

# Improving Collaborative Practice to Address Offender Mental Health: Criminal Justice and Mental Health Service Professionals' Attitudes Toward Interagency Training, Current Training Needs, and Constraints

**Sarah Hean, PhD, MSc, BSc; Sue Staddon, BSc, MSc, CQSW;  
LeeAnn Fenge, DProf, MSc, BA, CQSW; Andy Clapper MA (Oxon);  
Vanessa Heaslip, MA, BSc, DN, RN; Eleanor Jack, BA, RGN, RMN**

## Abstract

*Background:* Professionals from the mental health and criminal justice systems must collaborate effectively to address offender mental health, but interprofessional training is lacking. Pedagogical frameworks are required to support the development of training in this new area. To inform this framework, this article explores the readiness of professionals toward interprofessional training and demographic differences in these. It explores expectations of interprofessional training, perceived obstacles to collaborative working, interprofessional training needs, and challenges facing delivery.

*Methods and Findings:* A concurrent mixed methods approach collected data from professionals attending a crossing boundaries interprofessional workshop. Data were collected through a combination of the Readiness for Interprofessional Learning Scale (RIPLS) questionnaire ( $N = 52$ ), free text questions ( $N = 52$ ), and focus groups ( $N = 6$ ). Mental health and criminal justice professionals' attitudes toward interprofessional learning were positive ( $M = 17.81$ ;  $N = 43$ ). They did not see their own service as insular ( $M = 4.02$ ;  $N = 44$ ) and reported strong person-centredness ( $M = 6.07$ ;  $N = 43$ ). These findings suggest professionals are open to the introduction and implementation of future interprofessional training. There were no significant demographic differences in these attitudes.

*Conclusions:* Professionals raised a range of generic curriculum and educator mechanisms in the development of future interprofessional training, suggesting the transfer of pedagogical frameworks from established interprofessional programs into this new arena is feasible. Context-specific factors, such as offender national policy agendas and the challenges of user involvement for mentally ill offenders, must be taken into account. Greater clarity on multi- versus interprofessional training is still required with this group of professionals.

*Keywords:* Mental health; Offenders; Criminal justice; Interprofessional training

## Introduction

Joint training in the form of interprofessional education is a common component of healthcare training. However, it is absent from professional development within the criminal justice and offender mental health systems. Offender mental ill health is a major societal challenge with between 7 and 9 out of every 10 prisoners demonstrating signs of at least one mental disorder [1]. This is far higher than the general population average and represents an area of severe health inequality. A meta-analysis of

62 surveys of 23,000 prisoners in 12 Western countries, for example, showed the prevalence of psychosis to be around 4%, compared to 1% in the general population; major depression 10–12%, compared to 2–7% in the general population; and personality disorder 42–65%, compared to 5–10% in the general population [1,2]. Offender mental and physical health is compromised if their mental health is not addressed. This impacts wellbeing, their ability to adjust to community life on release, and the likelihood of social inclusion and reoffending. The latter places an economic strain on the public purse and prison/mental health hospital places. Offender mental ill health has knock-on effects on the family, fellow prisoners, frontline police/court/prison staff, and public safety [3]. Professionals within the criminal justice system (CJS) need an awareness of mental health conditions, treatments, and services to refer to if offender mental health arises or impacts sentencing options. Similarly, mental health services (MHS) workers need to support patients if they offend and find themselves negotiating the criminal justice system.

At a national level, lack of collaborative working between MHS and the CJS is acknowledged by the UK's Bradley report, a countrywide review of offender mental health [4]. Here, mentally ill offenders are reported to fall into the grey area between MHS and the CJS. Liaison and diversion schemes are proposed as one solution to this issue. These represent socially innovative service reorganizations being rolled out across England and Wales, designed to physically locate MHS workers within courts to screen and assess offenders and to advise CJS professionals on mental health issues. If appropriate, offenders are diverted from courts and legal systems into healthcare (e.g., medium-security units). In other cases, offenders receive a custodial sentence (or community service order), but a mental health treatment plan is negotiated. The need for MHS and CJS professionals to work collaboratively has increased in profile because of these new schemes, with the Bradley report [4] recognizing a requirement, but current deficit, in joint training for these professionals. The form this joint training should take is currently unexplored. It is the aim of this article to address this shortfall.

It is proposed elsewhere that joint training include interprofessional training, preparing MHS and CJS professionals for collaboration, bringing them together to learn with, from, and about each other [5-9]. Interprofessional collaborative competencies are required by professionals from both the legal and mental health realms if they are to collaborate with each other effectively to deliver the liaison and diversion agenda, and if the needs of mentally ill offenders are to be met. A pedagogical framework to underpin collaborative practice training between the MHS and CJS must be developed.

Before this development can take place, however, the likelihood of engagement in interprofessional training must first be explored. This article therefore first explores the readiness of MHS and CJS professionals for any future interprofessional training developed. Financial constraints in the public sector mean training resources are limited, so there is a necessity that joint training be targeted in the first instance at only certain priority groups. Demographic differences in attitudes to interprofessional training (by gender, profession, sector, managerial role, or geographical location) were therefore explored to determine if prioritization could be drawn along these demographic lines.

The recent Lancet Commission report on health professional education for the 21<sup>st</sup> century [10] describes the interdependence of the health system (and other practice systems such as the CJS) and the education system. The education system needs to respond to the rapidly changing demand of practice systems by producing sufficient quantity and quality of professionals to service the needs of the population. In the offender mental health context, educators need to determine what professionals themselves view as the contemporary skills required if they are to be collaboratively ready [11] to work together and with offenders to address their mental health.

This article therefore reports the outcomes of a workshop bringing MHS and CJS professionals together with educators, a nexus between education and practice [12], to share their expectations of interagency training, the perceived obstacles to collaborative working between professionals, their perceptions of their own joint training needs if they are to effectively respond to liaison/diversion agendas, and the challenges that face the delivery of this type of training. Addressing these aims will help educators and policy makers determine the feasibility of developing and implementing interagency training for MHS and CJS professionals and the relevance of this training to professionals as part of their continuous professional development.

## Method

### Workshop

Data collection occurred during an interprofessional workshop offered to MHS and CJS services working in the area of offender mental health. In keeping with the *Lancet's* [10] call for a systems-level approach to training, the workshop drew on Engeström's activity system triangles to articulate theoretically the components of the MHS and CJS systems, respectively, and explore where contradictions in the two systems lay, especially when they overlap as they do when offender mental health is an issue [13]. We used Engeström's crossing boundary workshop method [13] in which a real life case study or authentic form of practice was used as a mirror to participants' experiences of interprofessional working between MHS and the CJS. This stimulated a discussion in which contradictions are identified and joint solutions co-created (more on this theoretical approach to the workshop design is reported elsewhere [14]).

### The sample

The workshop targeted professionals in MHS and CJS services working in two counties in South England (County H and County D) and with an interest in the liaison and diversion agenda (Table 1). One of the authors, a regional lead in offender mental health (SS), recruited professionals ( $N = 52$ ) (Table 1) from her contacts in the region. Previous work in the area [15] demonstrated the wide range of services surrounding mentally ill offenders but showed that mapping the range of services and connections between these has yet to be accomplished. Identifying the full population of services and professionals from whom to recruit for the workshop was therefore challenging, and meant we had to rely on a convenience sample based on the practice contacts of SS. The sample is acknowledged to be limited to those services in the network of a single, albeit experienced, regional mental health offender lead

and potentially meant participants were already biased toward interprofessional training. This experience calls for future scoping exercises that identify accurately the range of interested services in the first instance and those professionals that would benefit from collaborative practice training in the second.

### Research design

A pragmatic methodological approach was taken in this investigation using a concurrent mixed-methods design, all triangulating data being collected on the same day of the workshop. A generic exploratory approach was taken for the qualitative stage of our research, as our research questions did not lend themselves to specific phenomenological, grounded theory, or ethnographic approaches.

### *Expectations of interagency training and obstacles to interagency working*

Participants were asked at registration to write on adhesive sheets two expectations they had of the workshop and two obstacles they had experienced when working with other agencies. Participants placed these on flip charts displayed to all participants. The latter was a source of superficial qualitative data, as well as a warm-up for later workshop discussion on the contradictions within mental health services and criminal justice system activity systems. Each expectation/obstacle noted by the participants was treated as a unit of analysis, and a thematic analysis of all notes was conducted as outlined below.

### *Readiness for interprofessional interagency learning*

Attitudes toward interprofessional learning were measured through a questionnaire administered to all workshop participants before the event ( $N = 52$ ). The instrument was adapted for the mental health/criminal justice context from the Readiness for Interprofessional Learning Scale (RIPLS) questionnaire developed for qualified health professionals by Reid et al. [16]. The latter has three subscales that measure (Table 2):

- attitudes toward shared learning to develop collaborative and team working skills,
- perceived uniqueness of their own profession/insularity, and
- person centredness.

The validation of the RIPLS instrument for the MHS and CJS context can be viewed elsewhere [14]. Likert scales ranging from strongly agree (score 2) to strongly disagree (score -2) were used. Demographic data were collected on participant age, home organization, managerial role, gender, and county of origin. An overall score was calculated for each scale through an unweighted sum of component items. The mean for each overall scale score (Table 2) and the median and mode of each individual item in the scale were utilized (Table 3) as a measure of central tendency for each frequency distribution.

Responses to each item were cross-tabulated against the independent variables of gender (male/female), age (<40/40 and above), location (County H/County D), man-

agerial role (yes/no), and organizational type (MHS/CJS). As cells, after cross tabulations, often did not contain sufficient numbers to meet test criteria, cells were collapsed to produce two-by-two contingency tables, and a Fisher's exact probability test was used to assess the significance of relationships between the responses to each item and the above variables.

### *Professionals' perceptions of training needs and constraints facing delivery of training*

The questionnaire and flip chart exercises were followed by uni- and then interagency group discussion (this discussion was unrecorded) of interagency collaborative practice. Focus groups followed, by which stage participants had warmed sufficiently to exchange freely on focus group topics. Although it is recognized that this order of activity could have biased the direction of the focus groups, the level of discussion generated outweighed this fear of bias.

Participants were divided into six focus groups (9–12 participants each), divided between MHS and CJS professionals to form a heterogeneous professional mix in all groups. Each group was facilitated by a single co-ordinator from university staff who followed a common interview schedule to promote dependability of data collection between groups. Participants were asked during these focus groups to reflect on two main themes:

- how to prepare the MHS/CJS workforce to collaborate effectively in the interest of the mental health of the offender population, and
- the constraints they worked under that would impact the feasibility of delivering interprofessional training for these professionals.

Recordings were transcribed and thematic analysis conducted. Three members of the research team engaged in the analysis. A process of familiarization took place for each researcher via data immersion through reading and re-reading the transcripts. Key concepts or codes were identified and grouped into categories. Constant comparison and contrast of each with the other was conducted until separate themes arose for the data [17]. To promote the dependability of the analysis, the research team met to agree on the codes, categories, and emerging themes.

Prior to the workshop, participants received an information sheet outlining workshop aims, the data collection process, dissemination plans, and data confidentiality. Written consent was obtained for all data recording and dissemination of findings.

## **Results**

### **Readiness of professionals in the mental health and criminal justice systems for interagency training: Findings from questionnaire**

The questionnaire response rate was 84.6% ( $N = 52$ ). The 15.6% non-responders may have been those with the least favourable attitudes toward interagency training, but it is hoped their views were captured more effectively in the focus groups that followed. The sample distribution by professional mix, sector of employer, managerial role, county of origin, age, and gender is displayed in Table 1.

*Table 1:*  
**Demographic description of sample (n = 44)**

Professional mix	<i>MHS services</i>	<i>CJS services</i>	<i>Non response</i>
	Court Staff, Police, Probation, Crown Prosecution Services, Judiciary, Magistrate services	Substance Misuse Services, Community Mental Health Teams; Crisis and Home Treatment Teams; Liaison and diversion schemes; Forensic Medical Examiners and Police Custody Nurses; Assertive outreach teams, Learning Disability Services, Appropriate adult services	
	52.3%	45.5%	2.2%
Sector	<i>Public sector</i>	<i>Not public sector</i>	
	88.6%	11.4%	0.0%
Managerial role	<i>Managerial</i>	<i>Non managerial</i>	
	40.9%	45.5%	13.6%
County of origin	<i>County H</i>	<i>County D</i>	
	45.5%	29.5%	25.0%
Age	<i>18-40 years</i>	<i>41-60 years</i>	
	72.8%	27.2%	0%
Gender	<i>Female</i>	<i>Male</i>	
	68.2%	31.8%	0%

Participants' attitudes toward shared learning with other agencies (Table 2) were very positive, as reflected in the overall scale score ( $M = 17.81, N = 43$ ). Most participants strongly agreed that mentally ill offenders would ultimately benefit if professionals from different services worked together to solve offenders' problems (75%), that learning together with professionals from other services would improve relationships in practice (61.45%) and that shared learning with professionals from other services would increase their ability to understand mentally ill offenders' problems (56.8%) (Table 3). Respondents did not see their service as being insular entities, nor did they see value in *not* learning with other professionals ( $M = -4.02, N = 44$ ) (Table 2). They majority strongly disagreed that problem solving skills should only be learned with professionals from their own service (59.1%) and disagreed that there was little overlap between professional roles or that they would feel uncomfortable if a professional from another service knew more about a topic than they did (59.1% and 47.7% disagreed, respectively) (Table 3).

Participants reported strong person centredness ( $M = 6.07, N = 43$ ) (Table 2). Most of them strongly agreed that thinking about the mentally ill offender as a person is important in getting treatment/disposal correct (61.4%) and that skills in interacting and co-operating with offenders were required (45.5%). The majority agreed with the importance of understanding the mentally ill offenders' side of the problem (59.1%) (Table 3).

Table 2:

**The three underlying scales of the Readiness for Interprofessional Learning Survey**

<p>Attitudes towards shared learning to develop collaborative</p> <p>Participants' openness to working and learning together and influence this has on enhanced team working and patient/client care.</p> <p>Cronbach <math>\alpha = 0.88</math></p>	<ol style="list-style-type: none"> <li>1. Learning with professionals from other services will help me become a more effective member of a team</li> <li>2. Mentally ill offenders will ultimately benefit if professionals from different services work together to solve offenders' problems</li> <li>3. Shared learning with professionals from other services will increase my ability to understand mentally ill offenders' problems</li> <li>4. Learning together with professionals from other services will improve relationships in practice</li> <li>5. Learning communication skills is best achieved alongside professionals from other services</li> <li>6. Shared learning will help me think positively about professionals in other services</li> <li>7. For group learning to work, participants must trust and respect each other</li> <li>8. Team working skills are essential for professionals from all services to learn</li> <li>9. Shared learning will help me to understand my own limitations</li> <li>13. Shared learning with professionals from other services will help me to communicate better with offenders with mental health issues</li> <li>14. I would welcome the opportunity to work on small group projects with professional from other services</li> <li>15. Shared learning would help to clarify the nature of the offender's mental health problems</li> <li>16. Shared learning during their training would help professionals become better team workers</li> <li>30. Shared learning with professionals from other services will help me to communicate better with other professionals</li> </ol>	<p>Mean: 17.81; <math>n = 43</math> (Possible range 28/-28)</p>
<p>Perceived uniqueness of their own profession/insularity.</p> <p>Participants' perceptions of uniqueness of their own profession. Some of these items have been described as illustrating a form of negative professional identity. These to a degree measure a professionals' lack of readiness for learning with professionals from other agencies.</p> <p>Cronbach <math>\alpha = 0.69</math></p>	<ol style="list-style-type: none"> <li>12. Problem solving skills should only be learned with professionals from my own service</li> <li>17. The function of mental health professionals working with mentally ill offenders is to provide support for those professionals working in the criminal justice system</li> <li>19. My profession has to acquire much more knowledge and skills than professionals in other services</li> <li>20. There is little overlap between my professional role and that of professionals in other services</li> <li>21. I would feel uncomfortable if a professional from another service knew more about a topic than I did.</li> </ol>	<p>Mean: -4.03; <math>n = 44</math>; Possible range 10/-10</p>
<p><i>Person centredness</i></p> <p>Professional's focus on patient/client and desire to empathise, understand or build relationships with them.</p> <p>Cronbach <math>\alpha = 0.86</math></p>	<ol style="list-style-type: none"> <li>25. I like to understand the mentally ill offender's side of the problem</li> <li>26. Establishing trust with the offender is important to me</li> <li>27. I try to communicate with compassion to the mentally ill offender</li> <li>28. Thinking about the mentally ill offender as a person is important in getting treatment/disposal right</li> <li>29. In my profession, one needs skills in interacting and cooperating with offenders with mental health issues</li> </ol>	<p>Mean: 6.07; <math>n = 43</math>; Possible range 10/-10</p>

There were no significant differences between participants by gender, organization, county, age, sector, or managerial position held by the participant on any of the three overall scale scores.

*Table 3*  
**Median and mode score have most highly rated items in each RIPLS subscale**

Item no.	Item	Median	Mode	Percentage of respondents in modal category
<b>Attitudes towards shared learning to develop collaborative and team working skills</b>				
2.	Mentally ill offenders will ultimately benefit if professionals from different services work together to solve offenders' problems	Strongly agree	Strongly agree	75.0
4.	Learning together with professionals from other services will improve relationships in practice	Strongly agree	Strongly agree	61.4
3.	Shared learning with professionals from other services will increase my ability to understand mentally ill offenders' problems	Strongly agree	Strongly agree	56.8
<b>Perceived uniqueness of their own profession/insularity</b>				
12.	Problem solving skills should only be learned with professionals from my own service	Strongly disagree	Strongly disagree	59.1
	There is little overlap between my professional role and that of professionals in other services	Disagree	Disagree	59.1
	I would feel uncomfortable if a professional from another service knew more about a topic than I did	Disagree	Disagree	47.7
	<b>Person centredness</b>			
	Thinking about the mentally ill offender as a person is important in getting treatment/disposal right	Strongly agree	Strongly agree	61.4
	In my profession, one needs skills in interacting and cooperating with offenders with mental health issues	Strongly agree	Strongly agree	45.5
	I like to understand the mentally ill offender's side of the problem	Agree	Agree	59.1

**Expectations of interagency training and obstacles to interagency working**

Of the 52 participants attending, 75 expectations of the workshop were recorded on the expectations flip chart. Analysis of these sheets lead to a range of key themes summarized in Table 4.

All 52 workshop participants took part in the focus groups. Three main themes arose from the analysis: the content of any potential interagency training, the delivery method, and, lastly, the constraints impacting delivery of interagency training.



Table 4

**Professionals’ perceptions of training needs and constraints facing delivery of training**

Expectations of an interagency workshop	Perceived obstacles to interagency working
<p>An opportunity to:</p> <ul style="list-style-type: none"> <li>• Network and build relationships</li> <li>• Increase knowledge that included:                             <ul style="list-style-type: none"> <li>an enhanced understanding of the perspectives of another agency</li> <li>the role/ processes etc. of other agencies</li> </ul> </li> <li>• Learning how to deal with a mentally ill offender more effectively</li> <li>• Improve practice through Improving interagency working</li> <li>• Share good practice.</li> </ul>	<ul style="list-style-type: none"> <li>• Problems with communication between MHS and CJS systems;</li> <li>• Lack of understanding of each others’ roles;</li> <li>• Problems with sharing information/confidentiality;</li> <li>• Getting hold of the right person / service;</li> <li>• Different targets / timings/ delays in response;</li> <li>• Different priorities and values within the MHS and CJS– care vs. control;</li> <li>• Difference of opinion about who is responsible (accountability);</li> <li>• Negative attitudes from other agencies</li> </ul>

*Content of training*

Participants discussed the knowledge/skills professionals required to respond to the liaison and diversion agenda. Many—both criminal justice and mental health—reported not being aware of the rationale for liaison and diversion services or what they could expect when these services were implemented. They identified a need for awareness training on this specific agenda. There was a need expressed also for more general training around how MHS and CJS systems worked as a whole and how these fit together. They called for a mapping of relevant services with which offenders would make contact in their journey through MHS and CJS pathways. There was acknowledgement that different agencies had little understanding of each other’s roles, targets, policy drivers, statutory requirements, legal responsibilities, and other constraints, nor how all of these impacted decision making. Knowledge of the latter was seen as necessary to improve interagency working through developing realistic expectations of other services and ultimately effectively addressing offender mental health. There was a need to understand the culture of the other agency.

I would like to see officers at a training level equipped with a greater understanding of mental health problems and disorders. They are not experts. That’s not their job. They’re police officers, and I get that bit, but if they knew a little bit more, and vice versa, if we knew a little more about how the criminal justice system works and your expectations of us, I think the relationship would improve no end really. (Focus group 6)

I think what was said this morning about magistrates have got their targets, police have got their targets ... with funding being cut and cut you are more and more expected to deliver to your targets. (Focus group 3)

Interagency training was seen as a means of enhancing communication skills and communication channels between MHS and CJS professionals, those between senior managers being particularly important.

If you make a referral, whether that's someone making a referral to the mental health team or any other service, a good rationale and a good description [is needed] ... of why you're doing something and why you're not doing something. Otherwise a simple "no, not our bag" is just so unhelpful. (Focus group 1)

There was an expressed need for interprofessional training to include content that would effect positive attitudinal changes within participants, changing their potential prejudice against offenders, the mentally ill, or other professional groups.

### *Modes of training delivery*

Unsurprisingly, given the importance of interagency working to the liaison and diversion agenda, the attendance of the workshop in the first place, and the findings of the RIPLS questionnaire, there was a strong endorsement of interprofessional training by participants. The crossing boundary workshop was regarded as a model of good practice and the absence of such events ordinarily was noted as a shortfall.

I don't think [there is] ... any substitute for we've done here. I've met professionals that I didn't even know existed! You get a totally different perspective and you get to appreciate and understand where they're coming from, some of the difficulties they have in doing their job ... there has to be more networking like this. (Focus group 5)

One participant cited the value of bringing people together from across a wide geographical area to compare different and good practice. Others spoke of the advantages of holding interagency training events on a smaller regional basis that could use local case studies to reflect and build local empathic working relationships. Case studies, especially real-life scenarios, were viewed as useful interagency learning opportunities, preferably conducted in small groups to facilitate learning. The involvement of service users in-person in training events was recommended as an authentic way of offering insight into offender experiences of interprofessional relationships. The offending and vulnerable nature of these users was raised as a potential challenge to this.

Authenticity also related to *who* delivered training as well as *what* was being delivered, with one participant suggesting that practicing professionals, in touch with practice realities, are better placed than academics to deliver training. Others feared that practitioners did not have the training skills, and suggested training be delivered in partnerships between educational institutions and practice.

Technology-supported learning was discussed as an alternative to course-based training, although limitations were identified, which included this medium not being taken seriously by some learners or the development of good interpersonal working relationships not being suited for this kind of interaction.

Well, some things might not be best suited to online package. ... Certainly the touchy feely stuff ... maybe that's not best learnt online. ... Maybe that's best learnt interacting with other people. (Focus group 4)

Others felt that technology could effectively enable networking and the sharing of information (through Twitter and Facebook, for example).

Although the main discussion was of training by attending events or online, some participants extolled the benefits of experiential learning through shadowing, placements, or interagency visits. The resource constraints that impede this were acknowledged.

What's a custody cell like? What's it like to appear in a magistrate's court? What's prison like? You don't really know. You've sort of got this second-hand account of things, but just having a visit or some sort of insight into that would help you understand better what that individual's gone through and what the processes are. (Focus group 3)

It was suggested interagency training be made a compulsory part of continued professional development and that performance review include workers' abilities/competencies to work effectively with other agencies.

Because there's usually some kind of a performance issue. You are required to do this training. In order for you to do this job we expect you to do this training and this will be monitored by your supervision. Do you have these skills? (Focus group 1)

Participants suggested that interagency training happen in two stages:

- a uni-agency foundation course run within each organization (e.g., mental health awareness for the police);
- an interagency phase where different agencies are brought together in interagency training to learn from and about each other. Inclusion of interprofessional training into both the undergraduate health and social care professionals and the basic training for the police and other CJS professions was recognized.

### *Constraints*

The two principal and interrelated constraints were budgetary pressure and staff release.

Everybody's becoming busier because of cuts. ... case loads getting bigger ... and I wonder whether there is going to be enough time to be able to facilitate what is in effect extra work, isn't it? (Focus Group 2)

But there's got to be funding specifically for it, and I think you're right, there is no money for training from our organization's point of view. It's mandatory training only. Anything else is a very nice to

have but not on our list, and I'm sure other organizations are in exactly the same situation. I think in the current economic climate if there isn't something in it for the agency they're not going to do it. (Focus group 4)

Technology-supported learning (see above) was seen as one way to overcome time release constraints, while the topic of economic constraints lead to discussion as to whether all professionals needed interagency training to the same level. Cascading training through a train-the-trainer approach was one solution offered, as was the use of existing training events/sessions. Participants recommend using the existing skills and knowledge of professionals within the agencies themselves rather than commissioning externally. They considered piggybacking interprofessional training onto existing training events and suggested that each agency open up existing events for other agencies to attend. This use of existing staff in agencies and providing reciprocal training was aimed at keeping costs down.

### Discussion

This study contributes to the future development of a pedagogical framework to underpin collaborative practice training between MHS and CJS professionals, an area in which interprofessional education is currently unexplored despite the need for close collaboration and integration of services surrounding offenders with poor mental health. The workshop, run by a higher-education institution, identified contemporary collaborative practice training needs of MHS and CJS professionals and the role of the university in responding to these needs. This responds to the Lancet Commission Report's [10] call for greater interdependence between education and practice systems, bridging the gap between these systems by exploring the views of interagency training held by professionals working with mentally ill offenders.

The WHO Framework for Action [11] recommends exploring interprofessional training within either local geographical or clinical contexts to determine factors that are generic, relevant for all interprofessional training, and what may be context specific. MHS and CJS professionals raise a number of generic and context-specific mechanisms as important in future interprofessional training in this new, unexplored field. Mechanisms are those factors that impact how interprofessional training is introduced and implemented [11]. These generic or context-specific mechanisms are subdivided into a range of subcategories including those factors related to the staff and institutions delivering the training (educator mechanisms) and the curriculum itself (curricula mechanisms) [11]. Generic curriculum mechanisms raised by participants included

- scheduling (when to apply training) and mandatory status of training. The inclusion of interprofessional training as a mandatory and competency-based part of professional education is well rehearsed in the wider healthcare arena [10,18]. So too is when to introduce interprofessional training: early on to prevent the development of

interagency stereotypes [19], or later on when professionals understand their own professional identity, roles, and responsibility and are better able to share these with other professionals [20]. MHS and CJS professionals could see the advantages of both options.

- program content. This included the need for communication skills and knowledge of the roles and responsibilities of other professionals/services. These are two key competencies outlined in existing interprofessional competency frameworks in the wider IPE literature [21,22]. MHS and CJS professionals, in line with the Lancet report [10], call for a systems approach to education in collaborative practice: They required an understanding of how individual dimensions of MHS and CJS systems fit together and overlap with each other as a whole. This sentiment is not unique to MHS and the CJS. The need for an increasing knowledge of the other agencies and interagency training has been at the forefront of many other service interfaces, including those linked to child safeguarding agendas, for several decades, although the impact of interagency training on practice change and patient/client wellbeing is notoriously difficult to establish [23]. The call of MHS and CJS professionals for a systems-wide approach to training (as well as one that promotes learning at an interprofessional level) is in line with similar calls in healthcare education more generally [10]. Systems-levels theories, such as activity systems theory [13], are useful frameworks to include in interagency training to offer this macro-level view of interagency training, in addition to frameworks, such as the contact hypothesis, that focus on interpersonal psychosocial relationships at a micro level.
- the use of adult learning techniques (such as small group and experiential learning experiences) and alternative learning methods (e.g., technology-supported learning).

Generic educator mechanisms were also raised by MHS and CJS professionals. They valued an authentic learning experience, both in terms of what is delivered (a curriculum mechanism) but also in terms of who does the delivery (an educator mechanism). Participants indicated they would value training delivered by fellow practitioners, those “at the coal face.” Higher education institutions still had a facilitative and co-ordinating role, bringing their theoretical understanding of collaborative practice and training to the table. Educators and professionals within the MHS and CJS need to work closely in partnership to co-ordinate training. Institutional support was alluded to in professionals referring to the importance of commissioner and manager attendance at these interagency events. Other key educator mechanisms [11] included a shared enthusiasm for interprofessional training in those that deliver and commission training. The RIPLS survey as well as the focus group data indicate that such enthusiasm is high in this albeit small and self-selecting sample of MHS and CJS professionals. Future research is required to access the broader spec-

trum of MHS and CJS professionals, following a scoping exercise of those professionals and services that feature most greatly in the mentally ill offenders' journey. There is then a need to recruit senior managers and training commissioners to events as described in this article, breeding enthusiasm in these quarters. A practice champion for interprofessional training is required in this context if it is to take root in this particular practice context.

Although MHS and CJS professionals describe mechanisms common to interprofessional education more widely, there were factors specific to the MHS/CJS context alone. The need for insight into specific agendas related to liaison and diversion was one example, and the role this service configuration (and others such as mental health courts [24]) has on promoting interagency practice between the MHS and CJS should be included in any future program content. Further, user involvement in training is seen as important for contextual learning in collaborative practice, but in the MHS and CJS environment, user involvement is difficult to manage, with patient vulnerability and security being a greater issue than in other clinical contexts. There is scope here, therefore, for digital storytelling, which could be conducted with offenders in a controlled environment [25]. Stigma associated both with offenders and with the mentally ill is particularly problematic in offender mental health [26] and adds to challenges with person-centred care or the wish of MHS professionals to collaborate with the CJS and vice versa. Finally, perhaps based on the legal side of patients' histories, MHS and CJS professionals were particularly focused on the legal and statutory responsibilities of other agencies. For example, mental health status has far-reaching legal implications, impacting the sentence received by the offenders or their diversion into secure mental health services. Legal responsibilities and constraints should therefore be a central component of any future program's content.

Similar to other clinical contexts in healthcare, MHS and CJS professionals at times failed to distinguish between multiprofessional training, where professions are brought together for reasons of economy of scale, and interprofessional training, and where the explicit purpose is to learn about, from, and with each other so as to improve interprofessional collaborative practice [27]. MHS and CJS professionals suggested opportunities for sharing training resources, opening up multiagency training events (on mental health awareness or the liaison and diversion agenda) to other services and agencies to tackle financial and time constraints. There is some concern that if unsupported, MHS and CJS professionals will encourage multi-, rather than interprofessional events, which will not explicitly or effectively develop the interprofessional and interagency relationships required. Some MHS/CJS professionals did recognize the need for managed contact between agencies (interagency placements and shadowing opportunities or formal visits between agencies being exemplars given). Although establishing contact between MHS and CJS agencies is a recognized tool in building relationships and minimizing intergroup stereotypes and prejudice, contact alone will not be enough [28]. While interagency placements, visits, and shadowing opportunities provide contact, a range of contact conditions must be present for these positive effects to occur. These conditions include: that agencies

should be working on common goals, that there should be institutional buy-in from those in authority, that intergroup contact should be such that participants are on a level and equal footing, and for similarities and differences between professions to be acknowledged [20]. If these contact opportunities are left unmanaged, however, and left open to serendipitous interprofessional learning, then the impact of contact may have quite the opposite effect, with stereotypes being reinforced and interagency relationships harmed [30]. Facilitation is key in these events. A pedagogical framework, and the prior marketing of joint training, needs to make explicit the clear distinction between multi- and interprofessional training, an argument already well rehearsed in other IPE literature [31].

Participants suggest that due to financial constraints and limited funding available to commission collaborative training, that collaborative practice training be targeted at priority groups. This coincided with our initial hypotheses that training might be targeted at those with the least favourable attitudes to shared learning and practice and those less person-centred in their views. However, in this study, demographic variables (gender, age, management role, sector, geographical location) did not influence these attitudes in any significant way. This may, however, be an artifact of the self-selecting nature of professionals in the workshop. A survey of a larger and wider population drawn from the wider MHS and CJS services is now required to get a better picture of general attitudes to collaborative practice and learning and the demographic differences within these. Training could also be targeted at professions based on their level of involvement with other services, for example, MHS staff involved with offenders specifically or CJS professionals dealing more regularly with offenders with typically higher levels of mental ill health. To be able to do this, mapping exercises are required—potentially social network analyses that map which agencies are involved with the offender and with each other.

## Conclusion

This study has shown that professionals within the MHS and CJS have strongly positive attitudes toward interagency training, suggesting there is scope for developing new training frameworks that bring MHS and CJS professionals together to prepare them to better collaborate in the interest of the mentally ill offender. Demographic differences in the attitudes toward interagency training were not a useful way of targeting those professionals most in need of this kind of training in the future. MHS and CJS professionals raise curriculum (e.g., scheduling, communication competence) and educator mechanisms (e.g., need for practitioners to deliver training, institutional support) that are seen generically in the interprofessional education literature. This means there is scope to transfer established pedagogical frameworks (e.g., competency frameworks) into this new clinical arena with some confidence, but context-specific factors such as the liaison and diversion agendas and the challenges of user involvement must be taken into account. There is a danger that educator commissioners in the MHS and CJS support multiagency professional (e.g., sharing courses on mental health awareness) rather than interagency training due to financial constraints influencing both sectors. Future research requires mapping of

the services surrounding mentally ill offenders more comprehensively and capturing their needs and attitudes toward collaborative practice and training more widely.

### Acknowledgement

We are grateful to all the participants from the mental health and criminal justice systems who attended the interagency workshop upon which this article is based and who participated freely and enthusiastically in the event and data collection.

### References

1. Fazel, Seena., & Baillargeon, Jacques. (2011). The health of prisoners. *Lancet*, 377(9769), 956–965.
2. Fazel, Seena, & Danesh, John. (2002). Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. *Lancet*, 359(9306), 545–550.
3. World Health Organization. (2005). *Mental health and prisons: Information sheet*. 1–6. URL: [http://www.who.int/mental\\_health/policy/mh\\_in\\_prison.pdf](http://www.who.int/mental_health/policy/mh_in_prison.pdf) [January 2014].
4. Bradley, Lord. (2009). *The Bradley report*. London: Department of Health. URL: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_098698.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf) [January 2014].
5. Hean, Sarah, Heaslip, Vanessa, Warr, Jerry, & Staddon, Sue. (2011). Exploring the potential for joint training between legal professionals in the criminal justice system and health and social care professionals in the mental-health services. *Journal of Interprofessional Care*, 25(3), 196–202.
6. Byng, Richard, Quinn, Cath, Sheaff, Rod, Samele, Chiara, Duggan, Sean, Harrison, Dean, Smithson, Philippa, Wright, Christine, Annison, Jill, Brown, Chris, Taylor, Rod, Henley, William, Qureshi, Adam, Shenton, Deborah, Porter, Ian & Warrington, Claire, & Campbell, John. (2012). *COCOA: Care for offenders continuity of access*. London: NIHR.
7. Clapper, Andy. (2012). Mapping liaison and diversion services for Hampshire and the Isle of Wight: A report for NHS South of England. Lymington: Andican Consultancy.
8. Borschmann, Rohan D., Gillard, Steven., Turner, Kati, Chambers, Mary, & O'Brien, A. (2010). Section 136 of the Mental Health Act: A new literature review. *Medicine Science and the Law*, 50(1), 34–39.
9. Borschmann, Rohan, D., Gillard, Steven, Turner, Kati, Lovell, Kath, Goodrich-Purnell, Norman & Chambers, Mary. (2010). Demographic and referral patterns of people detained under Section 136 of the Mental Health Act (1983) in a south London mental health trust from 2005 to 2008. *Medicine Science and the Law*, 50(1), 15–18.
10. Frenk, Julio, Chen, Lincoln, Bhutta, Zulfiqar A., Cohen, Jordan, Crisp, Nigel, Evans, Timothy, Fineberg, Harvey, Garcia, Patricia, Ke, Yang, Kelley, Patrick, Kistnasamy, Barry, Meleis, Afaf, Naylor, David, Pablos-Mendez, Ariel, Reddy, Srinath, Scrimshaw, Susan, Sepulveda, Jaimie, Serwadda, David, & Zurayk, Huda. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *Lancet*, 376(9756), 1923–1958.
11. World Health Organization. (2010). *Framework for action on interprofessional education & collaborative practice*. Geneva: WHO. URL: [http://www.who.int/hrh/resources/framework\\_action/en/](http://www.who.int/hrh/resources/framework_action/en/) [January, 2014].
12. Brandt, Barbara F. (2014). Update on the US National Center for Interprofessional Practice and Education. *Journal of Interprofessional Care*, 28(1), 5–7.
13. Engeström, Yrjö. (2001). Expansive learning at work: Toward an activity theoretical reconceptualization. *Journal of Education and Work*, 14(1), 133–156.
14. Hean, Sarah, Staddon, Sue, Clapper, Andy, Fenge, Lee-Ann, Jack, E., & Heaslip, Vanessa. (2012). *Interagency training to support the liaison and diversion agenda*. Bournemouth, UK: Bournemouth University and SW Offender Health.
15. Hean, Sarah, Heaslip, V., Warr, J., Bell, H., & Staddon, S. (2010). A women's worker in court: A more appropriate service for women defendants with mental health issues? *Perspectives in Public Health*, 130(2), 91–96.
16. Reid, Ross, Bruce, David, Allstaff, Katie, & McLernon, David. (2006). Validating the Readiness for Interprofessional Learning Scale (RIPLS) in the postgraduate context: Are health care professionals ready for IPL? *Medical Education*, 40(5), 415–422.
17. Glaser, Barney, & Strauss, Anselm. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine De Gruyter.



18. Bainbridge, Lesley, Nasmith, Louise, Orchard, Carole, & Wood, Victoria. (2010). Competencies for interprofessional collaboration. *Journal of Physiotherapy Education*, 24(1), 6–11.
19. Hean, Sarah, Clark, Jill M., Adams, Kim, & Humphris, Debra. (2006). Will opposites attract? Similarities and differences in students' perceptions of the stereotype profiles of other health and social care professional groups. *Journal of Interprofessional Care*, 20(2), 162–181.
20. Carpenter, John, Barnes, Di, Dickinson, Claire, & Wooff, David. (2006). Outcomes of interprofessional education for community mental health services in England: The longitudinal evaluation of a postgraduate programme. *Journal of Interprofessional Care*, 20(2), 145–161.
21. Orchard, Carole A., & Bainbridge, Lesley A. (2010). *A national interprofessional competency framework*. Vancouver, BC: Canadian Interprofessional Health Collaborative.
22. Wilhelmsson, Magaretha, Pelling, Staffan, Lars Uhlin, Lars, Dahlgren, Lars Owe, Faresjö, Tomas, Forslund, Kenneth. (2012). How to think about interprofessional competence: A metacognitive model. *Journal of Interprofessional Care*, 26(2), 85–91.
23. Charles, Marian, Horwath, Jan. (2009). Investing in interagency training to safeguard children: An act of faith or an act of reason? *Children and Society*, 23(5), 364–376.
24. Steadman, Henry J., Redlich, Allison D., Griffin, Patricia, Petril, John, & Monahan, John. (2004). From referral to disposition: Case processing in seven mental health courts. *Behaviour Science and Law*, 23(2), 215–226.
25. Hardy, Pip, & Sumner, Tony. (2014). *Cultivating compassion: How digital storytelling is transforming healthcare*. Chichester, UK: Kingsham Press.
26. Hean, Sarah, Warr, Jerry, & Staddon, Sue. (2009). *Final report evaluation of the south west mental offender Health South West*. Bournemouth, UK: Bournemouth University and SW Offender Health.
27. Gilbert, John H.V., Yan, Jean., & Hoffman, Steven J. (2010). A WHO report: Framework for action on interprofessional education and collaborative practice. *Journal of Allied Health*, 39(3), 196–197.
28. Hewstone, Miles, Carpenter, J., Franklyn-Stokes, A., & Routh, D. (1996). Intergroup contact between professional groups: Two evaluation studies. *Journal of Community & Applied Social Psychology*, 4, 347–363.
29. Dickinson, Clair, & Carpenter, John. (2009). "Contact is not enough": An intergroup perspective on stereotypes and stereotype change. In Colyer, H., Helme, M., & Jones, I. (Eds.), *The theory-practice relationship in interprofessional education* (pp. 23–30). London: Higher Education Academy.
30. Carpenter, John, & Hewstone, Miles. (1996). Shared learning for doctors and social workers: Evaluation of a programme. *British Journal of Social Work*, 26, 239–257.
31. Bainbridge, Lesley, & Wood, Victoria I. (2012). The power of prepositions: Learning with, from and about others in the context of interprofessional education. *Journal of Interprofessional Care*, 26(6), 452–458.