a psychiatrist, psychiatric nurses and hopefully will have the resources to access other professions as needed. The team

operates on the basis of internationally recognized standards, evidence-based methodology and clinical treatment guidelines. The team works both onsite (within the prisons) as well as using teleconferencing equipment when needed or when appropriate. The team works closely with employees of the prison service, mental health teams in the community, health care institutions and other service providers to ensure continuity of services once the detainee has left prison

Italy: Act No. 180 of 1978 (the so-called Basaglia law, from the name of the psychiatrist behind this reform) granted dignity and rights to those suffering from serious psychiatric disorders; it abolished mental asylums, a total institution in which inpatients felt their identity had been erased, and identified the territory as the most appropriate place of intervention for the protection of mental health.

However, the Judicial Psychiatric Hospitals, so called since 1975 (i.e.: OPGs in Italian), which used to house offenders suffering from psychiatric problems, remained in operation. These facilities depended on the Penitentiary Administration Department and therefore suffered from the prevalence of custodial needs over treatment needs.

The Italian Parliament decided to close the OPGs by Act No. 81/2014 that entered into force on 31 March 2015. This epoch-making reform replaced the OPGs with the Residential facilities for the Execution of Security Measures (REMS in Italian), managed by the Regions, to ensure assistance and care inspired by the principles of deinstitutionalisation and social inclusion.

Therefore, the criminal offenders who are acquitted on grounds of insanity are, since then, subject to either non-custodial (probation) security measures or custodial (REMS) security measures, in accordance with Act No. 81/2014.

However, until 2019, no such protection existed for those who had not been identified at the trial stage (i.e. acquitted on grounds of insanity) or for those who had witnessed the onset of the illness during the execution of the sentence and, therefore, were not subject of a security measure.

The Constitutional Court's judgment no. 99 of 2019 has intervened, in accordance with Article 3 of the Constitution, to ensure the care of detainees with psychiatric problems by cancelling such an unequal treatment between those who suffer from a serious physical infirmity and those who have a psychiatric pathology, thus allowing the enforcement of alternative measures even in cases of serious mental illness that emerged eventually.

At present, therefore, judges can enforce a set of rules which ensure equal treatment to all persons with mental problems who enter the penal circuit, whether they were identified beforehand and were therefore regularly recipients of security measures or they were already detained and their pathologies emerged subsequently. If a serious psychiatric illness manifests itself during imprisonment, the judge may order that the offender be treated outside the prison. The alternative measure of home detention may be granted, as is already the case for serious physical illness, even when the remaining sentence is more than four years. In addition, the measure of Probation may be granted under the supervision of the local Social Service in order for the offender to continue or undertake a therapeutic and

psychiatric assistance programme. This measure shall be monitored by the Probation Services of the Ministry of Justice in close cooperation with the Region's Mental Health Department.

Latvia: No data has been gathered on the mental health of people on probation as of now but there are plans to do this in the future.

Lithuania: Law on Mental Health Care; Lithuanian Health Strategy for 2014–2025; The Mental Health Strategy.

Malta: We don't have any specific guidelines related to probation, however, recently a 10-year national mental health strategy was launched (encompassing 2020 to 2030). Link: https://deputyprimeminister.gov.mt/en/Documents/National-Health-Strategies/Mental_Health_Strategy_EN.pdf

Montenegro: There is no any recent national document (in the form of a policy, procedure, guide or report) relating to the treatment of persons with mental disorders or disabilities who are under probation service supervision.

Northern Ireland: PBNI employ a number of Forensic and Clinical Psychologists who provide a dedicated Psychology service across the province. This includes the delivery of regular mental health awareness training to all staff. The content of this training focuses on an awareness of the different types of mental disorders, presentation of associated behaviours, recognising signs and symptoms of mental illness and associated disorders. The training also includes information and awareness on the wide range of medication prescribed to service users as well as potential side effects, an overview of services available both within PBNI and externally across the region e.g. mental health services, community/voluntary sector services. The training contains a practical element of working through case studies and providing guidance to probation staff on a range of approaches to utilise when working with service users who may be experiencing mental health problems, suicidal ideation or engaging in self-injurious behaviour.

Portugal:

Report "Case Management: Need analysis and guideline proposals" (Directorate-General for Probation and Prison Services, November 2016): 42% of community measures include the court order of mental health treatment, including treatment for addictions; such order is the most frequent among probation measures (between 52 and 58%); for parole, mental health treatment is present in 12% of the measures, most frequently related to the treatment of addictions; mental health treatment is most frequently imposed in domestic violence crimes (50%), theft (58%), road offences (41%), drug related crimes (37%) and sex crimes (33%). It is also a very common order in arson crimes (48,2%).

Report "Probation intervention in security measures for non-criminally responsible offenders" (Directorate-General for Probation and Prison Services, October 2018): all offenders are subject to mental health treatment (required by law); most common disorders are intellectual disability (37,8%), psychosis/schizophrenia (32,4%), personality/impulse control disorder (13,5%) and bipolar disease (10,8%).

Report “Probation and community mental health services” (Directorate-General for Probation and Prison Services, November 2019): The majority of the community mental health services that collaborate with probation teams are NGO (32%), followed by hospitals (29,5%), institutions for the treatment of addictions (23,0%) and primary healthcare units (13,0%).

Recommendations for referral and collaboration between probation and community mental health services (under development): joint recommendations are being prepared between the Directorate-General for Probation and Prison Services (Ministry of Justice) and the National Mental Health Program (Ministry of Health) to define procedures for the referral of probationers and parolees with mental health treatment orders and/or mental health problems. Such procedures stem from the need to overcome difficulties that have been identified when requesting mental health interventions, as well as communication problems between institutions.

Romania:

The approach of mental health issues is still being a challenge for the Romanian probation system due to the difficulties faced in working with mental disorders and to the lack of specialization regarding training the probation counsellors in addressing such issues. First, it is important to mention that the probation supervision in Romania is focused both on control and assistance/support for the supervised person in order to address the social and criminogenic needs and to diminish the reoffending risk. The two central elements of the probation work are the main directions of the supervision process, and also, are applicable in working with mental health probationers. The balance between control and support is very sensitive in working with mental health disorders, having in mind that most of these aspects are not medically diagnosed (certified by documents) and the probation counsellor has only a few clues about it, observing the changes regarding behaviour of the persons (violent and aggressive actions, impulsivity, abuse of drugs/alcohol, refuse of cooperation, excitement and others). In working with mental health disorders it is important for the probation counsellor to identify the signs and symptoms which could lead to medical diagnosis regarding a mental health disorder. In this respect, some guidelines are offered by the Probation Counsellor Manual, which contains a distinct chapter dedicated to approaches of the mental health disorders in probation and specific aspects in working with mental illness.

The main activities of the Romanian probation services are related to the following stages of the criminal trial:

- before the trial, during the prosecution - the pre-trial reports for juveniles in order to assess the reoffending risk and the risk factors;

- during the trial, before the sentencing - the pre-sentential reports for minors and adults, at the request of the court (similar like before, the assessment of the risk) ;

- post-trial - stage- the execution of the community sentences and post release phase (the supervision of educative noncustodial measures imposed for minors, the supervision in case of the postponement of the sentence, the suspended sentence under probation supervision, the conditionally release from prison).

1) The principles of the Romanian probation system

It is relevant to emphasize the most important principles of probation work in Romania in order to show a clear overview of the probation system. Thus, according to the legal provisions and to the probation working standards, the most relevant principle is the case management, meaning the coordination of the following stages: the assessment of the supervised person, planning the intervention, guiding and monitoring the control measures and the assistance process and effectively implementing the sentence or only coordinating the community institutions involved within this stage. This principle is relevant in addressing mental health probationers in order to conduct the assessment, to plan and monitor the intervention within the community by the probation case manager and to cooperate with medical care units in order to offer an adequate framework for a specialized intervention.

As well, we can highlight the proportionality of the intervention during supervision, according to the level of risk and to the criminogenic needs in order to guide the intensity of the control measures and the intervention. The signs of mental illness are explored during the supervision meetings with the case manager and are addressed accordingly, within the probation service or within the community institutions, in special in medical care units, through specialists.

Last, but not least, in case of mental health disorders identified within the probation population, the proper approach envisages a multidisciplinary intervention, based on the case referral within the community in the first stage for a focused and adequate/appropriate support, which involves social care, psychotherapy, psychological counselling and sometimes, medical treatment, recommended by a psychiatrist.

2) Assessing the defendants with mental health problems

The reports for defendants are an important tool used by the courts in order to impose the penal sanction having in view the individual and the offence. Actually, the conclusions of the pre-trial reports as a result of the assessment process are used by the court to guide and justify the sentence, in most cases. Thus, the assessment process conducted in order to prepare the pre-trial/pre-sentential report for juveniles or adults includes the following aspects and items: a complete analysis of the criminal behaviour, criminal record, information concerning the social and familial environment, with an accent on the support, resources, values and principles, the educational and school instruction level, the working status and working experience, skills, motivation to change the problematic behaviour, the physic and psychological health and addictions, and as well, other information regarding the general behaviour of the defendant within the community. Based on the above mentioned dates, the

probation counsellor is able to evaluate the reoffending risk, the factors that could increase and decrease the level of the risk, and to propose to the court an adequate measure or sanction, including some specific obligations according to the social and criminogenic needs of the assessed person. As we mentioned above, the pre-trial assessment is focused on the evaluation of the general health of the person and medical/psychological issues, and in this respect, the probation counsellor can cooperate with specialists (psychologists and psychiatrists) in order to address properly mental health issues and to obtain useful information for the report. In such cases, the conclusions of the assessment report are related to the identified mental health problems and could include the recommendation to follow medical and psychological treatment within the noncustodial or custodial sanction imposed by the court. As well, it is important to early detect the sings of the mental illness for an adequate plan that could help take measures and guide the intervention.

3)Working with persons under probation supervision

If we have in view how we specifically address the mental health issues, it is relevant to highlight a few aspects regarding the supervision process as it is developed and implemented within the Romanian probation system. Starting with the first probation meeting between the probation counsellor case manager and the supervised person, focused on building the professional relationship, gaining trust, showing respect and offering all the necessary information related to the sanction and the supervision process, the next stages envisages the risk and needs evaluation, planning the sentence and the whole process and developing the proper intervention (or only monitoring the intervention when it is conducted by another specialist) and at the end, assessing the finalization of the supervision. As it is mentioned before, the social assessment of the criminogenic needs in order to estimate the level of the reoffending risk could guide the following steps: the supervision plan and the intervention. The signs of mental health illness are explored and approached within the first probation meetings and at the end of the initially assessment, the case manager would be able to decide the referral of the case to another community institution for medical care, psychological therapy or counselling or medical treatment. If the probation counsellor has some doubts about the signs of mental illness, he can collaborate with specialists in order to clarify and obtain an accurate overview of the case. Usually, in such cases it is difficult to obtain the consent of the probationer (because sometimes he denies or he doesn't recognize the problem) in order to follow a treatment program, if the court hasn't imposed a specific obligation for the convicted person.

According to the Romanian criminal code provisions, such obligation could be to comply with the requirement of treatment and healthcare measures - for drug and alcohol addiction and for other medical conditions. This specific obligation it could be established by the court when decides a community sanction for the defendant, and as well it could be disposed during the supervision at the request of the probation counsellor case manage. In this respect, an important and useful tool of the probation case manager is the possibility of changing the content of obligations imposed by court according to the criminogenic needs and the level of reoffending risk. Thus, during the supervision period, the case manager could ask the court to impose the obligation to comply with medical care measures, if the case. The revocation of

the sentence is possible in case of breaches related to the obligation; in such cases the person could serve the sentence in prison.

Another obligation that could be imposed to the supervised person is to follow a social reintegration program, meaning, according to the probation working standards, the following:

- intervention programs, focused on cognitive-behavioural therapy;
- intervention programs, such as those focused on the Goldstein method, the Moreno method;
- psychotherapy;
- psychiatric treatment;
- occupational therapy;
- educational, prevention and short-term intervention program;
- informative programs, including legal issues;
- psychological counselling;
- vocational counselling;
- support- counselling;
- relationships counselling;
- motivational counselling;
- any other type of assistance and counselling activities, which aims to adequately cover the identified criminogenic needs.

The access to mental health care providers is problematic. Making sure that individuals have access to mental healthcare could improve their lives and could raise the safety within the communities and also could facilitate the reintegration process during the probation supervision. For many, it could dramatically reduce or eliminate the risk of suicide, clarify legal issues, solve family conflicts, employment issues, address substance abuse and further mental and physical health problems. Even the probation system deals with many issues in order to support the reintegration of these persons in the community, it is important to understand the access the mental healthcare services, in order to ensure this access during the supervision term; as well inter-institutional collaboration is very important, and the case management is playing a central role in this respect.

Trainings for probation staff in order to identify the mental health issues during the risk and needs assessment process and to manage mental health probationers is also a key for improving the social intervention during the supervision period.

The increased number of supervised persons with mental illnesses represents a big challenge for the probation counsellors and also for the entire society. The support relationship between probation counsellor and probationers with mental illnesses has a significant importance in this area, despites the fact that we don't have interventions designed specifically for this type of problems and also we don't have training initiatives designed to prepare probation staff about mental health issues. The lack of specific programs and interventions to address mental health probationers is one of the Romanian probation system needs and in this respect it should be developed and implemented measures and actions.

In Romanian probation system, the mental health education by developing special social programs is a reality and the need of specific approaches in order to decrease stigmatization and to increase the knowledge of mental illnesses among probation staff it is known and accepted as a direction to follow.

Slovakia: There is no special policy or guidance regarding the persons under probation service supervision who experience mental disorders or disabilities in SK.

Spain: First, we want to clarify that we will include under the term "probation", offenders serving an alternative sentence and offenders on conditional release // Regarding people who are serving a sentence or an alternative measure, there are two options: In some cases, the court decision includes the obligation of the offender to participate in a mental health treatment programme. In that case, the probation officer refers the offender to a public resource and makes a follow up of the case, informing the court periodically. // When an offender with a mental disorder is sentenced to a regular alternative measure (community work or suspended sentence) because his/her mental condition has not been identified in court, the probation office may refer him/her to the Extended Bridge Programme (EBP). The main objective of the program is to detect these cases and establish a connection between the offenders and the community resources, both social and health, thus improving their health and at the same time avoiding new prosecutions and imprisonments. For example, if the probation officer detects that an offender who has to serve a community service sentence has a severe mental disorder, he/she will propose to the judge the possibility that the offender serves the sentence through his participation in the EBP. This will prevent compliance breaches and will contribute to a better rehabilitation of the offender. // Similarly, for offenders with intellectual disabilities, the Integrate Programme (IP) is available. The main objective of this program is the early detection of intellectual disability, improving their health and establishing connections with community social and health resources. This programme is in a pilot phase. // It is intended that these types of interventions continue when the offender finishes his/her sentence. // For people on conditional release there is the Bridge Programme. The objective of this programme is to facilitate and develop a process of reintegration into the community for people with mental disorders who are in open regime in any of its modalities, also covering the period of conditional release. Different types of intervention are carried out: psychosocial care, support for psychiatric and psychosocial rehabilitation, acting as health mediators, providing legal advice, foster care and family support, and job development programs.

Sweden: In Sweden persons serving probation sentences are included in the general health care system, it is called "a principle of normalization". The Swedish Prison and Probation Service do not provide any national policies apart from general policies from the national health care services. In prisons there can be special policies due to security reasons.

Turkey: Individual plans and programs are developed for probationers who experience mental disorders or disabilities.

Intensive Individual Interview

As a result of the determination of risk and needs, the suicidal attempt of the responsible person is determined by factors such as his / her history of violence, self-harm behaviour, and the demand for more frequent guidance. In these interviews, the relevant factors are discussed first.

Individual Intervention Interviews (Long Term Individual Interview)

Group work is not planned for different reasons such as physiological and psychological health problems, criminal history, or it can be carried out with probationers are not eligible for the relevant study as a result of evaluation interviews and / or group work sessions. These interviews; It refers to all individual works aiming to create a change in behaviour in the probationers.

United Kingdom

A. **England**: The Government take mental health very seriously and recognises that providing the right interventions at the right time is vital to improving outcomes for people with mental health needs. Offenders often have complex health and care needs and generally experience poorer physical and mental health than the general population. In order to improve health outcomes and tackle the root causes of offending it is essential we take a whole system approach to healthcare provision for people in the criminal justice system.

The Community Mental Health Framework for Adults, now in early stages of implementation by NHSE/I, is a new approach in which place-based and integrated mental health support, care and treatment are situated and provided in the community.

- This framework will support local community mental health services to move away from siloed, hard-to-reach services towards joined-up care and whole-population and whole-person approaches.
- This should include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, support with medicines management and for self-harm and coexisting substance use.
- One of the aims of the framework is to maximise continuity of care and ensure no “cliff-edge” of lost care and support by moving towards a flexible system that proactively responds to ongoing care needs.

Integrated Care Systems

In the recent White Paper, ‘Working together to improve health and social care for all’, the Government set out its ambition for every part of England to be covered by an integrated care system (ICS). Building on work set out in the NHS Long Term Plan, the move towards ICSs will enable different parts of the health and care system to work together more effectively, in a way that will improve outcomes and address inequalities, including for people on probation.

The Community Sentence Treatment Requirement Programme

Through the Community Sentence Treatment Requirement (CSTR) programme, health and justice partners are working to increase the use of Mental Health Treatment Requirements. This aims to screen/assess those with mental health and/or substance misuse needs and associated vulnerabilities with the ambition to increase the use of community treatment orders rather than custodial sentences.

Liaison and Diversion Services

The Liaison and Diversion Programme was created in 2010 following on from the publication of the Bradley Report in 2009. Liaison and Diversion services now cover 100% of England. Liaison and Diversion services place clinical staff at police stations and courts to provide assessments and referrals to treatment and support, including those with mental health needs. Information can then be shared with police and courts (with consent) to inform sentencing and disposal decisions. Offenders may be diverted away from the criminal justice system altogether, or away from custody. This may include diversion into a community sentence with a treatment requirement.

RECONNECT and Enhanced RECONNECT

In England, NHSE are rolling out RECONNECT, a Care After Custody service. This service will support those coming out of prison custody to navigate the complexity of health and social care provision and thus maintain and safeguard health improvements made in custody and thereby improve health outcomes and reduce reoffending.

The Enhanced RECONNECT service (with funding from Health), is currently being co-developed and piloted with MoJ to support the reduction of reoffending of prisoners with complex health needs (that are related to offending) who are released from prison with a high risk of harm to self or others. This service will work with the most complex and high-risk individuals for up to 1 year post release to ensure that they not only engage initially, but continue to engage with community based health and support services.

The OPD Pathway

The Offender Personality Disorder (OPD) pathway programme is a cross-government change programme that jointly commissions, designs, co-finances and delivers a connected pathway of services for people in contact with the Criminal Justice System who are high risk, and likely to satisfy the diagnosis of 'personality disorder'. This is a joint responsibility between NHS England and Her Majesty's Prison and Probation Service. The pathway includes delivery of a range of processes and interventions, including case screening, psychological consultancy for Offender Managers, as well as treatment and progression services for people in prison, those in secure mental health services and to those on probation. The pathway incorporates some CSAAP accredited interventions within its range of treatment options, such as Democratic Therapeutic Communities and Mentalisation Based Therapy (MBT). Through delivery of the pathway, the Offender Personality Disorder (OPD) Pathway Programme aims to more effectively manage risk of harmful offending, reduce repeat serious harmful offending, improve psychological health and wellbeing, and improve the competence, confidence and

attitudes of staff working with complex offenders, whilst aiming to increase overall efficiency and cost effectiveness.

B. **Scotland:** The Community Payback Order Practice Guidance (https://www.gov.scot/publications/community-payback-order-practice-guidance/pages/11/) outlines the operation of, and best practice for, Mental Health Treatment Requirements as part of a CPO, for justice social work services.

The Memorandum of Procedure on Restricted Patients – a reference document for those who are involved with the management and care of patients subject to a compulsion order with restriction order, a hospital direction or a transfer for treatment direction; that is, patients who are subject to special restrictions. This is aimed at those working in forensic mental health services. Apart from the growing body of trauma-informed practice training for justice social work services, there is no other specific policies/guidance etc.

Appendix II

The complete survey results for prisons and probation

Method

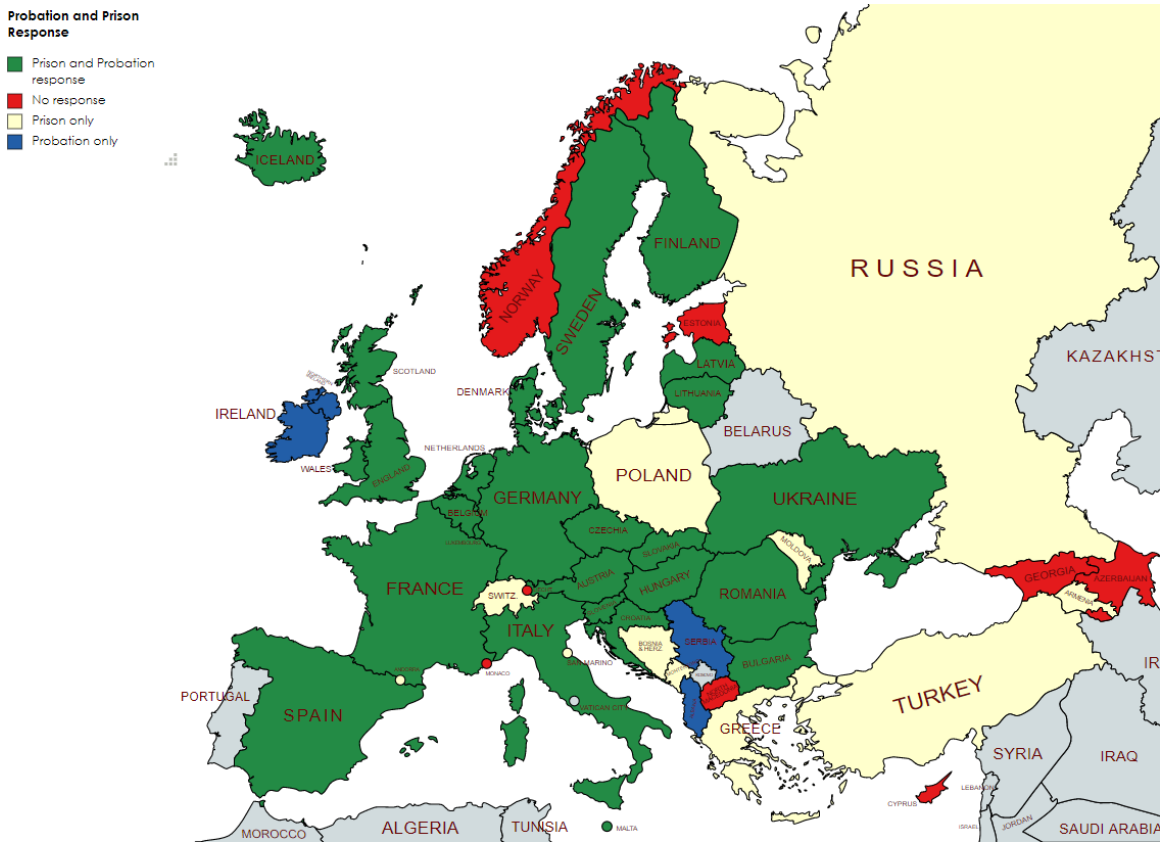
Design

Two questionnaires were designed by the PC-CP and sent out to the Council of Europe's member states and jurisdictions. The survey instruments are appended at Appendix A and B. The questionnaires aimed to elicit government policies and practical approaches to mental health disorders in probation services and in prisons. The survey was out in the field for approximately 10 weeks and a number of reminders were sent to non-responders. In the light of the Covid pandemic and the extra work that has been caused a response rate of 63% for prisons and 66% for probation was good (see Table 1 and Figure 1).

Table 1 – Response

	Prisons	**Probation Services**
Number of Total Returns	Note: Germany sent 10 different responses (out of a possible 16), Spain sent 2 Thus, there was a possibility of 67 'Response Units' Data is reported from 42 out of a possible 67 'response units'	Note: Germany sent 11 different responses (out of a possible 16), Belgium sent 3 and Spain sent 2. The UK sent 3/4. Thus, there was a possibility of 67 'Response Units' Data is reported from 46% out of a possible 67 'response units'
% Overall Response	63%	66%

Figure 1 Map of Different Types of Response



Data were set up on Excel spread sheets and a full copy of all responses can also be found on the Council of Europe's website at: [Mental Illness in Offenders on Probation: Draft Preliminary Survey (coe.int)]

Analysis

Simple quantitative analysis was undertaken and mostly yielded percentages although some median values are reported. The qualitative data was analysed in terms in relation to emergent themes. We also sought to ascertain examples of Good Practice. Some follow-up requests were made for further information.

Results

Where possible data for prison and probation services are reported together which allows for simple comparison between the two sectors.

First, the existence (or otherwise) of Government policy was examined (see Table 2 below). In probation there was a fairly even split between countries/jurisdictions supported by

Government policy or not. In prisons, the answers indicate that almost all countries/jurisdictions have in place policies at Government Level that regulates the treatment of prisoners with mental health disorders.

All data relating to this question is given at Appendix C.

Table 2 The existence of Government policy for the treatment of prisoners or probationers with mental health disorders.

	Prisons**	**Probation***
'Yes, policy exists	39/42 (92,8%)	17/32 (53%)
No, there is no policy (N/A)	3/42 (8,2%)	15/32 (47%)

*Countries where Government policy exists in probation include: Austria, Flemish speakers (Belgium), Czech, Finland, Albania, Baden-Wurttemberg (G), Lower Saxony, Malta, Iceland, Italy, Lithuania, Northern Ireland, Portugal, Romania, Spain, Turkey, England, Scotland

** Countries where government policy exists in prisons include:: Andorra, Austria, Belgium, Bosnia and Herzgovina, Bulgaria, Croatia, Germany (all answers), Greece, Iceland, Italy, Lithuania, Latvia, Luxemburg, Malta, Montenegro, The Netherlands, Portugal, Romania, Russian Federation, San Marino, Slovak republic, Spain, Catalonia, Sweden, Switzerland

All relevant Government policies are given in Annex 1.

Probation and mental health awareness training

Table 4 below indicates that only half the proportion of probation staff are given mental health awareness training compared to prisons (37% vs 74%). 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).

Table 4 – Receiving mental health awareness training

	Prisons	**Probation Services**
Number receiving training	31	14
No. of Valid responses	42	39
% 'Yes' training received*	74%	36%
Range	N/A	N/A

Probation and budgets for mental health services

Very few countries were able to provide details about the budget for mental health service input to probation (see Table 5). By far the greatest majority of countries stated that mental health care was provided by external agencies (health and the voluntary sector) and therefore costs were unknown. The response from Northern Ireland is worth highlighting as forensic psychologists are employed across the service from the probation budget itself.

'There is no dedicated budget for the provision of mental health care for people on probation in N. Ireland. PBNI have employed their own Forensic/ Clinical Psychologists over the years to work directly with and in partnership with probation staff in the management of this complex cohort of individuals. The Psychologists work very closely with the local Health Trusts and

Community Forensic Mental Health Teams/ Regional Psychiatric Secure Unit to ensure that service users are able to access appropriate mental health care in the community'

Table 5 – Total budget for mental health expressed per head of prison/probation population

	Prisons	**Probation Services**
No of valid responses	4	30 (2 valid responses) 27 = unknown
List budgets for all replying countries	450,000 (Iceland); 1,5 Million Euros (Malta); 15,5 Million Euros (The Netherlands); 20 Million Euros (Finland)	1. Baden-Wurttemberg (Germany): 12,50 Euro per employee per year 2. Iceland: 450,000 euros

Probation and the prevalence of mental health disorders

The survey response to the question about prevalence of mental health disorders in prisons and probation elicited a highly variable response (see Table 6). The range of prevalence reported in prisons was 0%-80% and in probation 2%-90%. This, despite the fact, that an attempt had been in the questionnaire to define 'mental health disorders' as follows:

'According to the World Health Organisation "Mental disorders include: depression, bipolar disorder, schizophrenia and other psychoses, dementia, and developmental disorders including autism.'

In probation, robust research, based on random samples, indicates that the 40% of probation clients experience a mental health disorder. The median value reported in this survey was 15% clearly an underestimate. In prisons the same variation occurred and then the median value was 18%. We asked countries jurisdictions on what basis the prevalence estimate had been calculated. In probation some estimates were based on research (Ireland, Finland, and Sweden). In other countries the response indicated that probation staff undertook assessments that that aggregated into national administrative data (Belgium, England, the majority of the states in Germany, Hungary, Malta, Northern Ireland, Portugal, Scotland,

Slovenia and Turkey). Only 3 probation services collected prevalence routinely (Catalonia, Northern Ireland and two German states: Berlin and Brandenburg).

Prisons and the prevalence of mental health disorders

From the 26 responses that were analysed, the range has a large variation and the median value was 18%.

Table 6 – Estimation of Prevalence of mental health disorders in Prisons and Probation

	Prisons	**Probation Services**	**Is data collected routinely?**
No of valid responses	26 (61.9%)	22(52.0%)	3 = yes
List estimates by Country/Jurisdiction	Andorra-20%; Armenia-12%; Bulgaria-0,36%; Croatia-10/80%; Czech Republic-60%; Finland-65%; France-6/24%; Greece- 9%; Iceland-15%; 10%-Lithuania-10%; Latvia-38%; Luxemburg-15%; Malta-20%; Montenegro-65%; Portugal-2%; Romania-16%; Russia-8%; San	Austria: 2.5% received a forensic order Belgium (French speaking): 30% Belgium (German speaking): 8% Catalonia: 7% Czech: 11.6% Denmark: 50% England: 11% Brandenburg (Germany): 50-60% Hessen (Germany): 15% Niedersachsen (Germany): 20%	Yes Yes

	Marino- 0%; Slovenia- 5-13%; Spain-4%; Spain-Catalonia-19%; Sweden-46%; DE- NI- 30%; DE-SH- 20%; England - 78%	Nordrhein-Westfalen (Germany): 13% Hungary: 13.55% Iceland: 15% Ireland: 40% Northern Ireland: 65% Portugal: 50-60% Schleswig-Holstein (Germany): 15-25% Thüringen (Germany): 10% Scotland: 70-90% Slovakia: 2% certified Slovenia: 15%	Yes
Range	0%-80% (Median 18%)	2-90% (Median 15%)	

Who provides care and treatment of mental health disorders in probation and prison?

Apart from health services and the voluntary sector very few organisations were involved in the provision of mental healthcare to probationers (see Table 7a and 7b). Probation mostly refers to external service providers apart from in Northern Ireland and Malta. In prisons, most countries rely on the MoJ to provide care inside prison, although in some countries the MoH is performing treatment as well.

Table 7a – Organisations providing mental health care in prisons and probation services

	Prisons	**Probation Services (n=37 valid responses)**
Ministry of Justice	a) 42,8%); b) 73,8%	7 (19%)
Healthcare	a) 14,3%); b) 21 (50%)	32 (86%)
Voluntary sector	b) 4 (9,5%)	10 (28%)
Other	a) 8 (19%); b) 2,3%	8 (22%)

a) Only institution providing mental health care
b) Combined with other institution

For more information about the 'other' category see A5

Table 7b – What is the role of prison/probation services in providing mental health care

	Prison	**Probation**
Valid responses		37
Proving interventions/treatment themselves	35 (83,3%)	5 (14%)
Inviting external services to work on the premises	27 (64,2%)	4 (11%)
Referring people to external services working elsewhere	26 (61,2%)	31 (84%)
Mixture of the above	23 (54,7%)	7 (19%)

Screening tools and probation

Table 9 shows that screening in probation takes place mostly at the court stage and also when people are about to leave prison (see Table 9). The screening tools used vary greatly and are generally used by the experts often pre-court appearance. However, there are two services, which both have in-house psychology teams that use structured screening tools. The probation service in Malta uses such the GAD (for generalised anxiety disorders) and the STAX (suitable for assessment of personality disorder). Whilst the service in Northern Ireland uses

the BDI (Beck Depression Inventory) and the PDE (Personality Disorder Examination). Bulgaria makes use of the Hare Psychopathy Checklist, an adapted suicide assessment schedule (PSRAC – Prison Suicide Risk Assessment Schedule) and structured tools to assess the severity of drug and alcohol consumption. In Iceland the Mini-Mental State is employed in order to assess symptoms of mental health. Spain has access to use of the CAGE (Alcohol consumption), the GHQ-28 (anxiety and depression). Otherwise, probation services do not assess mental health disorders themselves although a description of current mental health status and previous contact with mental health services is integrated mostly into routine data collection that seeks to examine risk. Table 9 below shows that most often screening takes place in court or prior to leaving prison.

Table 8 – When does screening take place in probation

	Probation
Valid responses	36
Arrest	15 (42%)
Court	34 (94%)
Prison	31 (86%)
Probation	16 (44%)

Furthermore, that general practitioners are most likely to be undertaking the screening function (see Table 9)

Table 9 – Who usually screens for mental health disorders in prison and probation?

	Prison	**Probation Services**
Valid responses	42	36
Prison Staff	12 (28,5%)	
Probation staff		11 (32%)
Other criminal justice staff	5 (11,9%)	2 (6%)
Nurse	16 (38%)	3 (8%)
General Practitioner	32 (76,2%)	11 (31%)

Screening and Prisons

In prisons structured assessment tools are mainly applied at the initial phase of imprisonment (Intake and Admission) and are conducted at least once a year, either by medical order or by request from the prisoner.

Mostly psychiatrists and psychologists screen.…….

Table 10 – When does screening for mental health problems take place in prison

	Prisons
Intake	30 (71,4%)
Admission	34 (80,9%)
Preparation for release	12 (28,5%)
Probation	

Table 11 – How often are prisoners screened for MH problems

	Frequency of Prisoner screening for mental health problems
By request of the prisoner	28 (66,6%)
By medical order	28 (66,6%)
Once a year or less	24 (57,1%)
Every two years or more	28 (66,6%)

Psychiatrist	33 (78,5%)	22 (61%)
Psychologist	35 (83,3%)	22 (61%)
Social Worker	17 (40,4%)	9 (25%)
Other *	1 (2,3%)	7 (19%)

***Others listed include:** Sociologist, teacher, Social pedagogues, Experts commissioned by courts and judicial authorities, mental health teams working within prison/probation, persons who work in the healthcare services

Table 12 – Does the prisons in your country/jurisdiction have special units to provide treatment to detainees with psychiatric mental health disorders?

	Prisons
No of valid responses	**42**
% stating 'yes'	29 (69%)

NB Respondents are asked to give examples

Probation and mental health treatment orders

Table 13 below shows that one-third of probation services can obtain orders for the mental health care of clients. Countries where this occurs include: Catalonia, England, France, Berlin (G), Mecklenburg-Vorpommern (G), Northern Ireland, Schleswig-Holstein (G), Scotland and Turkey.

More than half of the countries mentioned that there are special units with specific resources (including physical conditions) adapted to the needs of prisoners with mental health disorders, for example, Armenia, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Chech Republic, Denmark, Finland, France, Greece, Italy, Lithuania, Latvia, Luxemburg, Malta, The Netherlands, Poland, Portugal, Romania, Russian Federation, Slovak Republic, Slovenia, Spain, Catalonia, Sweden.

Table 13 – Does the service, prison or probation, have any special order/requirements for people with mental health disorders?

	Prison	**Probation services**
No of valid responses	42	38
% stating 'yes'*	16 (61,9%)	12 (32%)

Probation and Suicide Monitoring

In probation services Bulgaria, France, Ireland, and Northern Ireland all say they monitor suicides but they give no examples of trends. England collects this information nationally and a website address was given (See Table 14 below) as follows: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/981212/Probation_Q4_2020.ods.

Prisons and Suicide Monitoring

In the prison context the rate of affirmative responses regarding the existence of a suicide prevention strategy is very high (90%), which includes not only the suicide prevention programs (Table 15) and a systematic collection of data related to the number of suicides that occur inside prison (Table 14).

Table 14 - Do you collate the number of deaths by suicide nationally?

	Prisons	**Probation services**
Valid responses	42	38
% stating 'yes'*	38 (90%)	5 (13%)

Table 15 – Is there a prison suicide reduction programme established in your country/jurisdiction

	Prisons
Valid responses	42
% stating there is such a programme	37 (89%)

Prisons and co-operation with the community

Almost 90% (Table 16) of the countries have co-operation with community and some include families (45,2% - Table 17)), in order to prepare the reintegration of offenders.

Table 16 – Do your organisation work in co-operation with the community on resettlement plans?

	Prisons
Valid responses	42
% stating there is such a programme	37 (88%)

Probation and prison work with families

Five countries say that efforts are made to engage with families where this is relevant (see Table 17) including: France; Italy; Spain; Turkey; Northern Ireland

Table 17 - Is there specific work with families?

	Prisons	**Probation services**
Valid responses	42	38
% reporting yes and countries listed	19 (45,2%)	5 out of 38 (13%)

Probation and prison: gender specific approaches

Table 18 below shows that in 27% of services gender-approaches were employed. Three probation services stated that their approach to women with mental health disorders in the criminal justice system was trauma-informed namely Scotland, England and Northern Ireland. In England the CSTR programme is an example of a gender approach to the delivery of mental health treatment requirements in primary care see the link here: Community Sentence Treatment Requirements | London City Hall. In Scotland some local authority social work services are developing specific services for woman involved in the criminal justice system. In Northern Ireland, 'gender approaches are always considered with a trauma informed lens in terms of appropriate assessment, intervention and treatment pathways.

In France research is being undertaken by SPCS by a team in Lille one aspect of which focuses on women le4aving detention. In the other 6 countries answering this question all made general statements about how important a gender approach was and that it was used in their services.

Table 18 - Is there a gender approach?

	Prisons	**Probation services**
Valid responses	42	38
% reporting yes and countries listed	20 (47%)	10 out of 38 (26%) Belgium (German speaking); Berlin (Germany); Brandenburg (Germany), Hessen (Germany); Iceland; Italy; Turkey; Northern Ireland; England; Scotland

Gender approaches were specified by nearly half of the prison services (47%). Twenty prison services stated that their approach to women with mental health disorders in the criminal justice system was a practice that they are developing and making investments and that the specific needs of the inmates, independent of their gender, are taken into account when they are placed in a prison facility, and for that matter they have special concerns.

For example, In Finland this individualized assessment and approach is in place in several prison establishments and in Portugal, there is a "Manual of Good Practices" being developed in order to establish and determine the procedures of assessment, placement and individual care for inmates with specific needs in terms of gender identity or other issues related to gender.

Conclusions from the survey findings

Probation

- There was good response to the survey boosted by the returns of 11/16 German states.
- Half the proportion of probation staff received mental health awareness training compared to prison staff (74% vs 37%)
- Estimates of the prevalence of mental health problems in probation varied from 2% (Slovakia) to 90% (Scotland) with a median of 15%.
- Robust research indicates that the figure is closer to 40% so largely probation services seriously under-estimated the prevalence
- Only 4 jurisdictions collected prevalence data routinely.
- By far the most common model for probation clients to access mental healthcare was through the use of external healthcare agencies (86%), 10% accessed services in the voluntary sector.
- Screening for mental health disorders was most likely to take place in the court (94%) or in prison (86%). Psychiatrists (61%) and psychologists (61%) were mostly involved although GPs were involved in nearly one-third of cases (30%)

- Most probation responses indicated that the role of probation services was to direct probationers to external services (as above). It should be noted that two countries, Malta and Northern Ireland, used an 'in-house' treatment service run by psychologists. England had a one-off initiative for offenders with a personality disorder.
- 12 (32%) countries/jurisdictions had specific treatment orders for mental health. In England, there had been concerted efforts to maximise the use of mental health treatment requirements in the CSTR project.
- 5 (14%) of countries jurisdictions monitor suicide rates in probation (Bulgaria, N Ireland, France and Ireland) but provide no data. England provides a website address showing that probation suicides have been examined for a number of years.
- A small number of probation services work with families (14%) and 27% provide a gender approach to probation which was often trauma-informed.

Conclusions: Prisons:

- Good reaction from members states to the questionnaire (63%).
- Extensive reports with detailed and relevant information about the state of the art in terms of the treatment of prisoners with metal disorders inside prisons.
- Clear increasing investment from member states on the mental health of inmates.
- Training and raising awareness on mental health disorders is provided for all prison staff in the majority of the countries (74%).
- Importance of research on the prevalence of mental health disorders among inmates in order to better acknowledge the specific needs of this population (62% of answers)
- Increasing shared responsibilities between MoJ and MoH in the treatment of inmates with mental disorders (66%).
- Existence of specials units with physical conditions and human resources specialize in the accommodation and care of inmates with mental health disorder and other disabilities (69%).
- Very impressive rate of positive responses to the collection of data related to suicide behaviours (90%).
- As well as the existence of suicidal prevention programs and strategies (89%).
- Good responsive rate referring to the work with the community in resettlement plans.

Appendix III

Collection of good practices

6. Good practice in Europe

Probation

Some examples of good practice were given in the survey by the respondents who were mostly the Chief executives of national probation and prison services. The examples for probation are given in Table 2 below:

Table 2: Examples of good mental health practice in probation by country/jurisdiction

Country	Example of Good Practice
Austria	The use of a not-for-profit company called Neustart. This uses a case management model including counselling across Austria
Belgium	VLOGG is a multidisciplinary platform for mental health has guidelines for probation and mental health. There is also a framework for forensic mental health care which describes standards.
Czech Republic	Has developed a manual for working with dependent people.
Germany (Baden-Wurttemberg)	Use probation trained mental health specialists in their nine centres for probation
Germany (Lower Saxony)	Developed standards for mental health in probation
Iceland	Employs a mental health multidisciplinary team in prisons which will develop to include probationers.
Italy	There is the equivalent of a mental health treatment order monitored by probation and the Regional Mental Health Depts.
Malta	Employs psychologists from probation resources to provide advice support and intervention
UK (Northern Ireland)	Also employs psychologists from probation resources to provide advice support and intervention.
Portugal	Monitor the involvement of community mental health services with probation (Report available). New referral procedures are being developed as there have been

	some problems. These criteria would be useful.
Romania	Guidelines in the probation counsellor manual. Mental health treatment orders can be imposed by the court.
Spain	The Extended Bridge Programme which aims to connect clients with a mental health disorder to community mental health services.
Turkey	Scope for individual plans and programmes for those in probation identified with mental health disorders
UK (England)	The CSTR project working to improve uptake of mental health treatment orders made by courts. Liaison and Diversion services working in the courts means some might be diverted away from the CJ system altogether. RECONNECT and Enhanced RECONNECT are care-after-custody services. Seek to promote engagement with community mental health services. OPD Pathway is a connected pathway of services for people who are likely to be diagnosed with a personality disorder.
UK (Scotland)	Mandated court orders for mental health treatment

The examples of good practice for prisons are given in Table 3 below.

Prisons

Table 3: Examples of good mental health practice in prisons by country/jurisdiction

Country/Jurisdiction	Example of Good Practice
Austria	There are different regulations and procedure specifically developed for inmates with mental disorders, intended to "improve the conditions of the detainees" and to assure a specific treatment and approach, including special unis and infrastructures.
Belgium	Besides several specific Laws and Orders, there is a "Collective Letters" approach that defines which prison establishments have "psychiatric departments". A Ministerial circular regulates the constitution of "multidisciplinary teams" that provides care in those psychiatric detention centres.
Bulgaria	Preparation of an "Action-Plan 2020-2030) to develop a "Mental Health" strategy.
Croatia	Implementation of the "Ombudsman's" recommendations in all prisons since 2018 with the purpose of protecting prisons with Mental Health disorders.
Denmark	Developed e-learning modules on how to deal with detainees with signs of Metal Disorders prisoners
Finland	Development since 2016 of polices and rules of good clinical practices, also available in the intranet of the prison system.
France	In 2019 the Ministry of Health and the Ministry of Justice signed an agreement for the development of studies and research of the mental health status of all prisoners during 2019-2022
Iceland	Establishment in 2020 of an interdisciplinary team for the prison system to provide, among other tasks, general and specialized mental health services in prisons, working independently but alongside and in close collaboration with other agencies.
Italy	In 2019 the "National Committee on Bioethics issued a paper on "Mental Health and Psychiatric Assistance in Prison", containing general guidelines on Mental health in prisons.
Luxemburg	Prisoners with mental disorders are under the supervision of the Prison Psychiatric

	Department, which consists exclusively of staff from Luxemburg´s neuropsychiatric hospital.
Montenegro	Developed and published in January 2020 a "Mandatory Mental Health Care Act" that regulates the rights of those who have to serve compulsory care in mental institutions.
Portugal	Recently (2019) a decree-law that foresees the improvement of quality of services provided for inmates who were considered non-responsible for their action due to a mental disorder, and that regulates and defines procedures and methods of assessment and treatment to all inmates in these conditions, independently if they are under a security measure inside a prison facility or in a psychiatric hospital.
Romania	Recently implemented their responsibilities foreseen in the "National Strategy for the Child and Teenager´s mental Health 2016-2020, including a "Crisis response Guide" for staff working with this target group which was developed in collaboration with the academy.
Russian Federation	Specific laws that approve the organization of provisional care for prisoners with psychiatric diseases.
Slovak Republic	Established an advisory board ("Mental Health Council") that coordinates and cooperates in creating the tasks of the National Plan for Mental Health.
Spain (Catalonia)	Ministries of health and Justices are carrying out a number of actions aimed to improve the quality of the treatment that is provided to patients that are inside prison or in psychiatric hospitals
Switzerland	The "Swiss Centre of Expertise in Prison and Probation is currently developing a handbook on psychiatric care in detention, containing recommendations for professionals who deal with inmates with mental health disorders.