



DEVELOPMENT OF A PARTNERSHIP ENHANCING TREATMENT REFERRALS, PATHWAYS AND INTER-AGENCY COMMUNICATION BETWEEN AN NHS MENTAL HEALTH TRUST AND A PROBATION DELIVERY UNIT

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Background

The murder of three men in Forbury Gardens, Reading, in June 2020 by an individual with a history of probation supervision and intermittent mental health service support needs exposed gaps in multi-agency practice. The coroner's report noted systemic failures across probation, community and prison mental health services, MAPPA processes, and counterterrorism agencies. A key theme was the lack of effective communication between probation and local NHS services, resulting in missed opportunities for intervention.

Individuals on probation frequently present with overlapping mental health needs including trauma, substance misuse, and personality disorder. These do not always fit neatly into existing service pathways, and variable engagement further complicates access to treatment. The Reading case underscored the risks of fragmented systems and the tendency to downplay risk where diagnoses such as Emotionally Unstable Personality Disorder (EUPD) and historical trauma were present.

Partnership Development

In response, one of the NHS Trusts that had been involved in community mental health provision in the Reading case and the local Probation Delivery Unit established a process to strengthen referral outcomes. From 2022, probation referrals declined by secondary mental health services could be escalated for review by two nurse consultants. This provided a

second opinion and encouraged dialogue with probation practitioners to clarify clinical information, explore alternative pathways, or provide signposting and assist probation practitioners (PPs) in navigating complex mental health systems, alongside helping those practitioners to understand what could realistically be offered to support individuals that were reporting mental health difficulties.

Concurrently, Probation Health and Justice Partnership teams, introduced nationally in 2021–22, provided coordination and oversight. Although initially focused on substance misuse, regional experience led to increased attention on mental health needs, supported by three coordinators and a regional manager in south-central probation region. This infrastructure proved essential for embedding the pilot process, problem solving issues and establishing a conduit to improve processes and relationships across the services.

Wider Policy Context

Over the past decade, policy has increasingly recognised the health needs of justice-involved populations. Commissioned services such as Liaison and Diversion (at the police custody stage), Mental Health Treatment Requirements (MHTRs) at court, and the Reconnect service for prison leavers exemplify this trend. The Offender Personality Disorder (OPD) pathway has also provided probation with psychologically informed formulations and, more recently, access to services such as the Intensive Individualised Risk Management Service (IIRMS).

Despite this, gaps remained. In the Reading case, although the OPD pathway identified trauma as a treatment need which might have been managed within this pathway, long waiting lists meant no intervention could be provided in the very short time following release of the perpetrator from prison provided before the offence occurred. It should be noted that the OPD pathway was commissioned nationally as a joint NHS and HMPPS funded endeavour. It was not commissioned within the local generic secondary mental health services which created a gap in service provision for individuals requiring the specialist skills required within this pathway. Referrals were therefore made to local trauma services in an attempt to manage this gap, and local crisis support was provided when required. It is essential when teams are trying to manage such gaps that communication between organisations and individual workers is clear, and that all are well sighted on support plans.

Method: Pilot Process

The pilot introduced a structured escalation pathway:

1. Referral review – all probation referrals declined by the single point of access into secondary mental health services could be reconsidered by nurse consultants if the probation practitioner was not satisfied with the response to the referral.
2. Liaison – nurse consultants discussed the case with probation practitioners for further information and context.

3. Guidance – where secondary care was not appropriate, consultants provided clear rationale, signposting, and advice for risk management. Where it was felt that secondary care may be appropriate, the nurse consultants liaised with the relevant team to support the referral being accepted for further review/intervention.

4. Training – teaching sessions were delivered to probation staff to improve referral quality and awareness of service structures, and what was appropriate for secondary mental health treatment interventions.

Data were collected on cases referred through the pathway, with feedback obtained from practitioners on timeliness, usefulness, and outcomes.

Findings

Referral Quality and Training Needs

Early review revealed probation referrals often lacked detail, with minimal clinical information ('mental health is poor'), limiting the mental health provider's ability to make informed decisions on the referral. Training sessions were introduced to improve understanding of thresholds and pathways, alongside resources such as *At a Glance* service guides, a one-page referral checklist, and a training video shared on the probation internal intranet pages.

Substance Misuse Barriers

Historically, alcohol and substance misuse frequently excluded individuals from psychological treatment, creating a *catch-22* where probationers with co-morbid needs could not access either service. This has been a national issue for many years and reflected in local challenges. While some exclusions were clinically appropriate, probation staff felt criteria were inconsistently applied. A significant amount of work has been undertaken to redress this locally for all mental health service users, including those under probation services, and having comorbid mental health, alcohol and substance misuse is not an exclusion to accessing services. The pilot highlighted the need to help probation staff to understand the complexities and rationale for signposting to alternative pathways where appropriate for people with comorbid presentations.

Risk and Service Boundaries

Referrals were sometimes declined due to an individual's forensic history, with redirection suggested to forensic services that were either inappropriate or decommissioned. This exposed gaps in service knowledge even within NHS teams. Nurse consultants helped correct misdirected referrals and challenged discriminatory blanket refusals based on criminal history, and extended expert advice and support to those involved in MAPPA decision making.

Communication and Collaboration

The pilot improved the speed of responses to probation queries, enabling timely case management decisions. Constructive relationships developed, including a nurse consultant joining the Thames Valley MAPPA thresholding panel, providing clinical expertise in high-risk case discussions.

Case studies

The Health and Justice partnership co-ordinator for Berkshire undertook a number of reviews of cases held by probation practitioners who had received a service from the nurse consultants. Examples are summarised (anonymously) here to illustrate outcomes of the pilot:

Case A: John

What issues did Probation Practitioner (PP) have with John's case?

PP was struggling to get any involvement from the mental health team while John was exhibiting severe behavioural issues, leading her to contact nurse consultant A (NCA) for assistance. PP faced difficulties with the crisis team's response, particularly due to John's neurodiversity, which seemed to create barriers to effective support.

How did PP find the response from NCA in helping her with John's case?

PP found NCA to be very helpful in assisting with John's case. She appreciated NCA's quick and supportive responses, which provided her with useful information and guidance. PP noted that NCA was approachable and willing to answer numerous questions, making him a valuable resource.

Did NCA and the mental health escalation pathway response support the PP in her ability to manage John's case more effectively?

Yes, the response from NCA and the mental health escalation pathway supported the PP in managing John's case more effectively. NCA provided valuable information about John's recent interactions with the crisis team and his history with the local inpatient mental health facility, which helped PP understand the situation better and facilitated the decision to refer John to the complex case panel.

Did the support/response the PP receive enable John to access mental health support?

Yes, the support and response the PP received enabled John to access mental health support. PP mentioned that John's case was eventually referred to the complex case panel, which facilitated further involvement and support from the mental health team.

Did the PP have any thoughts or considerations about the mental health escalation pathway and how it could be improved further?

The PP had several thoughts and considerations about the mental health escalation pathway and how it could be improved:

1. PP suggested that having regular reminders about the escalation pathway during all sentence meetings would be helpful. This would ensure that practitioners are consistently aware of the available resources and how to access them.
2. PP mentioned that having a generic inbox for mental health escalation could distribute the workload more evenly and prevent burnout, as currently, most practitioners reach out to NCA directly. [NB This proposal was implemented shortly afterwards]
3. PP also highlighted the importance of having accessible and easily available information, such as through QR codes or a one-stop page, to save time and ensure practitioners can quickly find the resources they need. This underlined the need for continued support with signposting alongside access to available materials which could support practitioners in developing their understanding.

Case B: Mohamed

What issues did PP have with Mohamed's case?

PP had limited contact with Mohamed as he was under Section 3 and in the hospital.

Mohamed was released from custody with a suspended sentence and no immediate support, leading him to sleep on the streets. Initially, there was a lack of communication between agencies, which made it difficult to manage Mohamed's case effectively. There was also confusion among partner agencies about the roles and responsibilities of probation, leading to unrealistic expectations. Without comprehensive information from the hospital, Mohamed's risk level appeared lower than it actually was, which could have led to inadequate support. This highlights the challenge on different agencies priorities for risk assessment and management, which may well be different from a health versus probation perspective.

How did PP find the response from NCA in helping her with Mohamed's case?

PP reached out to NCA for support prior to a professionals meeting. While he was unable to attend the meeting, he was able to offer support outside of this forum as noted below.

Did NCA support the PP in her ability to manage Mohamed's case more effectively?

Yes, the support from NCA and the mental health team helped PP manage Mohamed's case more effectively. The pathway facilitated better communication and coordination between mental health services and probation, ensuring that Mohamed's complex needs were addressed comprehensively. This collaboration allowed for a more holistic approach to his care and risk management.

Did the support/response PP receive, enable Mohamed to access mental health support?

Yes, the support and response PP received enabled Mohamed to access mental health support. The collaboration with mental health services, including the involvement of a social worker, which ensured that Mohamed's mental health needs were identified and addressed. This included sharing critical information about his risk factors and creating a comprehensive care package that involved supported accommodation and compliance with medication.

Did PP have any thoughts or considerations about the mental health escalation pathway and how it could be improved further?

PP did not explicitly mention any thoughts or considerations about how the mental health escalation pathway could be improved further. However, she did highlight the importance of clear communication and understanding between different agencies, as well as the need for better awareness of each other's roles and capacities. However, the PP stated that this case was her best experience working with someone needing intensive mental health support. She praised NCA for avoiding jargon and ensuring clear communication. The PP shared her experience of attending multiple professional meetings about Mohamed, where the focus shifted from assigning responsibility for his care and management to collaborative problem-solving. This change in approach led to a more effective and supportive environment for managing the case.

PP discussed the importance of having a comprehensive risk assessment for Mohamed, which included information from the mental health inpatient unit. This assessment helped in creating a tailored support package for Mohamed, ensuring his safety and the safety of others. The PP discussed the importance of balancing the needs of the individual, victims, and public protection. They emphasized the need for a fair and ethical approach, avoiding actions that may compromise the individual's well-being.

The PP expressed that having a point of contact for mental health support has reassured her and made her more confident in working with individuals with severe mental health issues. She emphasized the importance of building a supportive network to manage complex cases effectively.

These cases highlight both successes (enhanced communication, improved planning) and continuing barriers (service exclusions, system fragmentation, information sharing).

Discussion

The pilot demonstrated that small-scale structural changes, such as escalation pathways and dedicated liaison roles, can significantly enhance communication between probation and mental health services. The presence of nurse consultants as a consistent point of contact fostered trust, improved referral decisions, and facilitated shared learning and problem-solving.

Nevertheless, systemic challenges remain. Service thresholds and commissioning arrangements continue to exclude some probationers with complex needs, particularly those with dual diagnoses and there is a need to address this through commissioning

channels. High caseloads and staff turnover in probation also limit capacity to engage fully with training and multi-agency processes. Mental health services are similarly challenged.

Sharing of information and the challenges around interpretation of guidance was a theme in this pilot study. Further attention is warranted nationally to ensure that barriers to information sharing around risk are addressed across all organisations that work with high-risk people who present with complex needs that require multi-agency responses.

Importantly, the pilot underscored the risk of services excluding each other from case discussions, reinforcing siloed practice. Embedding mental health expertise within probation forums (e.g., MAPPA panels, professionals' meetings) proved an effective counterbalance, promoting joint ownership of cases.

While this pilot focused on collaborative working between probation and secondary mental health services, it also highlighted gaps with other partner agencies such as prisons and other statutory services that may have benefited from testing this approach.

From a mental health provider perspective there was some concern that the pilot would result in a significant increase in referrals into services, however this was not the case and referrals numbers remained similar to pre pilot figures and remain fairly consistent.

Conclusion

This partnership project illustrates the potential of targeted initiatives to bridge systemic gaps between probation and NHS mental health services. By establishing a structured review process, strengthening referral pathways, and enhancing practitioner training, the pilot supported more effective management of high-risk individuals.

The initiative also highlights broader challenges: the need for flexible service thresholds, integrated approaches to co-morbid substance misuse, and sustained investment in inter-agency communication. While further work is required to embed these practices at scale, the pilot offers a model for enhancing collaboration, reducing risk, and improving health outcomes for people on probation.

The positive findings of this qualitative pilot study have resulted in a commitment to embed the model permanently and further evaluation is planned. While the numbers of referrals remain fairly low and consistent, the complexity of these cases is significant. Facilitating expert consultation to support probation referrals into secondary mental health services has undoubtedly improved outcomes for these individuals, as well as enhancing skills of individual workers. There is a need to extend such approaches to include prisons and other agencies. Much more exploration of pragmatic methods to improve multi-agency working with high risk, complex individuals who touch many services is warranted on a much broader scale, using more robust and scientific approaches.