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Probation's Role in Offender Mental Health

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Probation's Role in Offender Mental Health

Purpose: To examine how the role in offender mental health for the probation service described in policy translates into practice through exploring staff and offenders' perceptions of this role in one Probation Trust. In particular, to examine barriers to staff performing their role and ways of overcoming them.

Design: Qualitative secondary analysis of data from semi-structured interviews with a purposive sample of 11 probation staff and 9 offenders using the constant comparative method.

Findings: Both staff and offenders defined probation's role as identifying and monitoring mental illness amongst offenders, facilitating access to and monitoring offenders' engagement with health services, and managing risk. Barriers to fulfilling this role included limited training, a lack of formal referral procedures/pathways between probation and health agencies, difficulties in obtaining and administering mental health treatment requirements, problems with inter-agency communication, and gaps in service provision for those with dual diagnosis and personality disorder. Strategies for improvement include improved training, developing a specialist role in probation and formalising partnership arrangements.

Research Limitations: Further research is required to explore the transferability of these findings, particularly in the light of the recent probation reforms.

Originality: This is the first paper to explore how staff and offenders perceive probation's role in offender mental health in comparison with the role set out in policy.

Keywords: probation service, mental health, qualitative secondary analysis, transforming rehabilitation, qualitative research, offender health

Paper type: research paper

Introduction

The limited research on the prevalence of mental illness amongst offenders on probation utilises a variety of methodological approaches, and often focuses on a sub-section of the population (e.g. those in probation approved premises). This makes comparison between studies problematic (Sirdifield, 2012). However, one can cautiously conclude from this literature that the prevalence of mental illness in probation populations around the world is high in comparison to the general population, and the prevalence of some disorders is higher in females than in males (see Sirdifield (2012) for more on this).

UK research undertaken in one probation Trust suggests that 38.7% of probationers have a current mental illness, and 48.6% have a past/lifetime disorder (Brooker et al., 2012). Moreover, there is a high rate of co-morbidity and dual diagnosis in this population, with over half of those with a current mental illness screening positive in more than one diagnostic group, and 72.3% also having a substance misuse problem (Brooker et al., 2012). This high prevalence and complexity of mental illness amongst probationers raises the question of what policy suggests probation's role in offender mental health should be, and how this translates into practice.

The probation service in England and Wales works with adult offenders on community orders, suspended sentences and on licence, including high-risk offenders. Its role includes providing advice to the courts to inform sentencing decisions, enforcing sentences, public protection, and offender rehabilitation. There is a tension between 'care' and 'control' in probation practice. Like many probation services in Europe it was founded in philanthropic principles. It then adopted a largely rehabilitative/'treatment' orientated approach to working with offenders (McWilliams, 1985, Vanstone, 2004), and has since been subject to many reforms and changing messages about the extent of, and rationale for, any focus on offenders' welfare needs.

Briefly, the literature charts a shift in policy from the collapse of the rehabilitative-scientific ideal (Bottoms and McWilliams, 1979) to probation becoming an increasingly managerial and risk-orientated service (Newburn, 2003, Whitehead and Statham, 2006). Concerns have been expressed that the balance between 'care' and 'control' could tip so far that traditional values would be lost (Whitehead and Statham, 2006). However, studies of the overall role of probation staff report that despite pressure to adopt an increasingly 'target-orientated' approach, staff remain motivated by 'people-centred' factors, and focused on providing welfare to offenders (Annison et al., 2008, Farrow, 2004, Willis, 1986).

There have recently been major changes to the criminal justice landscape. When the data for the research presented here were collected, probation consisted of Probation Trusts. Following *Transforming Rehabilitation* (Ministry of Justice, 2013) probation has been restructured into a public sector National Probation Service (NPS), and 21 Community Rehabilitation Companies (CRCs) consisting of private and voluntary sector organisations. The impact these changes on probation's role in offender mental health remains to be seen.

Several policy documents and reports outline a role for the probation service in offender mental health (Table 1).

[Table 1 here]

Firstly, this involves working in partnership with health and social care agencies. The precise role expected of individual agencies within such partnerships is somewhat unclear in the literature, but ultimately they aim to ensure that offenders' mental health needs are identified and inform healthcare commissioning, and offenders are supported to access to services.

Secondly, probation's role centres on providing information to the courts to inform sentencing and bail decisions, including diverting offenders away from custody when appropriate (Home Office, 1990, HMI Probation et al., 2009). Staff advise on the use of 'mental health treatment requirements' (MHTRs) for offenders with a mental illness that does not require treatment in a secure in-patient setting. To be able to consider mental health needs when advising the courts, probation staff need knowledge of the signs and symptoms of mental illness, and local healthcare provision, although increasingly support is provided by court liaison and diversion services.

Despite some lack of clarity in the literature on the nature of the relationship between mental illness and re-offending (Peay, 2011), identifying and addressing mental health needs has been cited as a pathway out of re-offending (Home Office, 2004, Social Exclusion Unit, 2002). Research suggests that new ways of working (e.g. specialty caseloads) may contribute to improving compliance with community orders and reducing re-offending (Heilbrun et al., 2012, Skeem and Eno Louden, 2006, Ministry of Justice, 2014). Thus there is increasing focus on addressing offenders' welfare needs as a means of reducing re-offending rather than simply as an end in itself.

In summary, the role expected of probation involves advising the courts on alternatives to prison such as the use of MHTRs; working in partnership to ensure that offenders' health and social care needs are met, and (potentially) contributing to improving compliance and reducing re-offending through focusing on mental health.

It is important to understand how this role translates into practice. However, to our knowledge, no research in the UK has directly focused on this area. This paper explores how staff and offenders in one Probation Trust perceived the role of probation in offender mental health prior to the recent reforms. It highlights barriers that need to be overcome to aid staff in performing their role, and considers the implications of these findings in relation to the latest reforms.

Methods

Qualitative secondary analysis was conducted with data from semi-structured interviews with 11 probation staff and nine offenders. Interviews were conducted by a Research Assistant previously employed by probation, a Clinical Studies Officer (CSO), and two service user representatives. For safety reasons, and to enable note-taking in case of recording failure, the Research Assistant and CSO worked as a pair and the service user representatives worked as a pair. A purposive sample of 24 offenders and 20 probation staff was selected based on 'appropriateness' and 'adequacy' (Morse and Field, 1996). Consequently it comprised offenders with a current mental illness and experience of accessing mental health services, and staff performing offender management roles.

Ethical approval was provided by the Local Research Ethics Committee in March 2009 (08/H0403/151). Participants received literacy-screened information sheets and consent forms and gave informed consent to the interviewer. They received a £10 store voucher for their time. Nine offenders were contactable and consented to participate. The remainder were either unreachable or they declined participation. After 11 staff were interviewed all of the offices across the county had been represented, and data saturation was reached. Participants were a mix of males and females, although (like the wider caseload) most offenders were male.

Secondary analysis is "the use of an existing data set to find answers to a research question that differs from the question asked in the original or primary study" (Hinds et al., 1997). This approach enables researchers to make maximum use of existing data rather than unnecessarily involving participants in further primary research. Several issues should be considered before conducting such analyses. Firstly, "the extent to which the research purpose of the secondary analysis can differ from that of the primary study" (Heaton, 2008, Hinds et al., 1997, Long-Sutehall et al., 2010), secondly, "the degree to which the data generated by individual qualitative methods are amenable to a secondary analysis" (Hinds et al., 1997, Long-Sutehall et al., 2010), and thirdly, how familiar the researchers are with the context of the primary study and the original recordings (Heaton, 1998, Hinds et al., 1997, Szabo and Strang, 1997).

The first question is important for considering whether re-use of data would violate the original ethical agreement (Heaton, 1998), and whether there are enough data of sufficient depth to answer the new research question. The primary study drawn upon here asked 'what are probation staff and offenders' experiences of trying to access (or facilitate access to) healthcare services' and 'what barriers need to be removed to facilitate engaging this client group with appropriate services'? Many of the interview questions were relevant to the secondary research (Table 2), which explored how staff and offenders in one Trust perceived probation's role in offender mental health, what (if any) barriers exist to staff performing their role, and how these could be overcome. Thus, we believed there were sufficient data in which participants described the role of probation in offender mental health and barriers that they encountered to justify the secondary analysis.

[Table 2 here]

The second question relates to the extent of missing data within the dataset. The purpose of the primary study was 'data gathering' rather than theory generation. Therefore, all participants answered the same questions, and there was no problem with missing data.

Regarding the third question, CS was part of the team conducting the primary study. She was familiar with interview context and had access to all of the digital recordings, allowing her to hear participants' tone of voice and emphasis.

Interviews were transcribed verbatim, imported into NVivo 8, and analysed using the constant comparative method (Glaser and Strauss, 1999) (Figure 1). Initially, text was coded into 'free nodes' based on the meaning of each segment, with care being taken to code sufficient text for each segment to retain meaning when read out of context (Coffey and Atkinson, 1996, Tesch, 1990). Each segment of text was considered in relation to text within existing codes. Through this iterative process the boundaries of each code were established, and sub-codes were created. As participants were drawn from a relatively small population, to preserve participants' anonymity individual identifiers are not displayed in the analysis. However, staff responses can be differentiated from offender responses, and the commentary indicates the proportion of participants expressing the views described. Several techniques supported the trustworthiness of the analysis (Lincoln and Guba, 1985) including an audit trail of decision-making, critical reflection, negative case analysis, triangulation of sources, and presenting excerpts from the transcripts.

[Figure 1 here]

Findings

This section presents the themes derived from the analysis and explores their relationships with each other. It details how participants described probation's role in offender mental health; and cross-cutting themes about factors affecting how this role is performed, barriers identified to staff performing their role, and strategies for overcoming them.

Participants' descriptions of probation's role in offender mental health

Both staff and offenders defined probation's role in offender mental health as involving a) identifying and monitoring mental illness amongst offenders, b) facilitating access to and monitoring offenders' engagement with health services, and c) managing risk. Staff placed a boundary on the first of these aspects, stating that whilst they may be expected to recognise potential signs and symptoms of mental illness amongst their caseload, they are *not* expected to diagnose or treat mental illness. This was reflected in one offender interview too.

Several cross-cutting themes were identified (Figure 2) around staff's ability to perform their role, and influencing how it was performed (see below).

[Figure 2 here]

Knowledge and understanding

Staff received very little formal mental health training. They relied on other sources of knowledge to identify and monitor mental illness amongst offenders. These included *a priori* knowledge from personal experience and/or previous work experience; learning 'on-the-job'; documents (e.g. psychiatric reports); and knowledge from social interactions with offenders, colleagues, and staff from other agencies. Consequently, staffs' approach to identifying and monitoring mental illness varied according to their prior experiences, work experience, and approaches to obtaining information from external sources. Whilst negative case analysis revealed that some staff felt that they had sufficient knowledge to perform this aspect of their role well, many desired more training, and many stated that they are not 'experts' in mental health. Staff particularly wanted to learn practical skills around working with people with mental illness:

> Staff: it's about…how to maybe engage someone with borderline personality disorder…somebody with schizophrenia and maybe to be aware of…signs or indications that it's deteriorating because I only know the basics

Care versus control

The broader tension between 'care' and 'control' in probation practice was also evident in probation's role in offender mental health. Focus on offenders' mental health needs was often viewed as voluntary, rather than a formal part of a community order (with the exception of cases with a MHTR). Some staff believed that there should always be a focus on mental health:

> Staff: Something that's a key factor is looking at what needs they have as an individual that could be met or supported through us…to get them the right support not only to address their offending but to meet their needs

For others, focusing on mental health was more of a priority if it appeared to be linked to offending behaviour (i.e. was a criminogenic need):

> Staff: If someone has got mental health issues it's also looking at if it's a priority. For me if it's linked to their offending…would be a key one

> Staff: Obviously we have some commitment to help them with their mental health, more so if their mental health issues are related to risk to themselves or other people

Whether or not mental health was viewed as a criminogenic need varied on a case-by-case basis:

> Staff: It depends on the individual you've got in front of you…it's an individual assessment. Mental health is not necessarily an automatic factor…but clearly you know there are…in some cases it's overwhelming it's a factor

Moreover, the relationship between mental health and offending was perceived as being mediated by substance misuse – people self-medicating for mental illness, or mental illness being believed to be caused by drug misuse:

> Interviewer: how close do you think the connection is between offending and mental health?
> Staff: In some cases I think they are very connected in others not so much…I've got one guy…his is linked very very closely with mental health issues…now whether that's caused by drug misuse or whatever else…

> Staff: It's an individual thing. I'm supervising somebody at the moment who I believe his mental health affected his offending…he was very low in mood, depressed etcetera and I

> believe because of that he was drinking to counteract the way he was feeling…so for him I don't believe he'd have committed the offence **if** his mental health had been average or good or whatever

Criminogenic and wider welfare needs were also viewed as interwoven, suggesting that staff should focus on them not only as an end in itself, but as a means of reducing risk and improving compliance:

> Staff: The priority for us has got to be risk…so if for example…not having accommodation increases their likelihood of alcohol misuse which then increases their risk then [we]…are more likely to concentrate on accommodation. However I personally don't think that you can support or change or…empower…without somebody being stable…you can use the punitive elements like curfews…but there has to be the welfarist considerations as well

> Staff: Putting forward some sort of package to sort of support all their needs and specifically as a probation officer criminogenic needs…However we do pick up…on…other areas that help people's stability that might not be criminogenic but…it helps them… in terms of compliance

Most offenders expressed their appreciation for staff adopting a caring, understanding and flexible approach, which included empathy, and discretion:

> Offender: They were actually better than the mental health service. Their support and their compassion, their empathy…a lot more adaptive…There were times when I couldn't get here because of a bout of anxiety…and she would come and visit me at my home and delay appointments, work my appointments around appointments with my psychiatric nurse

Indeed, a third of offenders described probation staff as providing a 'listening ear' or acting like a 'life coach':

> Offender: It's kind of like having a life coach more than anything else

> Offender: They were there as an information, as a support, not…somebody with a big stick who's going to beat you every time you step out of line

However, some participants felt that the amount of discretion staff have should be increased:

> Offender: I'm too worried about where I'm going to sleep tonight, where I'm going to wake up tomorrow, what I'm going to eat rather than you've got to have your probation. If you don't stick to your appointment you get breached and you're back in jail and…there's no give

> Staff: I'm having to breach this young man because he hasn't been in touch with me…and I'm really loath to do it…However I'm going to have to

The analysis indicated a relationship between two aspects of probation's role - facilitating access to and monitoring offenders' engagement with health services, and managing risk. The type of action that staff take to address offenders' mental health needs related to their assessment of risk, with more emphasis being placed on monitoring mental health and ensuring that offenders engage with external agencies in high risk cases:

> Staff: the level of monitoring differs with each case. I mean if I thought that someone was deteriorating quickly and you know was a risk to themselves then certainly I would definitely get another agency involved

Thus both staff and offenders discussed probation's role in offender mental health in relation to both 'care' and 'control'. Staff work flexibly to support those with mental health needs, but variation was apparent in the circumstances in which they would do this.

Individualised referral networks and processes

Staff discussed barriers to facilitating access to and monitoring offenders' contact with health services. Firstly, a lack of formal training, knowledge of mental health services and referral procedures, and service level agreements. Staff did not take a uniform approach to this aspect of their role. Instead, they had developed their own individualised referral networks and processes. Staff and offenders stated that a first step to link someone known or suspected to be mentally ill with appropriate services was a referral to a GP. One offender stressed that registering with a GP can be problematic, particularly for those that are homeless.

Starting with a GP could be seen as the 'best route' (particularly for those with a common mental illness), or result from a belief that staff were unable to refer directly to mental health services. For some this was an area of confusion:

> Staff: I don't think I mean I could be wrong, that I can make a referral to mental health
>
> Staff: I spoke to my manager about it and she wasn't sure whether we should be doing that directly without going through the GP

Other routes, included encouraging self-referral, direct referrals into mental health services, and referring via a Health Support Service within the Trust (a multi-agency team focused on providing health advice and brief interventions and improving offenders' access to mainstream health services). Offenders discussed these routes, with one participant believing that probation could act

as an advocate to reduce waiting times for service access. Conversely, one offender stated that probation could not refer directly to mental health services.

Just over a third of staff reported direct referrals to be rare. This may be due to the confusion outlined above, or a lack of knowledge of mental health services. Some staff attributed this to offenders having engaged with services prior to their community order:

> Staff: they're quite often in the system by the time they get to me anyway
>
> Interviewer: How often do you make referrals to mental health services?
> Staff: Very rarely…they are either already engaged with the service… or they've been referred by the time they come to me…and are waiting for an assessment

This was supported by data from a third of the offender interviews:

> Offender: …all the help was offered but I was already in the mental health system and I'd already been assigned a psychiatric nurse …so there wasn't really anything that they could do for me that I hadn't already had done

When staff did liaise directly with services, they had developed their own individual networks in terms of which services they worked with and how, which also varied according to their perception of offenders' needs, and the extent of an offender's prior engagement with services:

> Staff: I tend to work a lot with the Assertive Outreach Team in [place]…and I work quite a lot with them in [place] which is quite unusual I think
>
> Staff: I'm a fan of working with a bloke called [name] from [service]…he's the kind of specialist mental health homes type worker

Some staff suggested that it would be beneficial to create a more formal referral procedure or agreement with external agencies. Some participants also suggested creating a specialist worker role:

> Staff: It would be nice if we had somebody within the service…who we could just…sort of ring up and just bat something by really…I think it would give me more confidence in thinking I've done the right thing

The importance of a trusting relationship

Staff and offenders stated that the quality of the relationship between staff and offenders affected the likelihood of an offender being open and honest, and consequently of staff identifying that someone was unwell and/or needing support. Two offenders illustrated this in detail:

> Offender: it depends on the person…I didn't trust them so I see them as a hindrance more than a help…the one I've got at the moment's like the best one I've ever had in my life…we got to a situation where she helped and like I kind of opened up to her. Rather as before I could come and see the probation…they'd ask…[are you] alright and my life was ****ed,…and I'd still lie to her and say "yeah everything's great"

> Interviewer: but you feel that the probation service do recognise the mental health problems that are
> Offender: Yeah I do actually…If you're honest with them…because I have lied to them for years like, but it's come to a stage where you think well it's about time I started telling the truth really…they can't recognise it if you're not honest with them

Inter-agency communication

Another barrier to facilitating access to and monitoring offenders' engagement with health services was problems with inter-agency communication and agencies' understanding of each other's remits, even in cases with MHTRs. Indeed, MHTRs were described as hard to obtain. This was another area in which participants said a specialist role could help:

> Staff: GPs or some of the mental health providers not being aware of what probation do and the reasons for why we're calling…we don't really know their policies and procedures…that sort of stuff

> Staff: probation would benefit from having a specialist mental health worker...that would help with the communication aspect as well……they do it over at the Youth Offending Service and it works excellently…you're talking to somebody while you're making a cup of tea and it…just stops those barriers

Staff experienced difficulties in obtaining information from external agencies, and variation in what information individuals would share:

> Staff: I mean there's conflicting legislation we have the Crime and Disorder Act 1998, which sort of enforces that authorities must comply when it comes to offending or risk of harm yet then we have the Data Protection legislation which says "ooh don't share information"… sometimes you find yourself getting quite frustrated as when you're talking to …a Social Worker that's saying well "I can't share that information"

Gaps in service provision

Finally, participants pointed to a gap in service provision for those with dual diagnosis and/or a personality disorder:

> Staff: The mental health side is saying well we can't do anything with them while they're self-medicated, can't properly diagnose and obviously I have, perhaps have trouble getting them to sort out their alcohol and drugs because obviously their mental health isn't stable enough to keep up appointments so…it's like a chicken and egg situation

> Offender: OK you've got depression which is a mental illness, so they tend to put you on anti-depressants and discharge you within a matter of days…and as for anything else i.e. personality disorder, it costs too much money and too much time

Discussion

Summary of Findings

Policy outlines a role for probation in England and Wales in offender mental health involving advising the courts on sentencing and working in partnership with other agencies to ensure that offenders' health and social care needs are met. This role was broadly reflected in interview data from both staff and offenders. However, staff encounter several gaps, limitations and barriers to performing their role, and there is variation within and between staff in how they perform their role. Several factors may explain this variation. Whilst some staff stated that probation should always focus on offender mental health, in many cases the extent of this focus was determined by an offender's perceived level of risk, whether they were subject to a MHTR, and whether mental health was judged to be a criminogenic need. Some offenders praised staff's discretion and flexibility in relation to enforcing the conditions of their order because of difficulties with attendance resulting from poor mental health. However, both offenders and staff believed increasing staff's powers of discretion would be helpful.

Limited formal training and a lack of service-level agreements resulted in variation in staff's confidence in identifying mental illness, and the referral routes they used. Clarification was needed on whether direct referrals into mental health services could and should be made, or whether access should be via primary care.

The analysis also highlighted the importance of staff developing a trusting relationship with offenders to encourage an open and honest dialogue about their mental health. Finally, there were problems with inter-agency communication, obtaining MHTRs, and gaps in service provision.

Strengths and Limitations

To our knowledge, this is the first study to specifically investigate probation's role in offender mental health. The role was investigated from both offender (n=9) and staff (n=11) perspectives. The study was a secondary analysis of a small-scale study in one Probation Trust. There were practical constraints on the number of offender interviews that we were able to conduct, but we feel that the depth of data contained in the interviews was sufficient for this to be an adequate sample. Staff were interviewed from all probation offices within the Trust, but as participation was voluntary, they may have had an above average interest in mental health. Staff also acted as gatekeepers to the offender participants. Analysis was restricted to an existing dataset so it was not possible to generate new data based on emerging themes or to pursue emerging questions such as the potential influence of length of service on practice and/or perceptions, or the influence of offending history on offenders' perceptions (Szabo and Strang, 1997).

Numerous steps were taken to ensure the trustworthiness of the findings (Lincoln and Guba, 1985). Credibility was enhanced through the approach taken to sampling and the triangulation of data within and between staff and offender interviews. Moreover, the interviewers' backgrounds were varied, reducing the risk of bias resulting from the influence of a single interviewer. Using the constant comparative method improved credibility by encouraging constant questioning of coding, and negative case analysis was used throughout (Lincoln and Guba, 1985, Patton, 1990). Dependability and confirmability were enhanced by keeping an audit trail, and transparent presentation of data excerpts. Transferability is considered below.

We know from the limited literature available that the prevalence of mental health disorders amongst offenders on probation is high in many countries (Sirdifield, 2012), and that probation has a role supervising people with mental illness in many countries (van Kalmthout and Durnescu, 2008). Thus, our findings may broadly be of interest to practitioners in a variety of settings. However, the extent to which findings are transferable to another probation setting requires further research. Many of our themes are supported by the wider literature, and may resonate with contemporary probation practitioners in a range of settings in England and Wales. They highlight factors that support probation in performing a role in offender mental health (e.g. good offender-staff relationships), and raise issues, and potential solutions to these issues, that all providers could

consider. However, this is was a small-scale study in one Probation Trust, which investigated probation's role in offender mental health within a particular geographical area. There are potential differences between settings both within and between countries. Moreover, as stated earlier, probation in England and Wales has been subject to reforms since the study was conducted in 2009 (i.e. the policy landscape has considerably changed since the data were collected). Consequently, further research is needed to explore potential similarities and differences between settings.

Implications for Policy and Practice

Within our study setting it appears that improving training and developing service-level agreements would be beneficial. It may be inappropriate to expect probation staff to diagnose mental illness (Canton, 2008) or provide treatment themselves, but enhanced training would improve their ability to identify the signs and symptoms of mental illness. This is essential for advising the courts and facilitating access to external services. It is particularly important that new providers are aware of the role that staff are expected to perform in offender mental health and provide appropriate training following concerns that the restructure may result in deskilling of the workforce (Burke, 2013). This could be supported by the new Probation Institute.

Participants suggested creating a specialist role to address barriers related to inter-agency communication and improve knowledge and understanding of mental illness and local service provision. There is some evidence from the USA that specialist roles and programmes are effective in supporting compliance (Lurigio, 2001). It may be beneficial to pilot such roles in the UK.

Establishing service-level agreements between probation and health agencies would be beneficial in our study setting to ensure a more systematic approach to referring those known or suspected to have a mental illness to health services. If combined with cross-agency training or a specialist role, this would improve staff's knowledge of local mental health services and referral procedures. Probation's role has expanded following *Transforming Rehabilitation* to encompass supporting continuity of care for those serving custodial sentences of less than 12 months, and the restructure may be detrimental to existing local-level partnerships (Probation Chiefs Association and Probation Association, 2013, Burke, 2013). Existing problems with inter-agency communication may be further complicated by the NPS-CRC split. Moreover, recent research suggests that 20% of clinical commissioning groups believe that "healthcare funding for probation is the responsibility of NHS Area Teams" (Brooker et al., 2015). As Canton (2008) states, we should be clear about the

circumstances in which a referral to a mental health agency should be made, how and by whom. Canton recommended regular meetings between partners to create a clear understanding between agencies of their responsibilities and how they will exchange information (Canton, 2008). Such meetings need to include the NPS, CRCs and health agencies to prevent the existing difficulties with inter-agency communication worsening as a result of the reforms.

The quality of the relationship between probation staff and offenders is key. The importance of this relationship for reducing re-offending has been discussed previously (see for example Rex, 1999, Lewis, 2014). If the new probation providers are to perform their role in offender mental health well, staff must demonstrate 'professionalism' – "the ability to understand and build a knowledge of, and rapport with, the offender…to enable a meaningful exchange of information based on trust" (Fitzgibbon, 2007).

Staff found it difficult to obtain MHTRs and identified gaps in service provision for those with dual diagnosis and personality disorder. The under-use of MHTRs (Khanom et al., 2009, Scott and Moffatt, 2012), and earlier initiatives like psychiatric probation orders (Grünhut, 1963, Lewis, 1980, Reed, 1992, H. M. Inspectorate of Probation, 1993) has been repeatedly lamented in the literature, and as yet it is unclear what impact the introduction of new providers will have on this.

Considering the transferability of our findings across England and Wales, training has been repeatedly raised as an issue nationally (see for example Reed, 1992, H.M Inspectorate of Probation (1993) and Bradley (2009)), suggesting this finding may be transferable. However, further research is needed to fully explore the extent of the transferability due to changes in the policy landscape since this study was conducted, and potential differences between probation areas. An operating model has now been developed to ensure consistent provision of liaison and diversion services across England. There have also been developments around working with offenders with personality disorder (e.g. development of Psychologically Informed Physical Environments in prisons), which include probation staff receiving Knowledge and Understanding Framework (KUF) training (Durcan et al., 2014). However, Durcan et al., (2014) also highlight training as an area in need of further work.

Probation-health partnerships exist in some areas (such as the Health Support Service the setting for this research). Space does not permit a full review of these, but examples include Health Trainers/Champions in probation settings (see for example Brooker and Sirdifield, 2007, Institute for Criminal Policy Research, 2011a, Institute for Criminal Policy Research, 2011b, Dooris et al., 2013), probation psychiatric services/clinics (Collins et al., 1993, Huckle et al., 1996, see for example Cohen et al., 1999) and projects such as the Forensic Mental Health Practitioner Service (Senior and

Kinsella, 2014). Here, probation staff are co-located with staff with more expertise in mental illness, working in partnership with them. Such partnerships (some of which may have formal service-level agreements) and training may directly or indirectly raise probation staff's level of mental health awareness.

Conclusion

Staff and offenders in the Trust participating in this research perceived the role of the probation service in offender mental health as: identifying and monitoring mental illness amongst offenders; facilitating access to and monitoring offenders' engagement with health services; and managing risk. Several barriers to performing this role were identified.

Further research is required to explore the transferability of findings as the purpose and structure of probation varies around the world, and within England and Wales services have been restructured and improvements have occurred in some areas following the Bradley Report. However, many of the findings are supported by the wider literature, and the question posed may be of interest to an international audience.

To ensure that staff can perform their role in offender mental health well current probation providers may benefit from focusing on formalising partnership arrangements to ensure the sustainability of local partnerships and achieve a more systematic approach to identifying, managing and supporting offenders with mental illness; ensuring provision of adequate training; and trialling a specialist role.

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Table 1 Overview of Literature on Probation's Role in Offender Mental Health

Document	Statements about probation's role in offender mental health
Home Office Circular 66/90 (Home Office, 1990)	• Stated that "the probation service should act as part of a network of agencies…providing accommodation, care and treatment in the community for mentally disordered offenders" (Home Office, 1990: 78)
Reed Review (Reed, 1992)	• Stressed the need for a multi-agency approach to identifying and meeting the needs of offenders with mental illness • Stated that probation officers should work as part of a multi-professional care team to support offenders with mental illness
Mentally Disordered Offenders Inter-Agency Working (Home Office and Department of Health, 1995)	• Stated that probation has a role in "fostering the development of close co-operation at a local level between the criminal justice system and health and social services" (Home Office and Department of Health, 1995: 18)
Bradley Report (Bradley, 2009)	• Added impetus to the agenda around considering offenders' mental health needs, in particular diverting people into care when appropriate • Stressed that real improvement in provision of care for offenders with mental illness can only be achieved through partnership working • Recommended mental health and learning disability training for probation staff • Emphasised the value of support from court liaison and diversion services that can provide probation staff with information about a defendant's mental health
Improving Health, Supporting Justice	• Published in response to the Bradley Report and discusses the role of probation in contributing to Joint Strategic Needs

(H.M. Government, 2009)	Assessments, identifying the needs of those in contact with the criminal justice system to inform healthcare commissioning
Transforming Rehabilitation (Ministry of Justice, 2013)	• Restructured the probation service, making assistance to the courts an NPS role

Table 2 Interview Questions Relevant to the Qualitative Secondary Analysis

Questions for Staff	Questions for Offenders
How would you describe the purpose of probation?	How would you describe the purpose of probation?
To what extent do you feel that it is your role to monitor offenders' mental health?	To what extent do you feel that mental health problems are recognised by the probation service?
When an offender presents with multiple needs, how do you decide which ones to work on with them?	Would you say that you had several needs whilst you were on probation? If so, how did you decide which ones probation could help you with?
To what extent do you think offending behaviour is linked to mental health problems?	To what extent do you think your offending is linked to your mental health?
To what extent do you feel that it is your role to refer offenders to appropriate mental health services?	To what extent has the probation service helped you to access health services?

Figure 1 Analysis Process

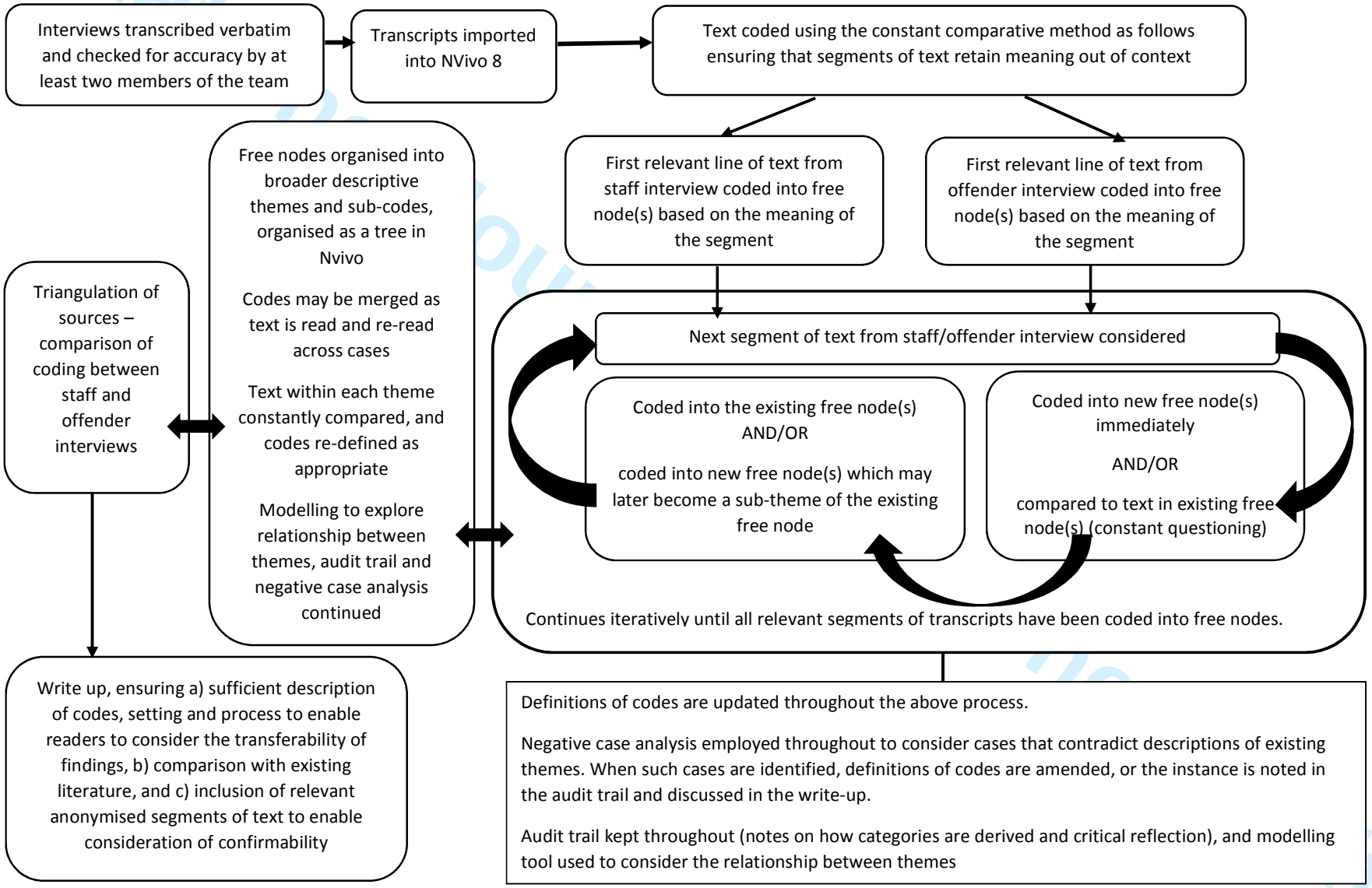

Figure 2: Model of Cross-Cutting Themes