The Bradley Report

Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system

April 2009

The Bradley Report

Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system

April 2009

Contents

Foreword

In December 2007 I was pleased to be asked by the Government to undertake a six-month independent review to determine to what extent offenders with mental health problems or learning disabilities could be diverted from prison to other services and what were the barriers to such diversion.

As a former Home Office Minister I was well aware of the large number of people with mental health problems or learning disabilities in our prisons and was therefore determined to examine whether prison was always appropriate for them, but always mindful of the need to maintain public confidence in the criminal justice system.

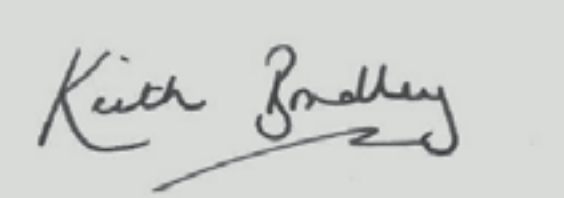
The initial focus of the review was the organisation and effectiveness of current court liaison and diversion schemes. However, it was very soon apparent that merely analysing such schemes would be a missed opportunity and a more comprehensive consideration of the 'offender pathway' and the associated mental health services would be more productive. It was agreed, therefore, to extend the review period to 12 months, and I reported to the Government in February 2009.

I was also very conscious that in the time available it would be important to understand the real practical barriers to effective diversion, so I undertook a wide-ranging series of visits throughout the country to police stations, courts, prisons, secure accommodation and mental health facilities in order to fully appreciate the complex issues that needed to be addressed. I talked extensively to staff at all levels and organised regional conferences to ensure that people working within the criminal justice system and in mental health care, as well as carers and service users, could contribute fully to the review.

My recommendations are therefore based on what I believe is a real understanding of the current situation and will, I hope, establish a new baseline of services for the future. I hope they will ensure that over time offenders with mental health problems or learning disabilities are properly identified and assessed, appropriately sentenced and helped with their rehabilitation and resettlement, thus reducing the number in prison and impacting on their offending.

It is not possible to thank everyone who helped with this review by name, but I am extremely grateful to all those who so generously gave me their time and imparted their considerable knowledge. I am particularly grateful to Rethink and the Prison Reform Trust for ensuring user and carer involvement in the review. My reference group was an invaluable source of expertise and I was ably supported by senior staff in the Department of Health, the Home Office and the Ministry of Justice, particularly Savas Hadjipavlou, who helped establish the review. I would also like to acknowledge the contribution of the University of Manchester.

Finally, I would like to thank Richard Bradshaw, Director of Offender Health, and his team for their support and encouragement throughout, and especially Dawn Anderson, who managed to organise my visits and engagements so efficiently. Most importantly, I pay tribute to Susannah Nisbett, who, as project leader, guided the review from start to finish, prepared briefing papers and the substantial drafts of this report. Her commitment and support were immense.



The Rt Hon Lord Bradley

1

Setting the scene

This chapter sets out the objectives of the report. They are to examine, where appropriate, alternatives to prison for offenders with mental health problems or learning disabilities and to make recommendations to bring about improvement.

There is a wide-ranging examination of the policy context and how proposals for reform have developed alongside key government themes and policy drivers.

I then go on to define key terms like 'diversion', 'learning disabilities' and 'mental health' in detail. I then examine the difficulties faced by particular groups: people with dual diagnosis, people from black and ethnic minority groups and women. Finally, I set out how evidence was gathered and how the report is structured.

Introduction

The Secretary of State for Justice asked me to undertake this independent review in December 2007, under the following terms of reference:

- to examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services and the barriers to such diversion; and
- to make recommendations to government, in particular on the organisation of effective court liaison and diversion arrangements and the services needed to support them.

I kept the remit of the review as broad as possible within those terms so that it could incorporate the range of severity of mental health problems, and could include diversion in all its potential interpretations, from prevention and early intervention through all the stages of the criminal justice system and back out into the community. In acknowledgement of the breadth of the remit, the length of the review was extended from the initial six months to one year.

I realised very quickly that if I looked at just 'diversion' in its traditional sense, i.e. schemes set up in courts, an opportunity would be missed to look at the whole offender pathway and make effective changes that would impact on this population. The lack of progress in this area seemed to be caused, in part, by the continual development of policies and practice in isolation from each other, affecting only small parts of the system, or addressing one problem at a time. I did not want to compound this lack of progress by taking the same approach. This review provided an excellent opportunity to take stock, look at the whole system and move the agenda forward.

The problem

While public protection remains the priority, there is a growing consensus that prison may not always be an appropriate environment for those with severe mental illness and that custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide. In addition, recent studies of mental health services for prisoners[1,2,3] suggest that there is still some way to go in achieving equivalence with mental health services in the community.

The 1998 publication of a survey for the Office for National Statistics on psychiatric morbidity among prisoners[4] was a comprehensive attempt to provide robust baseline information about the prevalence of psychiatric problems among male and female, remand and sentenced prisoners. The information gained from this study has been invaluable; it set out the scale and nature of mental health problems among prisoners and has helped to inform policy decisions to this day.

Some key findings from this survey report showed that:

- over 90% of prisoners had one or more of the five psychiatric disorders studied (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence);
- remand prisoners had higher rates of mental disorder than sentenced prisoners; and
- rates of neurotic disorder in remand and sentenced prisoners were much higher in women than in men.

This information is now 10 years old, but it is still being referred to today. In the interim, smaller-scale studies, reports and research have suggested that numbers remain high. Since June 1995, the prison population in England and Wales has increased by 60%, or more than 30,000 people, to reach the record levels seen today.[5] Figures for January 2009 put the prison population at 82,240.[6]

There is now an added sense of urgency attached to addressing these problems as the Government considers larger-capacity prisons in its response to increasing pressures on the system. The figures from the survey, if considered alongside the increase in the prison population over the last 10 years, suggest that there are now more people with mental health problems in prison than ever before.

Public opinion

Concerns around the profile of the prison population are no longer exclusively felt by professionals and pressure groups. There is increasing evidence to suggest that they are finding their way into mainstream public opinion, including that of victims of crime.

SmartJustice (an alliance of organisations currently based within the Prison Reform Trust), in partnership with Victim Support, published the results of a survey undertaken in 2006,[7] which asked victims how they thought the criminal justice system should deal with people who commit non-violent crimes. The findings challenged many preconceived views that victims always want penalties to take the form of imprisonment. Instead, it demonstrated that they support a range of measures that they believe are more effective in stopping further offending. The survey showed that seven out of ten victims wanted to see more treatment programmes in the community for offenders suffering from mental health problems, and for drug addicts, to tackle the causes of non-violent crime.

Last year also saw a resolution at the Women's Institute's Annual General Meeting concerning the inappropriate imprisonment of the mentally ill. The resolution focused in particular on the impact on prisoners' families and was carried overwhelmingly. The issue now constitutes one of the Women's Institute's current campaigns.[8]

The policy context

So what work has been done over the years to try to reduce the high prevalence of mental health problems in prisons? As early as 1990, the Home Office issued Circular 66/90[9] to promote effective inter-agency working, so that wherever possible mentally disordered offenders should receive care and treatment from health and social services rather than be dealt with via the criminal justice system. This was followed by the 1992 Reed review of health and social services for mentally disordered offenders.[10] The review recommended that there should be nationwide provision of properly resourced court assessment and diversion schemes to support this goal. Reading back through the Reed review's recommendations, it is hard to believe that what was relevant 16 years ago is just as relevant today and that we are still struggling to resolve the same problems. Some of the key issues highlighted by the report were as follows:

- the need for a positive approach to the individual needs of patients, many of whom, including women and people from ethnic minorities, may have special or differing needs;
- a flexible, multi-agency and multi-professional approach, the aim of which is to identify and meet most effectively the needs of mentally disordered offenders;
- improved access to more specialised services in mental health and learning disability services, and recognition of the role played by more general services in providing care and treatment for most mentally disordered offenders; and
- closer working between the police, health and social services to avoid unnecessary prosecution of mentally disordered suspects.

The issues may remain the same, but what has changed over the intervening years is the political and social context in which the recommendations of my review will be received.

Criminal justice policy

The Reed review suggested that contracting in services from the NHS could bring about the improvement of mental health services for prisoners. The following years saw the publication of the report *Patient or prisoner?*[11] by the then HM Chief Inspector of Prisons, Lord Ramsbotham, followed by *The future organisation of prison healthcare*,[12] which set in train the process of transferring budgeting and commissioning responsibility for health services from the Prison Service to the NHS, a process which was completed in April 2006. This in turn enabled the NHS, particularly primary care trusts, which were now commissioning services for the prison population, to become directly engaged with this agenda and helped to highlight health issues in other areas of the criminal justice system.

The profile of prisoners and their mental health problems was raised again more recently by the current HM Chief Inspector of Prisons, Dame Anne Owers, in her 2007 thematic review of the mental health of prisoners.[13] This report also touched on many of the areas covered by this review, and made recommendations for better provision of diversion schemes and improvements in mental health services provided to prisoners.

The same year saw the publication of Baroness Corston's report focusing on women in the criminal justice system who have particular vulnerabilities,[14] including mental health problems and learning disabilities. As well as looking at the problems experienced by women in custody, the Corston report highlighted that there was a need to look more broadly at the reasons and circumstances that can lead women in custody to the point where they are at risk of harming themselves.

Public protection

I am aware of a small number of individual cases where poor decisions have been made concerning people with severe mental health problems, which have had tragic consequences. Safeguarding the public must always remain a top priority and I hope that the types of interventions recommended in this report not only improve treatment and outcomes for offenders and their families but also contribute positively to the public safety agenda.

In 2006, the Government published *A five year strategy for protecting the public and reducing re-offending.*[15] This strategy set out the public protection agenda, and made clear that imprisonment was not the only way to punish offenders and keep the public safe.

A stronger emphasis on community sentencing and a focus on offering offenders the chance to change and address their offending behaviour were put forward as other ways of contributing to public protection and reducing crime. This included addressing the multiple problems that many of the most persistent offenders face, such as poor health.

Social exclusion agenda

The publication of the Social Exclusion Unit report *Reducing re-offending by ex-prisoners*[16] in 2002 firmly established the link between offending, re-offending and other wider factors that influence offending and re-offending. The nine key factors were identified as:

- education;
- employment;
- drug and alcohol misuse;
- mental and physical health;
- attitudes and self-control;
- institutionalisation and life skills;
- housing;
- financial support and debt; and
- family networks.

"The majority of offenders with lower-level [mental health] disorders are not dangerous and could be better treated outside the prison system without any risk to the public."

HM Government's *A five year strategy for protecting the public and reducing re-offending*

The report supported the view that mental health problems were often one element in a complex mix of needs that would require a multi-sector response, with agencies working together to achieve positive outcomes. It also firmly linked prisoners to a history of the common causes of social exclusion, including high levels of family, educational and health disadvantage, and poor prospects in the labour market. This report was further complemented by the publication of the *Mental health and social exclusion* report[17] two years later.

Health policy

We know that socially excluded groups are historically poor at accessing services, not least in engaging with primary care services which are in effect the gateway to secondary mental health services. The NHS has recognised this link and several recent initiatives focus strongly on addressing health inequalities in socially excluded groups.

The White Paper *Our health, our care, our say*[18] built on the foundations of *Choosing health*[19] and identified issues affecting and arising from health inequalities. This White Paper set out a vision of good-quality social care and NHS services available to people in the communities where they live. To achieve these aims, family doctors, primary care trusts and local authorities that have direct contact with patients and service users have increasing discretion in how best to plan and buy services for local communities.

The challenge to service commissioners and providers is to ensure that the goals set out in *Our health, our care, our say* are implemented for the whole of their population, including offenders and those at risk of offending. They will need to work in partnership to ensure that community-wide approaches are developed to more effectively meet the needs of excluded and deprived groups. Lord Darzi's recent review of the NHS[20] sets out in more detail how NHS services might be configured in order to achieve this. The focus will be on six key goals, which include reducing alcohol harm, treating drug addiction and improving mental health – three areas that are extremely relevant to the potential offending/re-offending population.

"The failure of mainstream agencies to deal with these aspects of social exclusion means that the Prison and Probation Service are in many cases being asked to put right a lifetime of service failure."

Social Exclusion Unit report, *Reducing re-offending by ex-prisoners*[22]

Mental health

The Mental Health Act 2007[21] has made several significant changes to the Mental Health Act 1983, which is the main legislation governing the care and treatment of people with mental disorders. Significantly, the 1983 Act provides the legislative framework for detaining people in hospital and for the assessment and treatment of their disorder against their wishes.

The Mental Health Act 2007 is more inclusive of all mental disorders and disposes of what was known as the 'treatability test'. While clinical judgement remains paramount in decisions to detain and treat, the Act establishes the principle that personality disorder, as a mental disorder, is now a mainstream condition requiring equal and appropriate consideration for assessment and treatment.

The move towards greater recognition of the need for improved services for this population is made clear by the inclusion of mental health services for offenders in this year's standard NHS contract for mental health.[23] For the first time, the contract contains non-mandated elements that relate to some key aspects of offender mental health: improved continuity of care; improved access to mental health care beds for prisoners; and criminal justice liaison teams. Further reference will be made to each of these elements later in this report.

Further, we are approaching the end of the 10-year lifespan of the National Service Framework for mental health.[24] The Department of Health has in place the New Horizons project, which involves a wide range of organisations and individuals developing a new vision to replace the National Service Framework. The process of consulting with those who commission, deliver, provide and use mental health services is already under way, and indications from early events show a desire among stakeholders for a future framework to include criminal justice links, which are not explicit in the current one.[25]

A further indication of how mental health services might develop has been set out in a discussion paper[26] by the Future Vision Coalition, which is made up of seven key national mental health organisations (Association of Directors of Adult Social Services, Mental Health Foundation, Mind, Rethink, Sainsbury Centre for Mental Health, Together and NHS Confederation's Mental Health Network).

This discussion paper sets out a new vision for mental health that would strongly support the offending population. The agreed aims of future mental health policy are set out as follows:

- to overcome persistent barriers to social inclusion that continue to affect those with experience of mental health problems;
- to improve the whole-life outcomes of those with experience of mental health problems; and
- to improve whole-population mental health.

The paper specifically supports a move towards a cross-government approach that focuses on prevention and early intervention. It also states that the "failure to adequately address the mental health needs of offenders is a fundamental cause of the chronic dysfunction of our criminal justice system". This represents a strong degree of consensus for this agenda from some of the key players in mainstream mental health services.

Joined-up government

Following the Comprehensive Spending Review[27] of 2007, the Government announced 30 new Public Service Agreements (PSAs), setting a vision for continuous improvement in the Government's priority outcomes for 2008–11. A key innovation of these new PSAs is that they are specifically 'cross-government' targets.

Each PSA is underpinned by a delivery agreement shared across all contributing departments and developed in consultation with delivery partners and front-line workers. A number of the PSAs will support a more co-ordinated approach to identifying and meeting the health and social care needs of offenders and those in contact with the criminal justice system as a specific group.

Of particular relevance is the PSA on reducing social exclusion among the most vulnerable adults. Its aim is to ensure that the most socially excluded adults are offered the chance to get back on a path to a more successful life, by increasing the proportion of at-risk individuals in:

- settled accommodation; and
- employment, education or training.

The PSA focuses on four client groups who are particularly vulnerable to multiple forms of disadvantage. The four groups are:

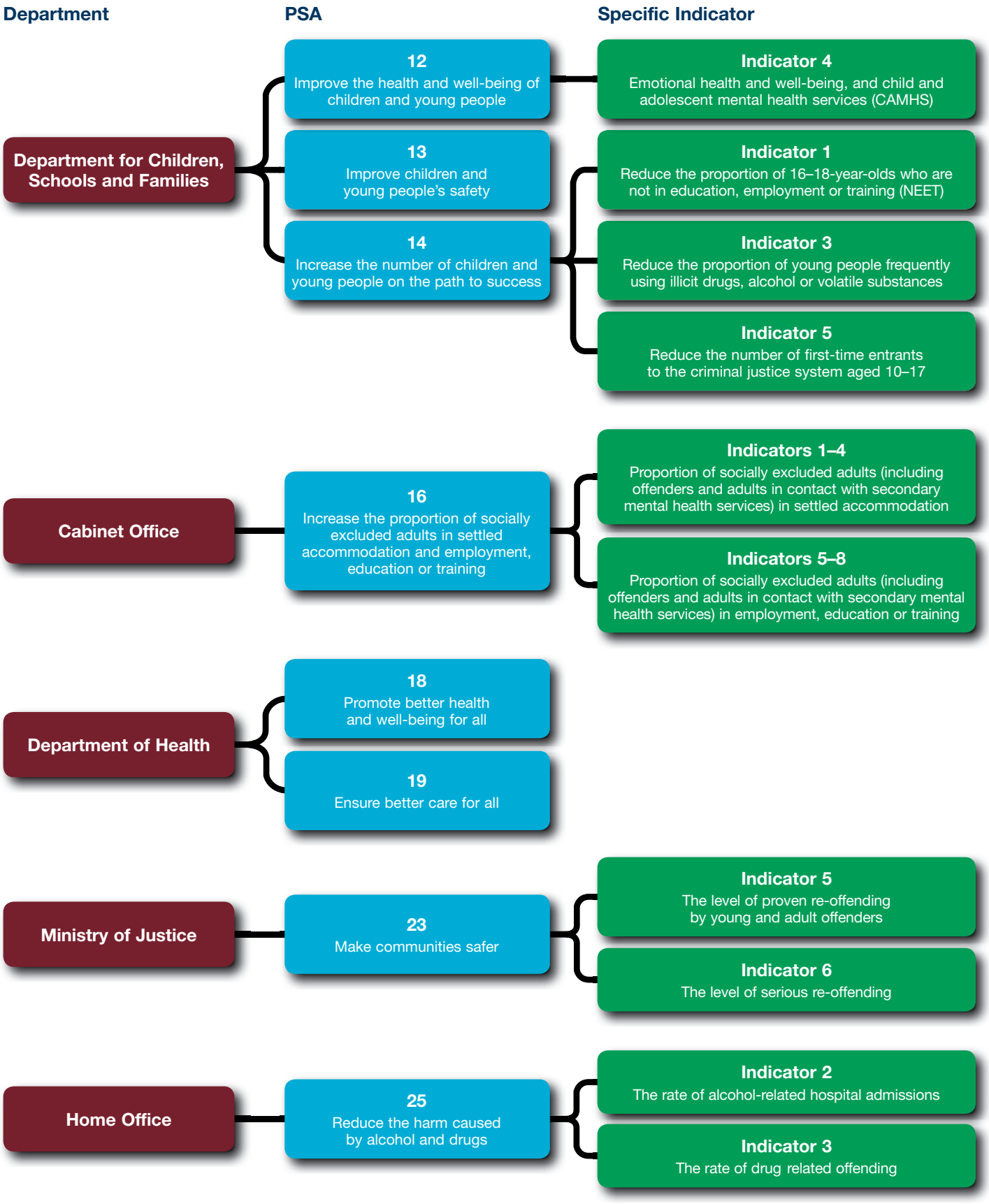
- care leavers;
- offenders under probation supervision;
- adults in contact with secondary mental health services; and
- adults with moderate to severe learning disabilities.

There are elements of other shared PSAs (see page 14) which are also relevant to this group, and this new approach to setting joint objectives lays the foundation for better working between government departments. In time, this must have a positive impact throughout the system and ultimately can only help to improve services for those sections of the community whose needs often stretch across traditional organisational boundaries. What is apparent is the interconnectedness between improving health and social care outcomes for those in contact with the criminal justice system and other government priorities, particularly reducing re-offending.

In summary, the policy of diversion for people with mental health problems or learning disabilities has been supported by the Government since as far back as 1990, but the lack of a nationally guided approach has meant that implementation has been at best inconsistent.

Policy developments across health and criminal justice over the intervening years have created a much more receptive background against which to properly embed the diversion approach. Offenders have since been recognised as a socially excluded population, subject to multiple disadvantage and often with complex and long-standing mental health needs. In addition, this is a population which services traditionally find hard to engage. Now that health inequalities and social exclusion are high on the Government's agenda, and there appears to be a more favourable public opinion towards this approach, an attempt to reinvigorate the diversion agenda would appear to stand a better chance of success.

Public Service Agreements relevant to the population covered by this review



The review

Definitions

One of the first barriers I encountered when I started this review was the issue of definitions. The target population was yet to be clearly defined; even the different organisations and agencies involved in this review used a range of different terms to describe mental health problems, learning disabilities and offenders, not to mention having very different views of 'diversion' and what it meant. One of the first tasks was to establish, for the purposes of the review, definitive descriptions.

"The term 'diversion' is in itself one of the biggest barriers because it means we get into ownership issues."

Delegate, North West Stakeholder Event, 2 September 2008

Defining diversion

There are no rules governing the point at which diversion can occur. Diversion can mean 'diversion from the criminal justice system' or it can mean 'diversion away from prison'. It can mean diverting someone away from the normal course of the criminal justice system either before they are charged with an offence or afterwards, and would depend on what is judged to be appropriate for each case.

There are inherent difficulties in using the term 'diversion'. For some, it implies that people who may have offended are not experiencing the consequences of their actions, or that people are being diverted away from justice.

The significant input from stakeholders I have consulted during the course of this review tells me there is strong support for the idea that offenders with mental health problems or learning disabilities can benefit from a criminal justice sanction. In mental health services, there is increasing concern about the level of violent offending committed while patients are receiving treatment. The NHS promotes a policy of 'zero tolerance' and the prosecution of service users who commit offences against staff or fellow patients (as the Royal College of Psychiatrists stated in a submission to the review dated 6 March 2008). For some offenders, proceeding with criminal justice sanctions will, at the very least, result in an accurate record of short- and long-term risk factors to others. A further benefit is of setting behavioural boundaries requiring offenders to confront the unacceptability of their offending and to take responsibility for their actions.

In order to reach an agreed definition, I also needed to take account of the fact that the decision to divert should strike the right balance between the rights of the offender, the rights of the victim and protection of the public. Literature reviews provided several different possibilities. The two that I felt most closely represented a definition I could use were, firstly:

"… a process of decision making, which results in mentally disordered offenders being diverted away from the criminal justice system to the health and social care sectors. Diversion may occur at any stage of the criminal justice process: before arrest, after proceedings have been initiated, in place of prosecution, or when a case is being considered by the courts."

Definition from NACRO[28]

And, secondly, the National Policing Improvement Agency[29] sets out a broader definition covering the whole of the criminal justice system:

- informal diversion by the police;
- by statute – implementation of section 136 of the Mental Health Act 1983;
- referral for psychiatric examination before a court hearing and subsequent discontinuation of prosecution proceedings;
- disposal via the mental health services, either at court or after sentence; and
- transfer from a prison to a hospital.

Therefore, for the purposes of this report, our definition is as shown below.

Definition: Diversion

'Diversion' is a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence.

Defining the population

Mental health and offenders

Defining this population is also open to variations in interpretation. At the start of this review I again realised that there were many different terms that could be classified as 'mental health problems' used by both criminal justice and health agencies, by those collecting data and those undertaking research. For example, one of the commonly used terms for this population in the criminal justice system is 'mentally disordered offenders'. Although used in the Mental Health Act, this is a term less in use by mainstream health services. In fact, there is no widely accepted definition of what a mental disorder constitutes. Some experts argue that to classify someone as a mentally disordered offender, there has to be a demonstrable link showing that the disorder has contributed to the offending behaviour.

I do not feel that this review is the right place to explore in any depth what the potential links might be between mental health and offending. This is an extremely complex issue, and within the broad context of my review there would not be sufficient time to do this issue justice. However, I feel that the following basic description, taken from a submission to the review from the Royal College of Psychiatrists, of the types of relationship between mental disorder and criminal behaviour is extremely useful in trying to understand this population.

- **The anti-social behaviour is directly related to or driven by aspects of mental disorder.** In this case, effective treatment of the mental disorder would be likely to reduce the risk of further anti-social behaviour.
- **The anti-social behaviour is indirectly related to mental disorder.** Treatment would be likely to make a contribution to a reduction in offending but would not be sufficient in itself to tackle offending behaviour.
- **The anti-social behaviour and the mental disorder are related by some common antecedent, for example childhood abuse.** Treatment of the mental disorder in itself would not be sufficient to tackle re-offending.
- **The anti-social behaviour and the mental disorder are coincidental.**
- **The mental behaviour is at least partly secondary to the anti-social behaviour.**

Extract from the submission to the review by the Forensic Faculty, Royal College of Psychiatrists, 6 March 2008

Taking into account the variety of terms used by different sectors, there is a significant difficulty when trying to identify the numbers of people who might fall into the broad category of people with mental health problems, and how many of those might be suitable for treatment in the health system as opposed to the criminal justice system. For the purposes of this review, again I set out to keep the definition broad in order to incorporate the whole range of mental health problems, from depression and anxiety through to personality disorder and psychoses. This means that the review covers how **all** people with mental health problems are dealt with when they are at risk of coming or come into contact with the criminal justice system. It also looks at what processes are in place to determine the best solution for dealing with their criminal behaviour and with their mental health problem.

We also tend to refer to this section of the population as 'offenders' in a way that is intended to include a wider range of people than just those found guilty of an offence. For the purposes of this review, we have used NACRO's definition.[30]

Definition: Offenders with mental health problems

"Those who come into contact with the criminal justice system because they have committed, or are suspected of committing, a criminal offence, and who may be acutely or chronically mentally ill… It also includes those in whom a degree of mental disturbance is recognised, even though it may not be severe enough to bring it within the criteria laid down by the Mental Health Act 1983 (now 2007)."

Mental health for children and young people

We have to be a little more specific when it comes to defining the mental health problems of children and young people. Mental health needs in children often do not manifest clearly as mental illness but in ways that are less readily defined.

The agreed definition of good mental health for children and young people is as set out by the NHS Advisory Service.[31]

Definition: Mental health for children and young people

- **A capacity to enter into and sustain mutually satisfying and sustaining personal relationships.**
- **Continuing progression of psychological development.**
- **An ability to play and to learn so that attainments are appropriate for age and intellectual level.**
- **A developing sense of right and wrong.**
- **A capacity to deal with normal psychological distress and maladaptive behaviour within normal limits for the child's age and context.**

Throughout the course of this review, I have given considerable thought to how best to approach the issue of children and young people with mental health problems or learning disabilities in the criminal justice system. I had originally intended to include this group as a key element of the overall population that is in contact with the criminal justice system. I have held meetings with organisations associated with the interests of this particular group, and have visited sites where services for children and young people are provided. However, as the review progressed it became clear to me that there are some key differences that set the population of children and young people apart, and this built a strong case for not including them as part of my review.

Firstly, as discussed in the previous section, there are key differences in the manifestation and identification of mental health problems in children and young people. This is an issue we have barely touched on, although I include a brief discussion as part of the early intervention section in the next chapter. This is a very complex area and I do not feel that the remit in this review has allowed me sufficient time to explore it adequately.

Secondly, the Youth Justice System itself is different to the adult criminal justice system in many respects, and this has implications for how diversion for children and young people should best be approached. For example, children and young people can come into contact with the Youth Justice System when they are identified as being at risk of offending as well as when they have committed offences; youth courts operate differently to adult courts; and young people sentenced to custody can be placed in a range of different settings.[32]

Lastly, and most importantly, this is probably the area that in the long term provides the best opportunity for diversion in its broadest sense. Effective interventions for this population not only have the potential to impact on immediate offending and re-offending rates, but also to influence children and young people away from an adulthood of offending. In conclusion, this is clearly a complex area that I am not able to do full justice to within the confines of this review. I therefore recommend to the Government that this vital area requires dedicated scrutiny in a separately commissioned piece of work.

People with learning disabilities or learning difficulties

As well as mental health issues, the Government was also keen for me to consider the experience of people with learning disabilities in the criminal justice system. As the report will demonstrate, there are many areas of similarity in some of the key issues for all vulnerable people in the criminal justice system. However, learning disabilities must be looked at as separate from mental health problems. Even when talking to professionals in this field, I found that there was a lack of consensus in defining the boundaries between learning disability, borderline learning disability and learning difficulty. The problems with definition are due, in part, to the lack of agreement on the most effective methods of identification and assessment.

“Learning disabilities often go unidentified: it is a ‘hidden disability’.”

Prison Reform Trust report, *No one knows*[35]

Most research uses a strict definition of learning disability based on IQ measures of 70 or below, or focuses on conditions such as dyslexia with relatively limited reference to other learning difficulties. For the purposes of the review, we will use the Government’s *Valuing people* White Paper[33] definition, which was also used by the Prison Reform Trust’s No One Knows programme of work, which defined learning disability as set out below.

Definition: Learning disability

- **“a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;**
- **a reduced ability to cope independently (impaired social functioning);**
- **which started before adulthood, with a lasting effect on development.”**

Learning difficulties can be even harder to define; the Education Act 1996[34] sets out the following:

“A child has a ‘learning difficulty’ if:

- he has a significantly greater difficulty in learning than the majority of children of his age,
- he has a disability which either prevents or hinders him from making use of educational facilities of a kind generally provided for children of his age in schools within the area of the local education authority…”

Added to this, there is currently no standardised measure used to identify offenders with learning disabilities. Differences in definition and identification mean that the prevalence of learning disabilities and difficulties is very hard to estimate.

Self-reporting of learning disabilities and reports of special schooling have been used by many studies as a quick and straightforward method of screening for learning disabilities; however, self-report measures can produce too many false positives. Special schooling is an inaccurate indicator as, over the last 20 years, there has been a trend to educate children with learning disabilities within mainstream schools. IQ testing is often used as an indicator of the prevalence of learning disabilities; however, this is felt not to meet the full definition, as it does not consider any additional impairment of social functioning.

In respect of the needs of offenders with learning difficulties and learning disabilities, this review has relied heavily on the excellent body of work, *No one knows*,[36] recently completed by the Prison Reform Trust. The No One Knows programme has explored the experiences of people with learning difficulties and disabilities at each key stage of the criminal justice system. I do not intend to duplicate this work, but have referenced key findings and recommendations where appropriate. The No One Knows programme estimates that 20% to 30% of offenders have learning difficulties or learning disabilities that interfere with their ability to cope within the criminal justice system.

In conclusion, I shall use the same remit as the No One Knows programme, which includes learning disabilities and learning difficulties, as referenced on page 19. When I refer to learning disabilities in this report, I am including both learning disabilities and learning difficulties.

“Women have been marginalised within a system largely designed by men for men, for far too long.”

Quote from Baroness Corston from her report on women with particular vulnerabilities in the criminal justice system[37]

Defined groups

Within the general population of offenders, there will be particular groups that will require an individual approach, specific to their particular needs, in order to ensure that equity of services and access to services can be achieved. I recognise that there will be many special groups that might fall into this category. I have not been able to include them all, but set out below three key groups that have emerged from my discussions with stakeholders as requiring particular attention.

Women offenders

As I have touched on earlier, Baroness Jean Corston recently undertook a review of women in the criminal justice system who have particular vulnerabilities. The report made a convincing argument for consideration of services specifically in relation to women, and how the impact of the criminal justice system on women varied from the impact on men.

My review acknowledges the work that Baroness Corston has already undertaken, and the subsequent work programme that is now being taken forward by the Government. Again, my review does not attempt to duplicate this work, but highlights specific areas where a gender-specific approach may be appropriate.

“Mental health problems disproportionately exist for BMEs, especially young black men. By the time they get to secondary care services and prison it is almost too late, so we must look more closely at earlier intervention to break the cycle.”

Melba Wilson, National Director, Delivering Race Equality, National Institute for Mental Health in England, London and South Eastern Stakeholder Event, 24 September 2008

People from black and minority ethnic groups

A recent report by Race for Justice, a Coalition for Equality in the Criminal Justice System[38] states that the most recent figures show that black and minority ethnic (BME) groups account for 26% of the prison population even though they constitute only 9% of the overall population in England and Wales. It also indicates that over-representation of BME groups in prisons and the criminal justice system increases year on year. Similar patterns of disproportionality are evident in areas such as mental health, where admission rates of black people into the mental health system are three or more times higher than those of all other groups.

For both learning disabilities and learning difficulties, precise information about prevalence among BME groups is virtually non-existent.

This is clearly an area that merits further investigation; however, during the course of the review I was considerably hampered by the lack of information available to identify the ethnicity of people with mental health problems or learning disabilities in the criminal justice system. Where I can, I have looked at issues that are specific to this group, but it is evident that there is much more to be done. One of the most compelling figures, taken from the results of the national 'Count me in' census in 2007,[39] is that BME groups are 40% more likely to access mental health services via a criminal justice system gateway. A study by NACRO[40] concluded that the criminal justice system is one of the key pathways by which BME groups enter mental health services, particularly younger black men.

"You get assessed for mental health and drug misuse services separately, you can fall below the thresholds for access to both – although taken together you have high support needs."

Comment from DrugScope Focus Group, 15 October 2008

People with a dual diagnosis

Throughout the course of this review it has become apparent that the issue of dual diagnosis (mental health problems combined with drug and/or alcohol problems) is a vital component of addressing the issue of mental health and criminal justice. In fact, at a workshop hosted for the review by the charity DrugScope, stakeholders sent out a clear message that no approach to diverting offenders with mental health problems from prison and/or the criminal justice system would be effective unless it addressed drug and alcohol misuse.

A recent study looking at prison mental health in-reach services[41] suggested that dual diagnosis should be regarded as the norm, rather than the exception. Another study[42] showed the following:

- 74.5% of users of drug services and 85.5% of users of alcohol services experienced mental health problems; and
- 44% of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels in the past year.

Despite the recognised high prevalence of dual diagnosis among offenders with mental health problems, services are not well organised to meet this need. In fact, services are currently organised in such a way as to positively disadvantage those needing to access services for both mental health and substance misuse/alcohol

problems. Individuals needing both services have to access one service at a time, or even miss out on treatment altogether, as the following extracts from two studies, some six years apart, demonstrate:

- "Lack of co-ordination and collaboration too often results in prisoners falling between the two sets of support and receiving no treatment at all… this is also mirrored in the community, where people with dual diagnosis typically fall between services."[43]
- "Mental health and substance misuse services in prisons need to provide appropriate, flexible care to those dually diagnosed, rather than using dual diagnosis as a reason for exclusion from services as is frequently the case in the community."[44]

This is further compounded for those with a dual diagnosis of mental health and alcohol problems, as there is a current imbalance between resource provision for the treatment of alcohol and illicit drug use, with much greater funding and provision being available for the latter.

Methodology

In undertaking this review I have taken the opportunity to seek contributions from a large number of individuals and organisations through a range of methods, including:

- literature reviews;
- individual meetings with heads of agencies, organisations and professional groups (**Annex C**);
- focus groups with service users and carers;
- visits to service sites across the country to review practice, good or otherwise (**Annex C**);
- a national call for evidence to enable those from the third sector, professional groups and the public to submit their views, culminating in an analytical report (the list of respondents is at **Annex D**);
- a call for evidence to members of both Houses of Parliament; and
- commissioning a preliminary cost/benefit analysis.

Towards the end of the information-gathering process, I held eight regional events to which I invited a wide range of key stakeholders. These events, which attracted over 500 delegates, provided an opportunity to road-test initial findings and to ensure that the report would have resonance with its audience and make a difference to the way people are treated in the criminal justice system. As part of this series of events, I included a visit to Wales to discuss the issues with stakeholders there. I am aware that Wales has devolved arrangements for its health services and so I will not formally report my findings to them. However, I was keen to include their experience in this area, and hope that they will find the issues I have raised of use. A report of the regional stakeholder events is available at www.dh.gov.uk/en/healthcare/offenderhealth/index.htm.

I was supported throughout the review by a multi-stakeholder working group (details at **Annex B**), who agreed on, and supported, the priority work streams that needed more in-depth exploration. In addition, I took soundings from members of our review reference group (details at **Annex A**), who provided a considerable range of additional experience and expertise.

Where appropriate, I have illustrated some of the key issues with case studies of individual experiences and examples of practice, some of which are taken from visits undertaken by the review. A full list of review visits and meetings is attached at **Annex C**.

I hope this report adequately reflects all that valuable information and input, and although I have picked out what I feel are the key issues, I accept that with such a broad remit and in the allotted time it is not possible to be exhaustive.

Structure of the report

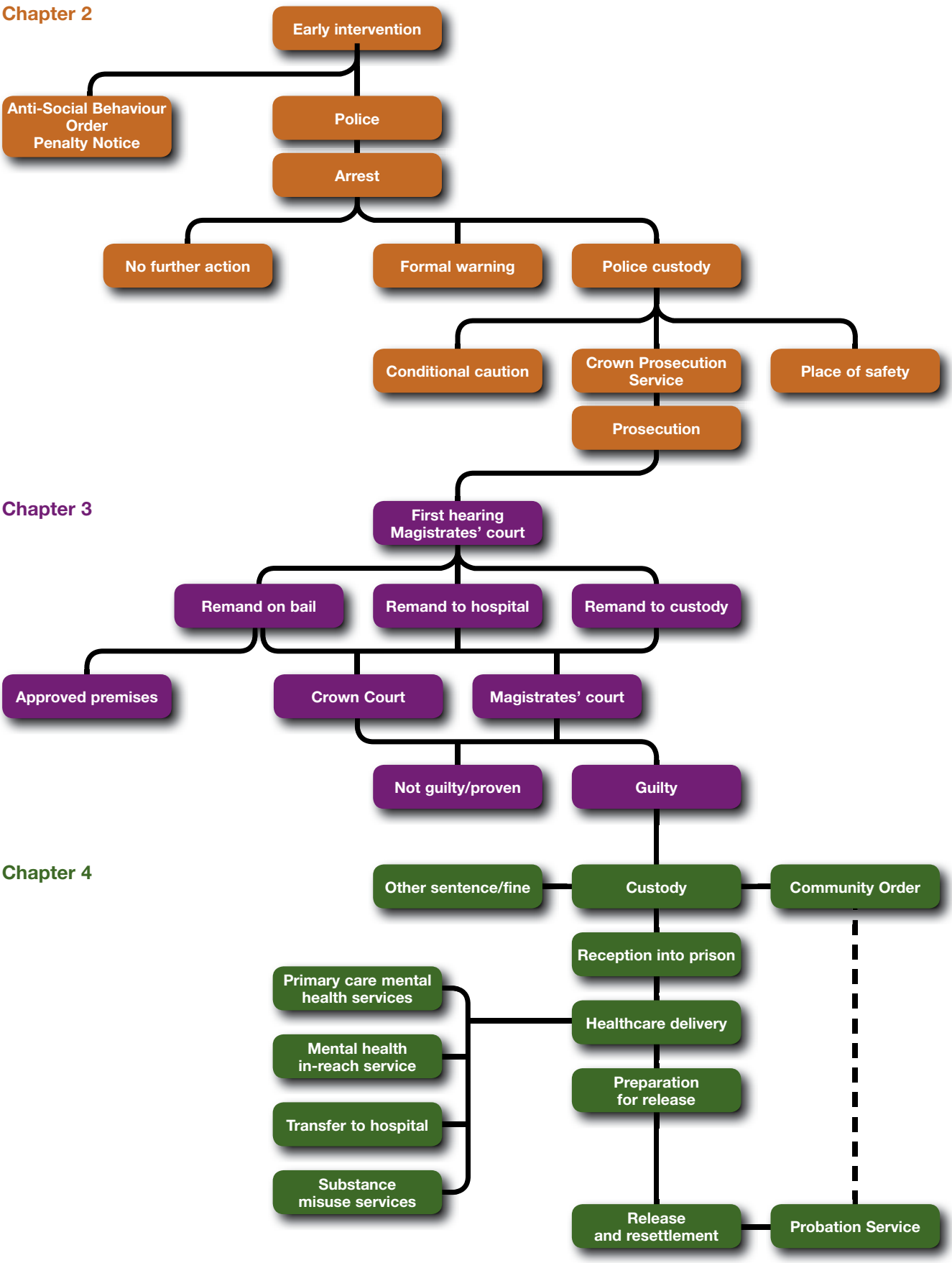
Often referred to as the 'offender pathway', the criminal justice system can be broken down into a series of stages that relate to particular activity focused on an individual from offence to release. For the purposes of structuring this report, I have used this pathway as a central 'backbone' to which interventions, services and structures relate. In reality, however, the pathway is far more complex.

Individuals may enter or leave the pathway at various points; they may serve their sentences in more than one part of the country; and they may have services provided by many different organisations. Even within the criminal justice system, it is not always possible to clearly define where one service ends and another starts. There are overlapping responsibilities, which can lead to either duplication or confusion over who takes the lead.

To complicate this further, the majority of organisations that support offenders and their families do not span the whole range of the offender pathway. For example, at most points of the system, offenders access mainstream NHS health services. However, the NHS does not currently provide services delivered to people in police custody. As the situation stands, most of the 43 police forces in England and Wales commission their own health services in over 600 custody suites from a range of different suppliers. In addition to this, the health service that currently provides court liaison services in an area might not also provide services in the local prison.

The key themes that I want to resonate throughout the report are: early assessment, continuity of care and support for the offender; and, for the organisations, working in partnership and better information flows. On that basis, it seemed sensible to use the pathway as a common reference point for the review. Throughout this report, I will examine how services relate to the pathway and recommend changes or improvements that can be made. A much-simplified diagram of the pathway and the points I will discuss in the report is presented overleaf.

Simplified diagram of the offender pathway



I have structured the chapters in my report so they relate directly to the activities supporting the pathway. This is reflected below.

Chapter 2 – Early intervention, arrest and prosecution

This chapter initially focuses on the period prior to an individual coming into contact with the criminal justice system, touching on prevention and early intervention. It identifies the crucial role policing has in supporting effective interventions at this early stage of the criminal justice pathway, while providing valuable information to the court and sentence stages. I look at the time in police custody following arrest and the role of the Crown Prosecution Service.

Chapter 3 – The court process

This chapter explores court proceedings, the use of remand (including approved premises), information and reports to the court and the use of specialist courts. Within this chapter I look at the implications of providing more comprehensive information to magistrates and judges and how this may influence decisions and outcomes.

Chapter 4 – Prison, community sentences and resettlement

This chapter looks at the options for custodial and community sentences available to the judiciary, the impact of these options on individuals with mental health or learning disabilities, and what services are necessary to support them. It will also focus, once again, on the importance of information to support decision-making. This is of particular relevance as the chapter explores resettlement and how services for individuals on release from custody may be improved.

Chapter 5 – Delivering change through partnership

Finally, my report ends with a chapter dedicated to the delivery of change. It sets out my recommendations for service improvement, leadership and governance arrangements that will support change.

Annexes

As with many complex systems, the language used and the acronyms routinely employed can be confusing; to that end I have added a glossary and list of acronyms as Annexes E and F.

References

1 Shaw J et al, 2008, *A national evaluation of prison mental health in-reach services*

2 Durcan G, 2008, *From the inside: Experiences of prison mental health care*

3 Brooker C and Ullmann B, 2008, *Out of sight, out of mind*

4 Singleton N et al, 1998, *Psychiatric morbidity among prisoners in England and Wales*

5 Ministry of Justice, 2007, *Lord Carter's review of prisons: Securing the future: Proposals for the efficient and sustainable use of custody in England and Wales*

6 www.hmprisonservice.gov.uk/assets/documents/100044D4Monthly_Bulletin_jan09.doc

7 www.icmresearch.co.uk/pdfs/2006_january_smart_justice_crime_survey.pdf

8 www.thewi.org.uk/standard.aspx?id=9384

9 Home Office, 1990, *Provision for mentally disordered offenders*. Home Office Circular 66/90

10 Department of Health and Home Office, 1992, *Review of health and social services for mentally disordered offenders and others requiring similar services (the Reed Report)*

11 HM Inspectorate of Prisons, 1996, *Patient or prisoner?*

12 Department of Health, 1999, *The future organisation of prison healthcare*

13 HM Inspectorate of Prisons, 2007, *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs*

14 Home Office, 2007, *The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*

15 HM Government, 2006, *A five year strategy for protecting the public and reducing re-offending*

16 Social Exclusion Unit, 2002, *Reducing re-offending by ex-prisoners*

17 Social Exclusion Unit, 2004, *Mental health and social exclusion*

18 Department of Health, 2006, *Our health, our care, our say: A new direction for community services*

19 Department of Health, 2004, *Choosing health: Making healthy choices easier*

20 Lord Darzi, 2008, *High quality care for all: NHS Next Stage Review – Final report*

21 www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en_1

22 Social Exclusion Unit, 2002, *Reducing re-offending by ex-prisoners*

23 Department of Health, 2009, *The NHS in England: The operating framework for 2009/10*, Annex D, The standard NHS contract for mental health and learning disability

24 Department of Health, 1999, *National Service Framework for Mental Health: Modern standards and service models*

25 www.southeast.csip.org.uk/silo/files/new-horizons-key-emerging-themes.pdf

26 The Future Vision Coalition, 2008, *A new vision for mental health: Discussion paper*

27 www.hm-treasury.gov.uk/spend_index.htm

28 www.nacro.org.uk/mhu/about/faqs.htm

29 National Policing Improvement Agency, 2008, *Review of literature on mentally disordered offenders*

30 www.nacro.org.uk/mhu/about/faqs.htm

31 Health Advisory Service, 1995, *Together we stand: The commissioning, role and management of child and adolescent mental health services*

32 www.yjb.gov.uk/en-gb/practitioners/CourtsAndOrders

33 Department of Health, 2001, *Valuing people: A new strategy for learning disability for the 21st century*

34 www.opsi.gov.uk/ACTS/acts1996/ukpga_19960056_en_1

35 Loucks N, 2007, *No one knows: Offenders with learning difficulties and learning disabilities – review of prevalence and associated needs*

36 Loucks N, 2007, *No one knows: Offenders with learning difficulties and learning disabilities – review of prevalence and associated needs*

37 Home Office, 2007, *The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*

38 Race for Justice, 2008, *Less equal than others: Ethnic minorities and the criminal justice system*

39 Healthcare Commission, 2007, *Count me in: National census of inpatients in mental health hospitals and facilities in England and Wales*

40 NACRO, 1990, *Black people, mental health and the courts*

41 Shaw J et al, 2008, *A national evaluation of prison mental health in-reach services*

42 Weaver T et al, 2003, Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *The British Journal of Psychiatry*, Vol 183, pp 304–313

43 Social Exclusion Unit, 2002, *Reducing re-offending by ex-prisoners*

44 Shaw J et al, 2008, *A national evaluation of prison mental health in-reach services*

2

Early intervention, arrest and prosecution

This chapter initially focuses on the period prior to an individual coming into contact with the criminal justice system, touching on prevention and early intervention.

It identifies the crucial role policing has in supporting effective interventions at this early stage of the criminal justice pathway, while providing valuable information for the courts and sentencing stages. I look at the time spent in police custody following arrest and the role of the Crown Prosecution Service.

Introduction

At the beginning of this review, it became clear that interventions as early as possible in the criminal justice system would provide the best opportunities for improving how people with mental health problems or learning disabilities are managed. The police are the obvious first point of contact for most people, with the potential for effective interventions on arrest and through police custody to prosecution. This chapter will examine these interventions in more detail.

However, as I examined the role of the police, stakeholders impressed upon me the importance of looking even further 'upstream'; firstly towards the role of neighbourhood policing in working with people with mental health problems and learning disabilities within their communities, and secondly more generally, to ways of preventing such people becoming involved in crime in the first place. Prevention and early intervention to avoid vulnerable children and adults entering the criminal justice system should clearly be the overriding objective; however, it was obvious that within the confines of this review it would not be possible to undertake as thorough an examination of all the issues as this subject clearly deserves. Instead, the early part of this chapter touches on some of the key initiatives that I believe provide the best opportunities for prevention and early intervention.

During the course of this chapter I will introduce, for the first time, liaison and diversion services. These are an important component of services for offenders with mental health problems or learning disabilities, and so form a constant thread running through all the chapters of my report. Chapter 3 sets out the background and detail of these services, and conclusions and recommendations in this regard are set out in Chapter 5.

"The failure to identify need, and provide support, at an early stage is the reason why some people offend in the first place."

Quote from HM Inspector of Prisons, *The mental health of prisoners*[46]

Early intervention for children and young people

There are a number of key policy documents that have been issued over the past few years which recognise the particular importance of early intervention for children and young people. The Government's recently published *Youth Crime Action Plan*[45] puts a welcome emphasis on the importance of early intervention by recognising that it is the minority of young people who commit crime, and that they are often disadvantaged by poor or indifferent parenting and display a range of difficulties (both of a personal and family nature) which means that they can often be identified early.

The 2005 Youth Justice Board report *Risk and protective factors*[47] identifies a number of key areas within a young person's life that have been shown to have both a positive and negative direct effect on future mental health and offending. The report stresses the important influences of the family, the school, the community in which they live and their own personal characteristics.

The recently published *Transforming community services and World Class Commissioning*[48] underlined the fact that society has a duty to promote the welfare of children and communities. The report went on to stress that this may only be achieved by agencies, including voluntary, statutory and independent sector, working in partnership to ensure that children and their families are provided with the most appropriate and highest quality of service. The effectiveness of prevention and early intervention is also clearly dependent on the support available from a wide range of universal, targeted or specialist children's services including Child and Adolescent Mental Health Services (CAMHS).

A particular focus of this better co-ordinated approach is for services to be developed around the whole family. For example, Sure Start,[49] which includes the Children's Centre Programme, has the welcome ambition for such centres to be available in every community by 2010. This should lead to effective child and family-centred multi-agency working. In addition, there are a range of new initiatives that are being expanded throughout the country following positive results from pilot projects. These include:

- **Family Nurse Partnerships (FNP)**[50]
  This project is testing a model of intensive, nurse-led home visiting for vulnerable, first-time young parents. FNP nurses visit parents from early pregnancy until the child is 2 years old, building a close, supportive relationship with the whole family and guiding mothers to adopt healthier lifestyles, improving their parenting skills and becoming self-sufficient.
- **Family Intervention Projects (FIPs)**[51]
  These projects aim to reduce anti-social behaviour in the most challenging and anti-social families. They were set up across the country in 2006, building on pioneering work by NCH (now Action for Children) and others. FIPs use an 'assertive' and 'persistent' style of working to challenge and support families to address the root causes of their anti-social behaviour.
- **Parenting Early Intervention Pathfinders**[52]
  These aim to increase support for parents of children and young people (8–13 years old) at risk of negative outcomes, particularly anti-social behaviour, and ensure that they receive an earlier, more effective, co-ordinated package of support.
- **Multi-systemic Therapy (MST)**[53]
  MST is a family and community-based treatment programme for young people with complex clinical, social and educational problems such as violent behaviour, drug abuse and school expulsion. MST therapists work in close partnership with the young person's family and community to strengthen protective factors known to reduce the risk of future offending and anti-social behaviour.

> **"Improving mental health outcomes for young offenders is only achievable with the support of a range of services that address the risk-factors underlying their reasons for offending."**

Quote from review submission from NCH, 28 February 2008

It was made clear to me, through discussions with stakeholders, that poor development and social exclusion in early years can lead to limited coping abilities, anti-social behaviour and potential contact with the criminal justice system. These initiatives provide an excellent opportunity to address these issues at a very early stage and would clearly benefit this population if there were a stronger focus on mental health issues included in them.

After the family, the education service from early years provision up to higher education is crucial for the identification of emotional or mental health problems, learning disabilities or speech, language and communication issues. For example, exclusions, absenteeism, achievement at school and the existence of special educational needs (SEN) can all be linked to the onset and persistence of a mental disorder.[54]

This issue is recognised by the Government in the *Children's Plan*[55] which was published in 2007, and set out a duty on schools to promote well-being. New incentives and specific programmes are currently being rolled out, including:

- National Healthy Schools Programme[56]
- Social and Emotional Aspects of Learning (SEAL)[57]
- Extended Schools provision[58]
- behaviour and attendance programmes[59]
- Quality Improvement Evaluation for School Nurses and Teachers (QUEST).[60]

These initiatives are valuable both in developing stable foundations for individuals at risk of developing mental ill health in the future, and also in training teachers and other practitioners to recognise and address early warning signs.

Following the publication of *Every Child Matters*[61] in 2003 and subsequent legislation, local authorities have established children's services departments to try to ensure a more effective and co-ordinated approach to meeting the range of needs of children including well-being, social care and education. Further, Children's Trusts, although at an early stage of facilitating co-ordinated care for vulnerable young people, will be of central importance in ensuring the provision of more effective responses to support the mental health needs of children and young people, and in ensuring early identification and intervention for people with learning difficulties or learning disabilities.

More generally, both for children and adults, GPs are often the first point of contact for someone suffering from mental health problems or learning disabilities. NHS primary care practices are bringing more and more services together including GPs, nurses, health visitors and midwives, and the recent review by Lord Darzi[62] provides further opportunity to both recognise and build on previous good examples of service provision to develop a wide range of services that will support our target population at primary care level.

"The fact that the vast majority have been excluded from school means that they are all known to services and more must be done at an earlier stage to identify them and intervene."

Professor Sir Al Aynsley-Green, Children's Commissioner for England, 19 February 2008

"Staff in the education system can be key to early intervention, and all people who work with young people need a strong understanding of mental illness."

Comment from the Rethink Service User Focus Groups, 11 November 2008

However, a number of studies in 2000[63,64] and 2003[65] found that GPs did not consistently recognise the signs of mental health problems, particularly lower level problems that are likely to be more responsive to early intervention. The training of all primary care staff, in particular GPs, in mental health and learning disability awareness will be essential if the opportunity is not lost at this early point of contact for the referring of children or adults into appropriate specialist services.

Recommendation

- **All staff in schools and primary healthcare, including GPs, should have mental health and learning disability awareness training in order to identify individuals (children and young people in particular) needing help and refer them to specialist services.**

Youth Offending Teams

Children and young people can come into contact with the Youth Justice System when they are identified as being at risk of offending as well as when they have committed offences. Youth Offending Teams (YOTs) play a key role in assessing young people, providing preventive programmes for those identified as being at risk, supervision and court-based services. A YOT comprises a multi-disciplinary team of professionals; local authority social services and education departments; the police, probation service and health authorities, and other agencies, such as housing, youth and community departments.

There are a range of preventive initiatives provided through YOTs aimed at both preventing offending and appropriately managing young people who do offend. Such initiatives include Youth Inclusion Programmes, Youth Inclusion and Support Panels, Mentors, Safer Schools Partnerships, Parenting Contracts/Orders, Acceptable Behaviour Contracts and Positive Futures. They have a particular relevance for this review as they support mental health promotion, provide an opportunity for specialists to access and assess people at an early stage, and promote appropriate coping skills in parents and children.

The recent review of CAMHS[66] highlighted the findings of a 2006 inspection report[67] in that over 30% of YOTs did not have a mental health worker even though 40% of the children and young people they work with have mental health needs. Consequently, given the high level of need, the report recommended that all YOTs should have a mental health worker. More positively, the inspection found that just over 80% of health workers reported good access to CAMHS, although 16- and 17-year-olds were particularly disadvantaged by the gap in services for their age group.

While I recognise the value of the close collaboration between YOTs and children's services, I believe that YOTs have a distinct and separate role to play in the management of the young offender population.

Recommendation

- **The membership of all Youth Offending Teams must include a suitably qualified mental health worker who is responsible for making appropriate referrals to services.**

As discussed in Chapter 1 of this report, I have only been able to touch on some of the issues that are particular to children and young people with mental health or learning disabilities who are offenders or at risk of offending. An in-depth examination of the issues, I believe, requires a specific focus that I have not been able to incorporate into such a wide-ranging review. I firmly believe that this is one of the areas that, in the longer term, provides the best opportunity for diversion in its broadest sense and undertaking a specific piece of work about this population will be vital in complementing the broader issues examined in my review.

Recommendation

- **The Government should undertake a review to examine the potential for early intervention and diversion for children and young people with mental health problems or learning disabilities who have offended or are at risk of offending, with the aim of bringing forward appropriate recommendations which are consistent with this wider review.**

Police

Introduction

In most cases, the police are the first point of contact with the criminal justice system and there is an early opportunity through police intervention and liaison to engage services and potentially avoid future problems. I was surprised to discover that the police stage is currently the least developed in the offender pathway in terms of engagement with health and social services, as intervention generally occurs further along the pathway at the court and sentence stages.

Therefore, as indicated, this point in the offender pathway provides the greatest opportunity to effect change. This includes improving access to services for offenders and potential offenders, improving safety for individuals and the public, supporting the police to fulfil their responsibilities and providing valuable information to agencies at the later stages of the criminal justice system.

Neighbourhood policing

Neighbourhood policing presents a significant opportunity for police to work proactively in local communities with local agencies to help to identify people with mental health problems, in particular those at risk of offending or re-offending.

The four key aims of the neighbourhood policing model are to:

- provide visible and accessible police in every ward;
- enable local people to influence policing priorities in their area;
- facilitate interventions where joint action between communities and partners can solve problems and harness everyone's strengths; and
- provide sustainable solutions to problems which will be evaluated by the community.

Further, Safer Neighbourhood Teams, comprising the police, community support officers, special constables and local authority neighbourhood wardens/ambassadors, have been established specifically to work closely with local communities and services to find long-term solutions to locally identified problems. Safer Neighbourhood Teams are dedicated to the needs of each individual neighbourhood, with the policing priorities for that area decided in partnership with local stakeholders including the public, Crime and Disorder Reduction Partnerships (CDRPs), local authorities and other local organisations. Safer Neighbourhood Teams would seem to be the ideal forum for looking at mental health and learning disability issues, and the early identification of people at risk of offending, particularly utilising the role of the community support officer as the 'eyes and ears' of the police in local areas.

However, the issue of training for staff is key here. Although I did come across good practice in individual forces, for example in Westminster where teams have a four-hour training session on mental health which includes input from local statutory services and service users, this is not common.

Practice example

Islington Neighbourhood Link worker pilot scheme

Revolving Doors Agency link workers have been working with the Metropolitan Police's Safer Neighbourhood Teams in Islington in order to support people with unmet mental health needs who are involved in low-level offending or anti-social behaviour. The project aims to prevent people becoming caught in an entrenched cycle of crisis, crime and mental illness.

Another good example of where the police and health services are working better together is the Diamond District Initiative under development in some London boroughs, where local authorities and the Metropolitan Police are jointly commissioning community police teams with attached mental health and social care support staff. In addition to these formal arrangements, the police have also initiated projects themselves, such as the Rainer Rapid Action Project.

Practice example

Rainer Rapid Action Project

Essex police are working in conjunction with Rainer (a national charity for under-supported young people). Rainer workers are based at police stations in the county and take referrals from police officers about children and young people they believe to be at risk. The worker completes checks with relevant agencies and makes a home visit within 24 hours. Assessment and intervention is carried out in partnership with the family and referrals to specialist services are made if necessary.

So there are pockets of good work under way, but this has yet to be consistently introduced across England and Wales.

Recommendations

- **Local Safer Neighbourhood Teams should play a key role in identifying and supporting people in the community with mental health problems or learning disabilities who may be involved in low-level offending or anti-social behaviour by establishing local contacts and partnerships and developing referral pathways.**
- **Community support officers and police officers should link with local mental health services to develop joint training packages for mental health awareness and learning disability issues.**

Opportunities for diversion prior to arrest

Before an arrest is made or deemed appropriate, there are several options for a police officer while at street level:

- Use discretion and take no further action.
- Impose a formal warning.
- When encountering a person who may appear to have a mental health problem, in the event of a petty crime, such as shoplifting or minor damage, the police officer may still record the crime but choose to take no further action.

'No further action' in this scenario should mean no further criminal justice action, but officers should signpost to or liaise with appropriate local health and social care services where a mental health or learning disability problem has been identified. This is clearly dependent on an officer's knowledge of local services, but anecdotal evidence from stakeholders suggests that in many cases this knowledge is far from comprehensive.

Practice example

Cheshire police

Cheshire Constabulary follows a procedure whereby, if a petty offence has been committed but mental health problems seem apparent, officers prioritise the care and treatment of the individual.

The officer has the option of inviting the person with mental health problems to the police station at a later date for a formal interview. During the interview, the individual is not placed under arrest and can leave at any time, although the presence of an Appropriate Adult is required. If an offence is admitted and the individual is entitled to a caution, then this course of action is followed, otherwise a report is sent to the Crown Prosecution Service (CPS) for their consideration.

Other forms of formal diversion include fixed penalties for public order offences or petty theft. These involve on-the-spot fines that the individual has up to 28 days to pay or face arrest for non-payment.

Clearly use of any of these options would be limited by an individual officer's ability to recognise a mental health problem or learning disability. Despite the potential high level of contact between the police and people with mental health problems, the police currently receive very little specific training in mental health awareness[68] and I recommend again that these issues be addressed. I refer to further recommendations at the end of this chapter.

Penalty Notices and Anti-Social Behaviour Orders

The majority of Penalty Notices for Disorder (PNDs) are issued for alcohol abuse, exhibiting distress or alarming behaviour, any one of which can also be indicative of mental health crises. If these Penalty Notices remain unpaid, the amount can be increased and converted to a fine. If the fine is not paid, this can lead to enforcement through the court. Anti-Social Behaviour Orders (ASBOs) are aimed at targeting behaviour by an individual that "caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as himself". The behaviour that prompts the issue of an ASBO can often be indicative of a mental health problem and, in addition, the conditions of an ASBO can be difficult to keep for people with mental health or learning disability problems.

Participants in the review have told me that neighbourhood policing teams are being encouraged to use ASBOs and PNDs, and they can have the perverse effect of accelerating vulnerable people into the criminal justice system, rather than to appropriate services, if they are not complied with.

Although guidance has been issued to sentencers urging more careful consideration when proposing ASBOs for people with mental health problems, a Home Office review of ASBOs found that for 60% of those issued with an ASBO there was a mitigating factor such as mental distress, addiction or learning difficulties.[69]

ASBOs can also be equally problematic for people with learning disabilities. Research into ASBOs found, for example, that people with learning disabilities or autistic spectrum disorders often did not understand the terms of the order or why it was imposed. This makes compliance with such community-based penalties highly unlikely, which in turn increases the likelihood of eventual custody.[70]

Recommendation

- **Information on an individual's mental health or learning disability needs should be obtained prior to an Anti-Social Behaviour Order or Penalty Notice for Disorder being issued, or for the pre-sentence report if these penalties are breached.**

"The use of ASBOs against children and young people can serve to speed up their route into the criminal justice system."

Extract from Review Submission from Coram, 26th Feb 2008

Arrest and police custody

Having looked at the options for diverting an individual away from the criminal justice system prior to arrest, I will now turn to the period post-arrest. This section looks at the role of the police from arrest onwards, and the contribution they make to ensuring fair, effective and appropriate interventions for individuals with mental health problems or learning disabilities with whom they come into contact.

Key facts

- **1,482,200** people were arrested for recorded crime (notifiable offences) in 2006/07.[71]
- Between **22%** and **25%** of detainees are reported to be 'drunk' on arrival at police stations.[72]
- In a study of arrestees, an average **69%** gave positive urine samples for at least one drug; **36%** tested positive for two or more drugs; and **38%** tested positive for opiates and/or cocaine.[73]
- The estimated number of mentally disordered suspects passing through police stations varies between **2%** and **20%**.[74,75]
- There are **43** separate police forces across England and Wales with **603** custody suites – all with potentially different approaches.

Police custody

The most common route to police custody is through arrest on suspicion of committing a crime. Although 1,482,200 people were arrested for recorded crime (notifiable offences) in 2006/07[76] there is no clear breakdown of how many of those were suffering from mental health problems. This is due, in part, to the current difficulties in identifying those who have mental health or learning disability needs.

I have already stated that training for police officers on mental health awareness is inadequate. In addition, identification at this point is made particularly hard by the high numbers of detainees that are reported to be 'drunk' on arrival at police stations and the common use of drugs. It is widely accepted that drugs and alcohol can often mask the presence of mental health issues and can make identification even more problematic.

Estimates of the prevalence of learning disabilities in police custody vary considerably, from 0.5% to 9% of all cases. The reason for such a broad differential is generally down to the fact that there is no formal testing of learning disabilities and that most studies have used IQ or self-reporting only, which are known to be problematic.

Screening and risk assessment

When a person is brought into police custody, the custody officer becomes responsible for their detention and opens a custody record that will include all available information concerning risk factors. The detainee is asked a series of direct questions which assist in the assessment of that risk, including questions on health.

In addition to this, there will also be checks on the Police National Computer and local police systems for any warning markers about risk, although these will not routinely record any known health problems.

As well as assessing risk, the legal responsibility for identifying mental health need in police custody rests solely with the custody officer. The custody officer is also responsible for determining whether a detainee is fit for detention and interview.

There are widespread concerns among stakeholders about the current assessment of detainees. Significantly, I have been told on a number of occasions that the perception is that if a person is detained in custody, they are in 'a safe place' and as such there is a delay in medical teams responding to assess a patient. In addition, screening services in police stations need to be more consistent, and include better availability of information about a detainee's previous contact with services. This is not to say that the police should be expected to undertake complete assessments of an individual's health needs, but it is important that they are able to assess risk. Assessment of risk requires different agencies to bring together the information they may have on an individual and it is possible that these assessments are currently being made without the benefit of comprehensive information on an individual's health.

If a mental health need is identified, the challenge for the police is to decide whether or not a criminal justice outcome should be pursued, and if diversion to health and social services is more appropriate. It is clear that this decision cannot be made without a fully informed risk assessment. One of the key considerations when deciding whether to prosecute or divert is public protection and a risk assessment based on incomplete information will not be accurate and could lead to tragic consequences.

Some of the reasons why assessments are not currently as accurate as they could be are set out below:

- A current reliance on self-reporting. The custody suite environment itself does not encourage people to disclose their mental health problems. In addition, there is still a stigma related to mental health problems and there may be a fear of discriminatory treatment. Previous negative experiences with the police would also contribute to a reticence to disclose information.
- There is no standard mental health assessment. Each force develops its own and they vary considerably in terms of how effectively they identify mental health needs.
- A lack of training for the police in mental health awareness. There is no national standard for police training in mental health, although there are examples of good practice where local forces have joint training programmes with local health service providers.
- The police generally have little recourse to advice or guidance on mental health issues.
- High numbers of detainees come into custody under the influence of alcohol or drugs, which can often mask the presence of mental health problems thereby making identification more difficult.

The following case demonstrates that the purpose of accurate assessment is not just to ensure that diversion options can be considered, but also to make sure that an individual is fit for interview and to determine if the presence of an Appropriate Adult is required. The Rethink Service User Focus Groups that this young woman was part of (on 11 November 2008) were unanimous in their view that everyone should be assessed by a trained individual prior to interview to ensure that anyone who was too unwell for interview would not suffer a similar experience.

Case study

Police interviewed a woman in her mid-20s with schizophrenia over an incident at the hospital she was staying in. She was suffering from a psychotic episode and experiencing delusions that she was going to be killed. Due to her statement being taken while she was delusional, she agreed to statements that led to a more serious charge being made.

Quote from Rethink Service User Focus Groups, 11 November 2008

Preliminary consideration of improved early assessment

The evidence clearly points towards a need to further explore the potential for placing responsibility for better identification and assessment of mental health problems or learning disabilities at this early stage of the offender pathway. As part of this review, I commissioned a report[77] to look at the cost/benefit analysis of three key interventions for this population at different stages of the criminal justice system. The first of those interventions was the screening and assessment process at the police stage, and the report explored how it could be improved, and what the potential cost of improvement might be.

Due to the paucity of data, which will continue to be a common theme throughout the report, the numbers are approximate at this stage. However, what they are able to do is provide a useful indication of what possible costs and outcomes might be, and whether implementation is feasible.

The report explored the costs and benefits of effectively identifying and treating individuals who have a mental health disorder on arrest and, where appropriate, diverting them out of the criminal justice system and into mental health services. It examined the impact of a specific example, which was of a triage process involving a short interview with arrestees who had either exhibited clear-cut symptoms of a mental health problem or had been identified as representing a significant risk through the standard Association of Chief Police Officers (ACPO) assessment.[78] This interview would be accompanied by a search to identify the presence of a Care Programme Approach record, which would signify previous engagement with mental health services. This would then be followed by a further assessment undertaken by appropriately trained members of staff such as a community psychiatric nurses, as is already the arrangement in some liaison and diversion schemes.

> **“The needs of the service user who is in the criminal justice system will be best served through the earliest possible diagnosis.”**

Extract from submission to the review from Commander Rod Jarman, then ACPO Mental Health and Disability Lead, 28 February 2008

The qualitative benefits of this example were identified as:

- swift and effective identification and assessment of mental health needs after arrest, with rapid access to treatment for people with mental health problems;
- ensuring that arrestees with serious mental health problems can be dealt with in an appropriate environment earlier, rather than spending time on remand before their condition is diagnosed at court;
- provision of information for court services about an individual's mental health disorder, so that judiciary staff understand the impact that the individual's disorder might have on the court process; and
- if an individual's mental health problem is the primary cause of their committing low-level crime, then facilitating their access to treatment might help to avoid subsequent re-arrest.

I also examine in the next chapter the impact of early assessment on the court process, remand and sentencing decisions, and the cost implications related to subsequent reports that might be commissioned by the court. This preliminary work has also guided my more detailed views set out in Chapter 5.

The cost/benefit analysis summary from the report commissioned by the review from Tribal is set out below.

Cost/benefit analysis – screening and assessment

Our early findings indicate that if these more comprehensive triage and assessment processes were in place at police stations, it could save up to **4,493** remand days, equating to **12** full time prison places and (based on an annual cost of £23,585 per prison place) nearly **£300,000** in annual savings.

There will also be wider implications still on the potential impact on reducing recidivism. To implement an effective triage and assessment service, our analysis indicates that it would cost between **£3m** and **£9m** nationally across all 43 police forces (depending on the level of assessment).

Individuals with serious mental health problems that have been identified by this triage process may require support from more specialist mental health services, such as secure accommodation; however, it is possible that these individuals, once reaching an acute stage in their illness, would have presented to such services at some point in any event. An early identification of their mental health problems and early intervention in more appropriate settings would improve their chances of an early resolution to their difficulties.

Although the financial impact of these measures has been difficult to quantify, due both to the limited data and the confines of this review, what is clear is that costs of implementing effective triage and assessment services across the police service may not be prohibitive, and may result in a reduction in required prison places (due to an overall reduction in the demand for remand places). These findings suggest that more in-depth calculation of the benefits of this approach is required, as well as some similar work around early identification of learning disabilities.

Tribal Report – ***Financial support to the Bradley review***, November 2008

Further opportunities for diversion from police custody

Transfer to hospital under the Mental Health Act 2007

Where custody staff have identified mental health need, a Forensic Medical Examiner (FME), whose role is considered later in this chapter, may be asked by police to undertake further assessment. FME attendance may instigate an immediate assessment under the Mental Health Act and, where appropriate, the individual can be diverted out of the criminal justice system into a psychiatric setting.

Conditional cautions

The Code for Crown Prosecutors[79] states that alternatives to prosecution should be considered when deciding whether a case should be prosecuted. Alternatives to prosecution for adult offenders include a simple caution or conditional caution. The National Standards for Conditional Cautioning require that certain conditions be met before a conditional caution may be administered.

However, a caution or conditional caution will not be appropriate if there is any doubt about the reliability of admissions made or if the individual's level of understanding prevents them from understanding the significance of the caution and from giving informed consent to it. Prosecutors are advised not to assume that all mentally disordered offenders are ineligible for cautioning or conditional cautioning, but there is no definition of or restriction on the particular form of mental condition or disorder that may make an admission unreliable.

Recommendation

- **The Crown Prosecution Service should review the use of conditional cautions for individuals with mental health problems or learning disabilities and issue guidance to advise relevant agencies.**

Access to an Appropriate Adult

Where there is any doubt about a person's mental state or capacity, the police custody officer has a duty to request the attendance of a responsible adult, who is known as an Appropriate Adult. The role of the Appropriate Adult was created in the Police and Criminal Evidence Act 1984 (PACE)[80] with the intention of further safeguarding the rights and welfare of young people and vulnerable adults in custody.

Studies into the use of Appropriate Adults have concluded that provision of the Appropriate Adult is very inconsistent. Firstly, the person's needs have to be identified, which we have already seen are often missed. Even when a need for an Appropriate Adult is identified there is currently a shortage of individuals who can perform the role effectively.

A study undertaken in 1993[81] used a range of psychological assessments and questionnaires on 163 detainees at two London police stations. On the basis of the researchers' clinical judgements, prevalence rates for mental illness were 7%, 3% for learning disability and 5% for language problems, therefore suggesting a need for an Appropriate Adult in 15% of cases; in contrast, the police called an Appropriate Adult in just 4% of cases.

A more recent study[82] stated that, in practice, the Appropriate Adult is rarely called. Research showed that after an analysis of over 21,000 custody records in four police stations in cities in the East Midlands area of England, the Appropriate Adult was used in only 38 instances (or 0.016%). Based on the lowest or most conservative extract of the numbers of mental illness in the population, there should have been about 400 (1.9%), and on the more generous estimate about 3,000 (14%).[83]

Case study

A service user told how when police arrested him they knew that he self-harmed and enforced strict suicide precautions upon his arrest. However, despite his vulnerability they failed to contact an Appropriate Adult to offer him the support he needed.

Quote from Rethink Service User Focus Groups, 11 November 2008

The role of the Appropriate Adult is extremely important in protecting young people and vulnerable adults; however, there seem to be difficulties in getting timely access to this service. In some cases the delay may be sufficient for suspects to forego this service rather than be detained for a longer period in custody. When an Appropriate Adult has been available, concerns have been raised about the lack of consistency in the role. Some schemes are heavily reliant on volunteers, and support for those volunteers is variable.

The current revision of PACE guidelines provides an opportunity to add some clarity to this role and the recent No One Knows programme of work sets out some very clear recommendations as to how this might be achieved for people with learning disabilities.

Recommendations

- **A review of the role of Appropriate Adults in police stations should be undertaken and should aim to improve the consistency, availability and expertise of this role.**
- **Appropriate Adults should receive training to ensure the most effective support for individuals with mental health problems or learning disabilities.**

It is clear that Appropriate Adults would benefit from access to mental health and learning disability specialists within the police environment, such as from liaison and diversion services. This access would provide advice on working with individuals with mental health or learning disabilities, training relating to awareness of the condition and links to organisations outside the police custody suite that may help to enhance their role. This is discussed further in Chapter 5.

Solicitors

Solicitors clearly play a crucial role in supporting individuals as they move through the criminal justice system, with the potential to advise and influence important decisions made by their clients. As part of my review, I commissioned the mental health charity Rethink to host some focus groups for service users and carers who had experience of the criminal justice system. One of the key concerns raised by the group was in relation to the knowledge and experience that solicitors and, in particular, duty solicitors generally have of mental health issues and the impact that it had on their cases. There was a considerable difference between the cases that were handled by a specialist mental health solicitor and those that were not. The key issues raised included the following:

- Where used, specialist mental health solicitors had been a great help for their case.
- None of the duty solicitors that the group had experience of had any knowledge of or training in mental illness.
- Individuals without access to a specialist mental health solicitor had not been given information on liaison and diversion services.

A source of information and advice on mental health issues would be of benefit to solicitors and their clients, like those available in police custody suites where liaison and diversion services are provided. Such a resource would be able to provide information and advice for a wide range of professionals working with offenders at this stage. I make a recommendation to this effect at the end of this chapter.

Police responsibilities under the Mental Health Act 2007

Meetings and discussions with stakeholders made it clear to me that it would be particularly important to look at the statutory responsibilities of the police under the Mental Health Act. Although people who come into contact with the police under Sections 135 and 136 of the Act may not fall into the category of ‘offenders’, this interaction represents an important aspect of the police/health interface and I feel it is relevant to address it within the remit of this review. One of the key issues here is the appropriateness and importance of the ‘place of safety’ for individuals who it is deemed necessary to make subject to the Act.

Section 135

Section 135 of the Mental Health Act 2007 allows for a warrant to be issued in order to assess a person known to have a mental disorder on private premises. This warrant can be sought by an Approved Social Worker (ASW), or the police; in any

event the police officer serving the warrant has to be accompanied by an ASW and a doctor. The removal of the individual to a place of safety may also require the co-ordination of ambulance services or police escort.

Discussions with the police and ASWs emphasised the importance of ensuring that agreements between the relevant agencies are in place for providing these services. I spoke to several ASWs who were concerned that there can be significant delays in moving someone to a place of safety because either police officers or access to ambulance services are not timely. Co-ordinating a number of different agencies can be both time-consuming and problematic. Where delays were much shorter, this could either be explained by the determination of an individual ASW, or pre-agreed protocols between agencies. Clearly, relying on the zeal of individual members of staff to improve performance of the agencies involved is not an acceptable solution and we must look to developing protocols for a more strategic and sustainable approach that can become embedded in practice.

Recommendation

- **All agencies involved in the use of Section 135 of the Mental Health Act 2007 must agree a joint protocol on the use of this section.**

“There are no reliable statistics on the use of section 136.”

Mental Health Act Commission[86]

Section 136

Section 136 of the Mental Health Act 1983 allows for the police to remove an individual suffering from ‘mental disorder’ from a public place to a ‘place of safety’. In the UK, it is psychiatric units, police stations and hospital accident and emergency departments that are commonly used as the place of safety, but for a number of reasons police custody is widely viewed as not being a suitable environment for people with mental disorder. These include the following:

- It has the effect of criminalising people for what is essentially a health need.
- The environment may exacerbate their mental state, and in the most tragic cases can lead to deaths in custody.

Accessing data on the numbers of people who are detained under this power again proved difficult; there is a lack of figures on detentions across hospitals, police custody suites and other locations. The limited statistical data that is available is of questionable value because of its incompleteness, and because of marked regional variations in practice which make generalisation difficult.

The best figures we have come from a recent study by the Independent Police Complaints Commission (IPCC),[84] which estimated that 11,500 people were detained under this power in 2005/06, with the average amount of time spent in custody being 10 hours.

Despite the recognition of the unsuitability of police custody as a place of safety, studies have shown that it continues to be used on a fairly wide basis. A survey conducted by NACRO in 2005[85] found that in 34% of Section 136 cases, police

stations were the only designated places of safety in the area. Since that time, the Department of Health has invested some £130 million in updating the mental health estate and ensuring that each mental health trust has access to an appropriate place of safety. Notwithstanding this investment, the IPCC report found that 41 of the 43 constabularies confirmed the continued use of a police station as a place of safety. Very often this was thought to be a way of avoiding long waits in hospital accident and emergency departments.

Recent guidance from the Department of Health made changes to the use of Section 136, under Section 44 of the new Mental Health Act 2007, which allows a person to be taken from one place of safety to one or more different places of safety. The guidance also states that police stations should only be used as places of safety in exceptional circumstances.

The use of Section 136 is a prime example of why the police and health services need to work so closely together. Even once a person has been removed to a place of safety, the speed of assessments is further determined by the resources and willingness of local health and social services to attend within suitable timeframes. ACPO has suggested that police forces must develop and agree protocols with mental health trusts and primary care trusts to identify a first choice place of safety, and the criteria for use.

Visit

Section 136 facility, Doncaster

This facility has been developed by Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust, to receive people held under Section 136 of the Mental Health Act 2007. The unit provides a bright and spacious environment supported by a programme of activities to help people on the road to recovery. The facilities allow for a seamless integration of the Section 136 suite with the Psychiatric Intensive Care Unit and the acute wards on the same site. It is also integrated with the Trust's community provision.

Since the unit opened all the agencies involved have noticed a marked improvement in the quality of facilities on offer and efficiency of response. The Trust also has an agreed liaison policy with local police, which includes matters relating to Section 136.

The IPCC report emphasises the importance of police working successfully with health and social care staff to ensure that detained individuals are assessed and treated as quickly and effectively as possible. In fact, many of the recommendations in the IPCC report, if implemented, would go a long way towards improving working relations between the police and health and social services. The recommendations

include a suggestion of parties meeting at a strategic level to look at reviewing current arrangements and existing protocols and agreements. Such an approach would be helpful not just for Section 136 cases, but also for other interactions between health services and the police, which this chapter will further explore.

Recommendations

- **All partner organisations involved in the use of Section 136 of the Mental Health Act 2007 should work together to develop an agreed protocol on its use.**
- **Discussions should immediately commence to identify suitable local mental health facilities as the place of safety, ensuring that the police station is no longer used for this purpose.**

Provision of healthcare in custody

PACE[87] sets out guidance for the police in matters involving people detained in police custody and the assessments that should take place. It states that the police are required to provide clinical attention to those presenting with physical and mental health needs. This requirement is fundamental to the risk management and prevention of deaths in custody. If a detainee requires medical attention then it is also the responsibility of the custody officer to ensure that healthcare professionals have all the available information relevant to the detainee's treatment.

As we have already heard, many detained in police custody will have multiple and complex needs. They will have had difficulty engaging with mainstream services in the community and the police have become the agency with whom they are most likely to have contact by default.

Health services in police custody are not currently commissioned by the NHS, but by each individual police force. There have been studies looking at different models of such provision that found that they broadly fall into one of, or a mix of, the following categories:

- Traditional Forensic Medical Examiner (FME) services
- Privately provided services
- Directly employed custody nurses
- Liaison schemes.

The first model has been the traditional method of healthcare provision in police custody and there have been many studies undertaken looking at the service it provides.

Revolving Doors Agency (2006)[88] has reported that many FMEs are extremely experienced and committed and, particularly in areas where there is a high demand for services, have developed significant specialisms and expertise. Where this is the case, FMEs provide an excellent and invaluable service to both detainees and the police, but the service remains variable. The report also evaluated the use of private healthcare contractors used by around half of police forces and it was found that

these companies often relied on doctors on short contracts who were often less qualified or experienced than traditional FMEs.

The Offender Health Research Network[89] found that there were concerns among healthcare professionals and those involved in the criminal justice system that medical care was not always available to police detainees when required, and often only available within normal working hours. There was a widely held belief that FMEs needed more specialist training in mental health issues in order to cope with the high prevalence of mental health and learning disability problems in custody. This issue is confirmed by an earlier study by Laing (1996)[90] which evaluated the available literature on the abilities of FMEs, and found that they were not required to have completed any formal psychiatric training in mental health issues.

In addition to these concerns, police custody is now the only major stage in the criminal justice system where primary NHS-commissioned care is not available, which means a break in the continuity of an individual's care and can cause difficulty in accessing information from NHS sources. Further, the quality of care in custody is therefore not subject to the same governance and performance measures as NHS services.

All these issues have led to the suggestion that responsibility for health services in police custody suites should be transferred from the police to the NHS. This call has been echoed in Baroness Corston's recent report into women with particular vulnerabilities in the criminal justice system;[91] and the 2007 Department of Health consultation on developing an Offender Health and Social Care Strategy.[92]

Recommendation

- **The NHS and the police should explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS at the earliest opportunity.**

People in custody with learning disabilities

There are a small but significant number of people arrested and taken into police custody who have learning disabilities. As set out earlier, there are no definitive numbers due to the inadequacy of identification, difficulty in diagnosis and also the lack of local systematic data collection.

A study[93] of significant pieces of research looking at the prevalence of learning disabilities concluded that the results for numbers in police custody varied from 0.5% to 9% of all cases. The suspected reason for such a variation in these results is the lack of formal testing of learning disabilities and the different methods of testing. There is evidence, however, to put the figure at the higher end of the estimate. A further study[94] looked at the prevalence rates with two forensically trained

community mental health nurses, who screened 9,014 custody record forms over a three-year period in an inner-city police liaison service. They judged 8.7% of suspects to have a definite or possible learning disability.

As part of the No One Knows programme, the Prison Reform Trust reported[95] on how the police respond to suspects with learning disabilities. The report's key findings confirmed that access to an Appropriate Adult was patchy, as suspects' needs were often not identified. Even when Appropriate Adults were available, there was a lack of individuals who could effectively undertake the role. This view of the Appropriate Adult is also reported in work undertaken by Leggett et al (2007);[96] experiences of people with learning disabilities suggested that there are problems with the availability and role of the Appropriate Adult during police interviews.

Further findings of the Prison Reform Trust report were as follows:

- Decision-making on enforcement, diversion and disposal options is inconsistent.
- In many areas there is limited referral of suspects for clinical attention, and there are inconsistencies in the attention received from healthcare professionals.
- Criteria for assessing fitness for interview lack clarity.
- Presentation and follow-through of suspects' rights to legal advice is sometimes poor.

The issue of diversion at this stage for people with learning disabilities is different from the same issue for those with mental health problems. In order for a criminal offence to have occurred, there must be adequate proof of 'mens rea', or an intention to commit an offence. If the police identify someone with learning disabilities and decide that they do not have mens rea, they can use discretion and decide not to prosecute. However, yet again this is dependent on police officers, untrained in mental health and learning disabilities, identifying that a suspect has particular needs.

Practice example

Cheshire police

In Cheshire, the community services and the police have been working alongside each other to develop their understanding of how the current system of working with offenders with learning disabilities operates and the roles of different services. Police are now contributing to risk assessments and advising community services; and there have been joint training sessions between police and learning disability services.

Role of the Crown Prosecution Service

The CPS also plays a major role in diverting offenders with mental health problems or learning disabilities from prosecution in the following ways:

- providing pre-charge advice to the police that results in the offender being cautioned or no further action being taken;
- prosecutors issuing conditional cautions where appropriate; and
- discontinuing criminal proceedings where the public interest does not require a prosecution.

The Code for Crown Prosecutors emphasises that there is a balance to be struck between the public interest in diverting a defendant with significant mental illness from the criminal justice system, and other public interest factors in favour of prosecution including the need to safeguard the public. If there is significant evidence that a defendant or suspect has a significant mental illness, a prosecution may not be appropriate unless it is needed in the public interest, for example because of the seriousness of the alleged offence or the likelihood of re-offending.

Access to information, therefore, is vital for the CPS to be able to undertake its role effectively. The CPS has no direct contact with detainees at the police station and relies solely on any information that they receive from the police with respect to any charging advice. The CPS has reported to the review that it regularly has to infer things, e.g. if there is an Appropriate Adult present during interview it usually means that the person has vulnerability, but this fact provides them with no more information than this. Consequently, issues concerning mental illness or learning difficulties may only surface at the court stage.

In a recent study by the CPS[97] an Expert Panel reviewed 45 case files involving victims and witnesses with mental health issues and/or learning disabilities, and found that the case file review did not reveal any consistency in the type, level or source of information that was used to inform decision-making. However, the Expert Panel considered that, in ideal circumstances, a case file should contain a full assessment of the cognitive abilities of the victim and/or witness, prepared by an appropriate medical (or other) professional, and relevant to the ability of the victim and/or witness to take part in the criminal justice process.

Information about an offender can come from a variety of sources. As an offender has a legal representative or advocate to represent them individually, they should raise relevant issues with the CPS on their behalf.

The custody record will detail the attendance of the FME and their conclusion as to whether the offender is fit to be detained or interviewed. However, this is not supplied routinely to the CPS in all areas when charging advice is sought, or kept with the case file when the police have already charged the suspect. The presence of an Appropriate Adult during interview is recorded usually on the typed interview summary, which is supplied routinely with case papers. Again this merely alerts the prosecutor to a potential disorder or vulnerability but provides no further information.

> **“Early, effective assessment at the police station is crucial.”**
>
> The Law Society, Mental Health and Disability and Criminal Law Committees, 5 March 2008

As described, prosecutors may not usually be aware of any disability or vulnerability until the defendant attends court, where the issue will often be raised for the first time by their solicitor. The CPS legal guidance on mentally disordered offenders recognises that prosecutors may also receive information about a defendant's needs at court from sources such as relatives and prison officers, who have observed the offender's behaviour or demeanour, and that this information may prompt further investigation to ascertain the nature and extent of the disability and its relevance to, and impact on, criminal proceedings.

Once the initial identification and assessment of need is made, liaison and diversion services, especially where based in police stations, have been able to ensure that this information is available to support decision-making at an early stage, for police, the CPS and the courts. There are already examples of such schemes that are also accessible to all criminal justice personnel including the CPS. Stakeholders tell me that such services are often held in high regard by the judiciary and are consulted frequently by the police and CPS when taking the decision whether to charge or prosecute.

The improvement in information gathered at the police station would allow prosecutors to make better-informed decisions on prosecution and use of cautioning or conditional cautioning options. This issue is further explored in the next chapter.

Information on the nature and degree of the mental health need or learning disability, its relevance to the alleged offence, available treatment and compliance with past treatment can also be provided. This is particularly useful where the team advises that the mental health problem has not influenced the criminal behaviour. It also informs the CPS decision whether to prosecute and if the case is to proceed, and the information will assist the court in managing the case and facilitating practical specialist support for the defendant if necessary, depending on their particular needs, e.g. allowing extra time for the trial if they require frequent breaks.

Practice example

Powys Diversion Scheme

In Powys there is a diversion scheme for offenders identified as having mental health needs. It aims to minimise the number of offenders with complex needs who are placed in the criminal justice system without adequate support. Custody officers can refer detainees to the scheme and community psychiatric nurses then assess offenders and make any recommendations or give evidence in court. Offenders can be diverted under the scheme to hospitals, housing schemes, bail hostels or support at home (either from community mental health teams or the voluntary sector).

The next chapter explores in more detail the decision-making processes at court, and how better provision of information on an individual's needs can influence these decisions and affect the outcome.

Case study

A youth attended court with his mother and solicitor, pleaded guilty to one offence of battery and was sentenced to a referral order. There was no indication in any of the case papers that the youth had any mental health issues, and his capacity was not raised by his solicitor or the court.

The case was later re listed and the referral order revoked, after the referral panel found that the youth had extensive brain damage and they could not work with him. He was resentenced to an absolute discharge. It was clear from his appearance that his head was deformed, as a result of the car accident that caused his brain damage, and his mother had informed the solicitor of his disability, yet this was not noticed or raised in court.

Example provided by CPS submission to the review, 28 February 2008

Just before the completion of this report, the CPS started a consultation exercise[98] seeking to inform policy and practice in dealing with cases involving victims and witnesses with mental health problems and/or learning disabilities. I welcome this consultation and would wish to support better training, access to professional advice and mental health specialists, and improvements in data management. These improvements should impact positively on all individuals with mental health problems or learning disabilities who come into contact with the CPS.

Training and advice

As we are already aware, despite regular interaction with individuals with mental health needs or learning disabilities, the police receive very little specific training in mental health or learning disability awareness. In addition, in many cases they do not have direct access to mental health or learning disability expertise. Where liaison and diversion services have been provided to police stations, many have accepted the responsibility for training and brought together different agencies, including the police, for joint training. Joint training initiatives can not only improve awareness of mental health and learning disability issues but also help to improve partnership working and understanding of each other's roles.

In addition, I am aware from my discussions with service users and carers that it can be difficult when solicitors and Appropriate Adults are not aware of how to manage mental health or learning disability issues. Again, where liaison and diversion services have been available at the police station, they have been able to become a source of advice for a range of individuals, including solicitors and Appropriate Adults.

Both of these areas of training and advice could be addressed if liaison and diversion services were routinely available in police custody suites.

Summary of the benefits of liaison and diversion at the police stage

The potential interventions undertaken by a liaison and diversion service at the police station could provide significant benefits by:

- identifying and assessing mental health or learning disability needs swiftly and effectively after arrest;
- ensuring that the police can make a fully informed risk assessment of the offender;
- identifying the need for the attendance of an Appropriate Adult;
- ensuring that those arrestees with serious mental health problems can be referred to mental health facilities before reaching court, which may have necessitated a period spent in custody on remand;
- providing information for the police and CPS on charging and prosecution;
- providing information and advice for solicitors at the police station;
- ensuring that people with mental health problems who would not necessarily progress to court stage are signposted to mental health services rather than just dropping out of the system; and
- providing information for court services about individuals' mental health or learning disabilities. This will help to inform decisions about the need for psychiatric reports at an earlier stage, about where an offender should be remanded and about sentencing. The next chapter will look at this issue in more detail.

"Correct decision-making for the service user can only take place if the decision maker is in receipt of full information concerning the subject."

Commander Rod Jarman, then ACPO Mental Health and Disability Lead, 28 February 2008

Recommendation

- **All police custody suites should have access to liaison and diversion services. These services would include improved screening and identification of individuals with mental health problems or learning disabilities, providing information to police and prosecutors to facilitate the earliest possible diversion of offenders with mental disorders from the criminal justice system, and signposting to local health and social care services as appropriate. (Further recommendations on such services are provided in Chapter 5.)**

Recommendations

- **Liaison and diversion services should also provide information and advice services to all relevant staff including solicitors and appropriate adults.**
- **Mental health awareness and learning disabilities should be a key component in the police training programme.**

Summary

The exact number of people with mental health needs coming into contact with the police is not known, as there is no national requirement for the police, or any other criminal justice agency, to keep statistics. The poor quality of information is obviously an issue when it comes to estimating the scale of the problem and the planning of services. What we do know, from discussions with stakeholders, is that contrary to the perception of danger associated with offenders with mental health problems, most contact with offenders from this population will be for minor offences.

As well as officers needing assistance from mental health professionals when they are dealing with difficult or complex situations involving persons with a suspected mental health problem, mental health professionals who are working without police support can often feel ill-equipped to handle some individuals presenting particular challenges. It has become increasingly apparent that when people with mental health problems in the community are in crisis, neither the police nor the mental health services alone can serve them effectively and it is essential that the two systems work closely together.

One of the key barriers to overcome if significant progress is to be made is to reach agreement with the police on the way ahead. There is currently a lack of consistency in moving this agenda forward because of:

- the different approaches of the 43 separate police forces, serving 603 custody suites;
- huge regional and local variations in resources, priorities, protocols and service provision in the different police force areas; and
- geographical boundaries not being co-terminous with those of NHS organisations (primary care trusts/mental health trusts/strategic health authorities) who will have different sets of priorities and budgets.

Overall, it is clear that the police interact with many other agencies on a regular basis and it is vital for respective roles and responsibilities to be clear in order for partnerships to work successfully. Towards the end of the review I was extremely pleased to host an event that brought together representatives from each of the forces to discuss this agenda. I was impressed by the level of attendance and the enthusiasm of the attendees to address some of the issues I highlight in this chapter. I hope that my review has acted as a catalyst for bringing local forces together to look at these issues at a strategic level with a view to resolving them.

References

45 HM Government, 2008, *Youth Crime Action Plan 2008*

46 HM Inspectorate of Prisons, 2007, *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs*

47 Youth Justice Board, 2005, *Risk and protective factors*

48 Department of Health, 2009, *Transforming community services and World Class Commissioning: Resource pack for commissioners of community services*

49 www.surestart.gov.uk/

50 www.cabinetoffice.gov.uk/strategy/seminars/family_nurse.aspx

51 www.communities.gov.uk/archived/general-content/communities/respect/familyinterventionprojects/

52 www.dcsf.gov.uk/rsgateway/DB/RRP/u015374/index.shtml

53 www.cabinetoffice.gov.uk/social_exclusion_task_force/multi_systemic.aspx

54 National CAMHS Review, 2008, *Children and young people in mind: The final report of the National CAMHS Review*

55 Department for Children, Schools and Families, 2007, *The Children's Plan: Building brighter futures*

56 www.healthyschools.gov.uk/

57 http://nationalstrategies.standards.dcsf.gov.uk/primary/publications/banda/seal/

58 www.charity-commission.gov.uk/supportingcharities/esi.asp

59 http://nationalstrategies.standards.dcsf.gov.uk/primary/publications/banda/eaudit/

60 www.nursinginpractice.com/editorial/attachment.asp?aaid=254

61 HM Treasury, 2003, *Every Child Matters*

62 Lord Darzi, 2008, *High quality care for all: NHS Next Stage Review – Final report*

63 Bashir K et al, 2000, The evaluation of a mental health facilitator in general practice: Effects on recognition, management, and outcome of mental illness. *British Journal of General Practice*, Vol 50, No 457, pp 626–629

64 Shelder J et al, 2000, Practical mental health assessment in primary care: Validity and utility of the Quick Psycho Diagnostics Panel, *Journal of Family Practice*, Vol 49, pp 614–621

65 Croudace T et al, 2003, Impact of the ICD-10 primary health care (PHC) diagnostic and management guidelines for mental disorders on detection and outcome in primary care, *The British Journal of Psychiatry*, Vol 182, pp 20–30

66 National CAMHS Review, 2008, *Children and young people in mind: The final report of the National CAMHS Review*

67 Healthcare Commission, 2006, *Let's talk about it: A review of healthcare in the community for young people who offend*

68 National Policing Improvement Agency, 2007, *Review of literature on mentally disordered offenders*

69 Campbell S, 2002, *Implementing Anti-Social Behaviour Orders: Messages for practitioners*

[70] Prison Reform Trust, 2007, *No One Knows: Prevalence briefing*

[71] Ministry of Justice, 2008, *Statistics bulletin*

[72] Robertson G et al, 1995, *Drunkenness amongst police detainees*

[73] Bennett T, 1998, *Drugs and crime: The results of research on drug testing and interviewing arrestees*

[74] Burney E and Pearson G, 1995, Mentally disordered offenders: Finding a focus for diversion, *Howard Law Journal*, Vol 34, pp 291–313

[75] Winstone J and Pakes F, 2005, *Mental health literature review*: *Effective practice*

[76] Ministry of Justice, 2008, *Statistics bulletin*

[77] Tribal, 2008, *Financial support to the Bradley review*

[78] National Centre for Policing Excellence, 2006, *Guidance on the safer detention and handling of persons in police custody*

[79] www.cps.gov.uk/publications/code_for_crown_prosecutors/

[80] www.police.homeoffice.gov.uk/operational-policing/powers-pace-codes/pace-code-intro

[81] Gudjonsson GH et al, 1993, *Persons at risk during interviews in police custody: The identification of vulnerabilities*

[82] Nemitz T and Bean P, 2001, Protecting the rights of the mentally disordered in police stations: The use of the appropriate adult in England and Wales, *International Journal of Law and Psychiatry*, Vol 24, pp 595–605

[83] Brown D et al, 1992, *Changing the code: Police detention under the revised PACE codes of practice*

[84] Docking M et al, 2008, *Police custody as a 'place of safety': Examining the use of section 136 of the Mental Health Act 1983*

[85] NACRO, 2005, *Findings of the 2004 survey of court diversion/criminal justice mental health liaison schemes for mentally disordered offenders in England and Wales*

[86] Mental Health Act Commission, 2008, *Biennial report: Risks, rights, recovery*

[87] www.police.homeoffice.gov.uk/operational-policing/powers-pace-codes/pace-code-intro/

[88] Kutchinsky N, 2006, *Development programme for extending offender healthcare support: Early interventions workstream, final report*

[89] Rennie C et al, 2008, *Offender health: Literature review and research priorities*

[90] Laing J, 1996, *The police surgeon and mentally disordered suspects: An adequate safeguard?*

[91] Home Office, 2007, *The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*

[92] Department of Health, 2007, *Improving health, supporting justice*

[93] Holland T et al, 2002, Prevalence of criminal offending by men and women with intellectual disability and the characteristics of offenders: Implications for research and service development, *Journal of Intellectual Disability Research*, Vol 46, Suppl 1, pp 6–20

[94] Scott D et al, 2006, The mental health needs of people with a learning disability detained in police custody, *Medicine, Science and the Law*, Vol 46, pp 111–114

[95] Prison Reform Trust, 2007, *Police responses to suspects with learning disabilities and learning difficulties: A review of policy and practice*

[96] Leggett J et al, 2007, *People with learning disabilities' experiences of being interviewed by the police*

[97] Lee V and Charles C, 2008, *Research into CPS decision-making in cases involving victims and key witnesses with mental health problems and/or learning disabilities*

[98] www.cps.gov.uk/consultations/mhld_index.html#a07

3

The court process

This chapter explores court proceedings; the use of remand (including approved premises); information and reports to the court; and the use of specialist courts.

Within this chapter, I also look at the implications of providing more comprehensive information to magistrates and judges and how this may influence decisions and outcomes.

Introduction

In Chapter 2, I describe how better screening and assessment at the police stage can impact positively on the later stages of the offender pathway. Now I will explore that impact in further detail, looking especially at how more comprehensive information at an early stage can influence the various decisions that magistrates and judges will need to make during the course of an individual's appearance at court.

We must also remember that liaison and diversion schemes have historically mainly provided services at the court stage. This chapter will examine these schemes in more detail.

Key facts

- There are **650** courts in England and Wales (**400** of which are magistrates' courts).[99]
- The overall numbers of people moving through the courts in 2006 were as follows:
  - **1,780,000** defendants dealt with by magistrates' courts;
  - **78,7000** defendants dealt with by Crown Court for indictable offences;
  - **1,363,000** people found guilty at a magistrates' court;
  - **58,000** found guilty at Crown Court;
  - **698,000** people directed to appear at magistrates' courts who were arrested and bailed (of criminal proceedings completed in 2006); and
  - around **123,000** who were arrested and held in custody until their first court appearance.[100]

There are very few studies with sound methodologies looking at prevalence rates of mental health problems in those presenting at courts.

One particular study provides a useful indication,[101] although in spite of using a good scientific methodology, with a psychiatrist making the mental health assessments, it may not be truly representative of the whole court population. The study was conducted in one urban magistrates' court setting and focused on people aged 21 and over, whereas the figures on the numbers passing through the courts nationally include people aged under 21, which will make a calculation of national rates based on this study less accurate than if it had looked at people of all ages.

Using the findings from this study as the most accurate currently available:

- of 698,000 people directed to appear at magistrates' courts who were arrested and bailed, **9,143 people will have a serious mental illness**; and
- of 123,000 people held in custody until their first court appearance, **8,081 people will have a serious mental illness**.

Little research has been conducted on the prevalence of learning disabilities in the court system. It is clear that further investigation is needed in order to get an accurate depiction of the prevalence of learning disabilities in UK courts (see Recommendation on page 138).

Context

Those appearing at court can have a complex range of needs. When a defendant appears in court for the first time, following a decision to charge, the information available about them is dependent on the strength of the information gathered at the police station (generally what arrives with them on the Prisoner Escort Record (PER) form) and how it is transferred. The PER form provides a standard system for listing and assessing the risks associated with individual detainees when they are being escorted or transferred between locations. Currently, the quality and amount of information will depend on whether liaison and diversion schemes provide services at the police station, ensuring appropriate assessment and links with services at the court.

Information on the needs of people arriving at court is essential to determine their immediate requirements. Firstly, it is needed to establish whether they are fit to plead; if they are not, whether a transfer to hospital is necessary; or, if they are, whether they will need support during the court proceedings. Secondly, it is needed to determine whether they should be remanded to custody, bail or hospital. And thirdly, the information will be vital to inform any decision that the magistrate or judge might make in relation to sentencing options.

“Magistrates regularly see offenders whom social services, the community, or society at large has failed.”

Magistrates’ Association submission to the review, 29 February 2008

Fitness to plead

It is extremely important that an individual’s mental health and learning disability needs are identified and taken into account to ensure that they are indeed fit to stand trial. Any individual standing trial “must be capable of contributing to the whole process of his or her trial, starting with entering a plea” (as the British Psychological Society stated in a submission to the review in February 2008). The main criteria used in determining fitness to plead are:

- capacity to plead with understanding;
- ability to follow the proceedings;
- knowing that a juror can be challenged;
- ability to question the evidence; and
- ability to instruct counsel.

The question of fitness to plead may be raised before arraignment by the prosecution, defence or judge. The defendant may be remanded to hospital for a report on their medical condition (using Section 35 of the Mental Health Act). This provision has the potential to be highly effective, as the accused can be evaluated within a psychiatric setting. The defendant may also be remanded for treatment (under Section 36 of the Mental Health Act) while awaiting trial. Currently Section 36 can only be used by the Crown Court and not by magistrates.

In the majority of cases it is likely that the defendant will respond to medical treatment and the trial will take place within a reasonable period. Alternatively, the defendant’s condition may be so serious that it will justify a hearing on the issue of fitness to plead.

The provisions of Section 51 of the Mental Health Act 1983 enable the Crown Court to make a hospital order (with or without restrictions) in the defendant's absence and without convicting them if they have been remanded in custody, but have subsequently been transferred to hospital for medical treatment.

People with learning disabilities

There has been little research conducted on the prevalence of learning disabilities in those who come before the court. However, it is clear that people with learning disabilities can have specific issues in relation to the workings of a courtroom, particularly in terms of understanding questions and when asked specific, leading or complex questions. A study[102] has also found that witnesses with learning disabilities are more prone to suggestibility and confabulation.

These issues may not necessarily mean that they are not fit to stand trial, but they may have problems at a level that requires support in the court environment.

There are special measures available to vulnerable victims and witnesses under the Youth Justice and Criminal Evidence Act 1999; these are intended to reduce the stresses associated with the court environment so that the individual can give their best evidence. This is particularly important with regards to communication. These measures are not currently extended to cover vulnerable defendants although it appears equally important in terms of exercising justice that similar support be given.

Recommendation

- **Immediate consideration should be given to extending to vulnerable defendants the provisions currently available to vulnerable witnesses.**

"You should have support in court – I couldn't read my bail conditions so I broke them. They should make the writing bigger and tell you what they are in court."

Quote from member of No One Knows Advisory Group, 13 May 2008

Remand decisions

When a defendant appears in court for the first time following a charge, the magistrates must decide whether to remand them on bail or in custody. Both magistrates' courts and the Crown Court can remand the defendant to hospital in order for a report on their mental condition to be prepared (under Section 35 of the Mental Health Act). A relevant report with all the necessary information will allow the court to decide on an appropriate disposal or outcome for the defendant and means that the court will not have to request additional information. Delays can mean that the defendant has to wait still longer, possibly leading to deterioration in their mental state.

The court has a duty to reconsider its initial decision at each subsequent stage of the proceedings, including after conviction and before sentence. All defendants have a right to bail unless one or more of various specified exceptions to bail apply. The main exceptions are where there are substantial grounds for believing that the defendant, if released on bail, would fail to surrender to custody, commit an offence while on bail, or interfere with witnesses or otherwise obstruct the course of justice.

There are other exceptions that can come into consideration when the defendant appears to have some kind of mental disorder. A remand in custody is permissible if the court believes that the defendant needs to be detained for their own protection from harm, including self-harm.

Remand remains a method of dealing with unpredictable individuals who are likely to re-offend; and although the crimes involved may be low-level, they are often high in number and impact on local communities. The annual British Crime Survey has indicated that in the first quarter of 2007 the general public's perception of anti-social behaviour crimes such as burglary, street gangs and car crime continued to show a high level of worry and limited confidence that the criminal justice system is able to manage these crimes. This will inevitably put pressure on courts to limit re-offending rates by remanding to custody.

Remand to hospital

Defendants appearing in the Crown Court with a severe mental health problem can be remanded to hospital for treatment under the Mental Health Act, instead of being remanded in custody, pending trial or sentence. This power may be used in cases where the defendant might otherwise be found unfit to plead, to enable a defendant to receive treatment prior to trial. The trial may then proceed at a later date when the condition of the defendant has improved.

Remand to custody

Key facts

- Numbers in custody on remand continue to increase and recent figures on this population show the following:
  - The total prison population in custody on 31 May 2008 was **82,822** (82,372 in prison, 234 in Secure Training Centres and 216 in Secure Children's Homes.
  - Of this total, the remand population in prison was **12,999**.[103]
- June 2007 saw **12,844** people on remand. Comparisons of prisoner characteristics by ethnic group at that time indicate the following key points:
  - Of the total prison population, all minority ethnic groups had a higher than average proportion of prisoners on remand (White **15%**, Mixed **19%**, Asian **20%**, Black **18%**, and Chinese or Other **28%** compared with an average of **16%**).
  - Similarly, all minority ethnic groups had a higher proportion of prisoners on remand who were untried than the equivalent proportion of White prisoners (White **9%**, Mixed **13%**, Asian **14%**, Black **13%** and Chinese or Other **21%**). These differences may reflect, in part, the variation between ethnic groups in terms of the types of offence for which offenders were remanded, or police objections for reasons that varied by ethnic group, for example the lack of a fixed address.

Figures show that there continues to be a heavy reliance by the courts on remand to custody. A reason for this could be that prison offers a speedy and reliable 'place of safety' for vulnerable individuals presenting at court. Quite often the police, the Probation Service and the courts are unclear what other alternatives are readily available, and will default to the prison option. Other factors in the decision to remand to custody are:

- public safety;
- lack of alternatives in local communities;
- lack of availability of services;
- lack of confidence in the safety and success of alternative options on the part of criminal justice system staff and courts; and
- balancing of the needs of the individual with the possibility of re-offending.

Homelessness is often a trigger for offenders to be dealt with differently by the criminal justice system, at the police and court stages, and can decrease the likelihood of an individual being granted bail or a community sentence. I recognise the strong link between mental health and homelessness: people who are homeless or living in temporary or insecure accommodation have higher rates of mental illness than the general population.[104] Between 30% and 50% have a significant mental illness.[105]

There is currently no data to identify how many individuals are remanded in custody pending a psychiatric report, how many are assessed as having a mental health problem, and how many are so unwell that they require transferring out of custody for treatment.

Women on remand in custody

There was a 78% increase in the number of women remanded in custody between 1996 and 2006, from 4,221 to 7,498.[106] These women spend an average of four to six weeks in custody and nearly 60% do not receive a custodial sentence.

We know that women are severely disadvantaged by spending time in custody. The impact on families is high. This is because women are often sole carers of children, and because the small number of women's prisons means that women are unlikely to be in prison close to home. The Prison Reform Trust and the Fawcett Society[107] have campaigned for defendants who are primary carers of young children to be remanded in custody only after consideration of a probation report on the probable impact on the children.[108]

People with learning disabilities

As we have experienced in other areas of the criminal justice system, information about people with learning disabilities on remand in custody is patchy; data is not available on the numbers placed in custody on remand or as a sentence. The impact of custody on those with learning disabilities or difficulties is explored further in the section on custody.

Mental health treatment on remand

Prisons, with their primary care trust (PCT) partners, have greatly improved health services in prisons over the past eight years. There has been new investment for the development of mental health in-reach teams, substance misuse services and a focus on primary care and assessment. Chapter 4 covers mental health services in custody in further detail.

In reality, remand does not offer much time to engage with treatment, and where prisoners on remand are released directly from court there are significant difficulties in ensuring that any care started in custody continues in the community. Chapter 4 again explores resettlement issues in more detail.

It is clear that the issue of overuse of custody for remand has been recognised at a national level. There is a new National Offender Management Service initiative under way to reduce the use of remand to custody in appropriate cases. The purpose of the initiative is to provide new accommodation and support services so that courts can be equipped with alternatives to remand to custody. The service offers opportunities for adult defendants who are unable to provide an acceptable bail address, or who could not be bailed without support.

However, there are concerns about the eligibility criteria and about difficulties in enabling offenders with complex needs to use these facilities. This inevitably poses the question as to whether this initiative will be of use to offenders with mental health problems or learning disabilities.

Remand on bail

Bail can be granted by the courts or the police and allows the person to be released from custody until the next date they attend court or the police station. Approved premises provide accommodation for a range of offenders on bail, including those with mental health problems, or for whom no other types of accommodation would be suitable.

Approved premises

There are 101 approved premises across England and Wales, having a total capacity of 2,205 beds. Approved premises, formally known as bail hostels, are considered the safest option for many offenders as they allow their risk to be managed outside of custody. Any breach of the conditions of residence or of the house rules renders an offender liable to clear sanctions, including a return to court if on remand or an immediate recall to prison if on licence.

The Probation Service makes the admission decisions on the basis of a thorough risk assessment. Admission to approved premises will normally be reserved for those offenders or bailees deemed to pose a high or very high risk of harm, on the basis of a full Offender Assessment System (OASys) assessment.

The functions of approved premises are outlined in Probation Circular 37/2005. Some of the key roles are:

- to contribute to the protection of the public from those who pose the most serious risk of harm;
- to provide a regime of 'enhanced supervision', together with other measures when necessary, in the interests of public protection;
- to provide a planned, structured regime of interventions, including one-to-one key working, derived from the offender manager's sentence/supervision plan and underpinned by pro-social modelling and motivational principles;
- to provide a safe and secure environment for residents and staff; and
- to co-ordinate delivery of a range of services (to include health, education, life skills, employment and resettlement services) in the interests of effective rehabilitation as determined by the offender manager's sentence/supervision plan.

A 12-month study was undertaken in 2004[109] to look at mental disorder among residents of approved premises within Greater Manchester. The following results were reported:

- Just over a quarter of all residents had a known psychiatric diagnosis, with **41%** of these having a known secondary diagnosis.
- **5.4%** had a diagnosis of psychotic mental illness.
- **9.4%** had literacy problems.
- **18.8%** had one or more physical health problems.
- **4.9%** had a learning disability.
- **30%** had an alcohol misuse problem.
- **34.3%** had a drug misuse problem.

"People are locked up in prison because other accommodation-based alternatives are not available."

Excerpt from submission to the review from St Mungo's, 29 February 2008

A recent joint inspection of approved premises[110] found that staff were dealing with high numbers of residents with physical and mental health problems. These conditions routinely included heart problems, diabetes and mental illness (including depression and schizophrenia). A significant proportion of residents had previous or current illegal substance misuse or alcohol misuse problems.

The report highlighted problems with information sharing between premises and healthcare professionals, and also inconsistency in access to training around mental health issues, despite the high prevalence of mental health problems among residents. Further work is currently under way to provide a national picture that will build on the work of the inspectorates but will look at a wider range of issues. The results of this work should be available shortly and will provide valuable data to inform any improvements to the service currently provided to residents with mental health problems.

Training for probation staff, including those working in approved premises appears to be variable, with only some probation areas working with local partners to facilitate the delivery of some form of mental health awareness training. Historically some probation areas have made contacts with local NHS services and tended in the main to bring in

training programmes from these local sources. Many probation staff are unsure of how they should manage offenders on their caseloads with mental health problems and of the types of local healthcare services to which they can refer individuals.

Practice example

Bracton Centre

The Bracton Centre Forensic Mental Health Service has been providing a service to probation hostels over the past 15 years. Funded by the Inner London Probation Service, with the aim of forming a partnership with the Mental Health Service, it offers specialist hostel provision for high-risk personality-disordered offenders. The partnership has aimed to bridge the gap between mental health and criminal justice services for a group of individuals who were at high risk of social exclusion due to their challenging behaviour and psychological needs.

There are also other examples of positive relationships between approved premises and physical and mental healthcare providers, and good examples of service specifications that have been agreed between the Probation Service and the local PCT to facilitate the provision of contracted services.

Practice example

Kew Hostel

The residents of the Kew Hostel in Surrey are men who have served long-term prison sentences for serious, often violent offences. The primary care needs of this client group are historically higher than average, with particular increased need for mental health services. Owing to their previous convictions, conditions of licence, and particular health histories and needs, the client group may also be seen as a risk group for the registering practice and its registered population. The local PCT recognises that additional support is needed to ensure the registration of these residents, their appropriate access to services and the appropriate level of support.

As a result, a service specification has been agreed between the Probation Service and the local PCT that outlines the specific responsibilities of the approved premises and the GP practice. The practice will participate in a health needs analysis of the hostel population every two years, and will work with the PCT in reviewing the service specification, in order to ensure service provision that meets the primary care needs of the client group.

Mental health services for people in approved premises

Out of the total 101 approved premises, there are only three that specifically deal with mentally disordered offenders and provide enhanced mental health services. Each of these works to a different model, and although it could be argued that any form of enhanced service provision might be beneficial, there is currently no evidence to show that the service is effective.

There has been strong feedback from stakeholders to the effect that there should be increased use of bail for this population, ensuring that they are only remanded in custody when absolutely necessary. However, there does not currently appear to be appropriate provision of mental health services to support individuals who might be housed in approved premises, and this lack places an unnecessary strain on probation officers, who may be untrained in mental health awareness.

There is a suggestion that the level of mental health services needed could be in line with those currently provided at the three sites that have enhanced mental health services, although provision of enhanced mental health services would appear to fall far short of the estimated need. However, no formal evaluation of these enhanced services has yet been undertaken, and this would seem a sensible first step before advocating further roll-out of similar services.

“The development of specialist mental health bail hostels linked to, and with high quality provision of mental health services, could be a viable alternative to remand.”

Excerpt from review submission by the Royal College of Psychiatrists, 6 March 2008

Recommendations

- **An audit should be undertaken of the mental health needs of individuals in approved premises, and of the capacity of local services to deal with the identified level of need.**
- **Primary care trusts should identify and address the health needs of residents in approved premises when planning local services as part of their commissioning plans.**
- **A full evaluation of the three approved premises with enhanced mental health provision should be undertaken. The evaluation should look at the effectiveness of the current service provision, and whether it offers value for money.**
- **The national approved premises training package addressing suicide and self-harm should be reviewed and updated to include mental health awareness training.**

Information for the court

Pre-sentence court reports

Individuals brought before the courts can present with a range of different health and social care needs, including mental health and substance misuse issues. In many cases, as we have already seen, they may arrive without accompanying information regarding any mental health problems or learning disabilities. Before reaching a decision about how best to deal with a defendant, the sentencer may ask the National Probation Service to prepare a pre-sentence report (PSR).

The purpose of a PSR, as outlined in the *Probation bench handbook* (2007),[111] is to provide information to the sentencing court about the offender and the offence committed and to help the court decide on a suitable sentence. This report will describe the circumstances of the crime, the factors involved and the risk the offender poses to the public. The report will propose a sentence, but it is the court that makes the final decision. Typically, the production of a PSR involves interviewing the offender, reading court papers and an assessment of the likelihood of reconviction and risk, which may include use of OASys.

There are two national PSR templates available:

- the Fast Delivery PSR – normally to be completed on the same day or the next working day. These are completed using the OASys risk of serious harm screening tool, but usually without a full OASys assessment; and
- the Standard Delivery PSR – for completion on adjournment based on a full OASys assessment.

For a mentally disordered offender, the PSR should address the following issues:

- **Culpability**: how does the mental disorder bear upon the offender's personal responsibility for their conduct?
- **Risk**: does the disorder make further offending more likely? Does the disorder increase any risk to self or others? What can be done to minimise any risk identified?
- **Feasibility**: does the disorder make it unlikely that the offender would be able to comply with the requirements of a Community Order? What would be the implications of a custodial sentence?
- **Supervision**: what work would be undertaken in the course of a Community Order? Is the offender able to participate in an accredited programme? Would the psychiatric services be involved? Can the order be supervised to Probation Service national standards?

In all PSRs, report writers must make a sentencing proposal. In many cases, the PSR sentencing proposal, following assessment of the offender and their offending, will concur with the court's provisional view. However, there will also be cases in which the PSR proposal recommends a different sentence from the one the court was initially considering. The report writer, after assessing the offender and their circumstances, may recommend that a fine or a discharge should be considered rather than a Community Order, or a Community Order imposed rather than a custodial sentence.

The level of responsibility in recommending a sentence is high. In many cases, an individual will arrive at court without any information regarding their mental health problems or learning disabilities. Currently, if there are no liaison and diversion services available, it can fall to probation staff working in courts, untrained in mental health or learning disability, to recognise the potential signs of a mental health problem or learning disability. Where a mental health problem is identified, this will lead to a request for a psychiatric report. Access to timely psychiatric reports is therefore vital, and I explore this issue in more detail in the next section.

The presence of liaison and diversion services across the offender pathway would mean that probation staff could be better supported in their role both at court and in approved premises. Firstly, they would be able to assess individuals before they get to court, so that identification of mental health problems was not left to a probation officer at court, and sufficient information would be available to inform decisions about further psychiatric reports. Secondly, access to liaison and diversion services at court would provide a source of advice and information to probation officers.

Further, liaison and diversion services would have close links with mental health services in the community, and could provide advice and support to probation officers on accessing services for individuals in approved premises.

Recommendation

- **All probation staff (including those based within courts and approved premises) should receive mental health and learning disability awareness training.**

Practice example
London Probation Area

Following a serious incident involving a mentally disordered offender, London Probation looked at how greater support could be made available to probation officers to help them understand and negotiate the complexities of inter-agency, multi-disciplinary working with mentally disordered offenders.

The London Probation Area is working with a national charity, Together (Working for Wellbeing) to provide a forensic mental health practitioner service across a number of London boroughs. The project currently operates three court liaison services in London (at Thames, Ealing and Feltham Magistrates' Courts) as part of a wider contract with London Probation in partnership with local PCTs and NHS Trusts.

The service aims to:

- **increase diversion of vulnerable offenders with mental health needs;**
- **provide appropriate and timely specialist advice to the court;**
- **reduce inappropriate court requests for psychiatric reports;**
- **reduce the number of remands and/or length of time spent on remand by offenders with mental health needs; and**
- **facilitate appropriate sentencing outcomes.**

The project also involves practitioners working closely with probation staff to provide them with advice and support on a day-to-day basis to help with the supervision of people with mental health problems.

Psychiatric court reports

Ensuring the provision of timely and relevant psychiatric reports for courts is crucial in terms of outcomes for the defendant and the public. If a custodial sentence is being considered the court should specifically ask the psychiatrist to address the impact of any custodial sentence on the defendant's disorder and any available treatments.[112]

In addition, a psychiatric assessment must be undertaken before a Community Order with a mental health treatment requirement can be given. As we have heard, it is currently often down to probation staff, untrained in mental health or learning disabilities, to identify the need for a psychiatric report. This lack of awareness of mental health issues among probation staff could mean that a mental health problem is not identified and a psychiatric report not requested. I discuss Community Orders in more detail in the next chapter.

Both magistrates' courts and the Crown Court can remand a defendant to hospital in order for a report on their mental condition to be prepared (under Section 35 of the Mental Health Act). This remand can occur before or after a conviction or the start of

a trial. Ensuring a report is available in a timely way means that the defendant will not have to wait unduly long on remand while a report is prepared. A relevant report with all the necessary information will allow the court to decide on an appropriate outcome for the defendant and means that a court will not have to request additional information.

Even if mental health needs are identified at this stage, and an individual is referred for a psychiatric report, there are many problems with the timeliness, quality and appropriateness of the reports received by the courts. My review received significant input from stakeholders on this particular issue, with an overwhelming view that there is inconsistent service provision which can contribute to unnecessary delays and costs to the criminal justice system. One stakeholder suggested that delays in psychiatric reports can lead to as many as six additional court hearings for a single case.

The production of a psychiatric court report entails, in effect, an assessment of the individual to decide their level of illness and the appropriate interventions to be undertaken, their fitness to plead and their fitness to take responsibility for their actions. Until these reports are produced and considered by the court in order for it to decide the most appropriate sentence, offenders are, in most cases, placed on remand and held in prison.

Where there are liaison and diversion services in place, information on an offender's mental health needs may already be available, allowing the requesting of a report much more proportionate to the offence that has been committed. When no information is available, the most detailed type of report is most likely to be commissioned, and this obviously takes longer to develop and costs more to produce.

Psychiatric court reports are currently commissioned as part of a consultant's private work and there is no effective mechanism to speed up their production. Delays in producing these reports will therefore lengthen the time an individual spends in prison on remand before a final sentence is decided. Courts also depend on a small pool of consultants to write these reports, which means backlogs can quickly build up. A report in 2006[113] estimated that some 2,000 psychiatric court reports were commissioned before sentencing each year for individuals with mental health disorders.

Her Majesty's Courts Service (HMCS) South West region and magistrates' courts in Brent, Harrow and Uxbridge, North West London are currently participating in pilot projects where courts are gathering information on the provision of psychiatric reports; this information will inform the development of a service level agreement for national application.

The South West pilot, among others, shows that there is significant scope for cutting the period on remand by reducing the time taken to produce written health reports for the courts. The pilot project includes a service level agreement that sets the target time for producing reports at 14 days. If this was achieved, then the time required to try a case would fall significantly, as would the period spent on remand, which currently averages 49 days.

"We can't have a situation where people are in the criminal justice system and shouldn't be for want of a well articulated psychiatric report."

Keith Stevens, Chair, Eastern Region Stakeholder Event, 9 September 2008

"How can it be acceptable that someone is left in prison on remand for six weeks just because they are waiting for a psychiatric report?"

Delegate from Eastern Region Stakeholder Event, 9 September 2008

Practice example
South West

The South West Health and Social Care in Criminal Justice Partnership Board is working with HMCS to improve the service available to defendants appearing in court who present with mental health difficulties.

The South West pilot involves HMCS commissioning an advice and assessment service from local mental health service providers in Bristol, Bath and Hampshire. HMCS has provided the pilot with funds for two years. The pilot is starting from the premise that people who come into contact with the criminal justice system are entitled to a health service in the same way as those referred through a GP or other source. What is different for defendants appearing before the courts, and what the pilot is commissioning, is the provision of timely advice in writing to the courts. This advice is being provided by a mental health worker – for example a community psychiatric nurse or mental health social worker – and by a psychiatrist only when the mental health service providers deem it appropriate (for instance when a hospital order is required).

The South West pilot is being evaluated by Bournemouth University.

I commissioned a brief study, based on information provided by one of the pilot sites,[114] to examine current practice in the commissioning of psychiatric reports for defendants at court, and to identify inefficiencies in this process and how they might be remedied.

As previously addressed in this report, the paucity of reliable data in this field has meant that work has been undertaken using the best figures available. There is no national data available on adjournments, trial length and trial costs, and consequently the cost estimate does not include any projected savings made through reduction in court time. The estimates do not represent an exact calculation, but clearly indicate that this is an area worthy of further exploration.

Cost/benefit analysis – court reports

The analysis suggested that there would be a minimal additional cost arising from implementing a different approach to commissioning and producing health and social care status reports and psychiatric court reports; however, this would have a positive impact on the criminal justice system of reducing the average period spent in custody on remand.

The analysis used a potential **10-day** reduction in the average remand period (feedback from pilots suggest this is a conservative estimate) to calculate that the total reduction in prison places required would be up to **122** places, with a subsequent reduction in annual costs of **£2.73 million**.

In addition to better use of resources, there are other benefits to be realised by an improved process for the production of reports to the court:

- Reports would be produced more quickly so that mental health issues could be addressed promptly as part of a sentencing package.
- A more efficient and effective court process would be in place, with fewer adjournments and shorter trial length.
- Court processes would be more effective, as appropriate information on the offender's mental health problem would be more swiftly available and impact on proceedings and sentencing.

Tribal – *Financial support to the Bradley review*, November 2008

Recommendations

- **Courts, health services, the Probation Service and the Crown Prosecution Service should work together to agree a local service level agreement for the provision of psychiatric reports and advice to the courts.**
- **All criminal courts should carry out a six-month baseline study recording psychiatrists' and psychologists' reports commissioned by the court and the cost of those reports, in order to inform the development of the service level agreement.**

Advice and training for the judiciary

As with all other professionals in the criminal justice system who come into contact with offenders with mental health problems or learning disabilities, training for magistrates and judges on mental health and learning disability issues is crucial. In addition to the training, it is also vitally important for them to have access to information on the offender, and available local services, in order to inform their decisions in court.

One of the key roles of liaison and diversion services has been, and should continue to be, the provision of information and the facilitation of training. In Chapter 2 I focused on this role in relation to the police, but the issues are the same in the courts, and liaison and diversion services should take responsibility for links with local services and input into training initiatives.

In addition, it will be important for consideration to be given at national level to how mental health and learning disability training might be adapted for use by the judiciary, and how it might be incorporated into their mainstream training and support.

I was very pleased to have had the opportunity to meet with a number of judges and magistrates during this review, both in individual meetings and during the course of my visits to various courts. I am grateful for the time and expertise that they have been able to share with me and I hope that they are able to see the issues they have raised reflected in this report. A summary of the key concerns raised by this group is as follows:

- early information regarding a defendant's mental health or learning disability needs;
- the proportionality and timeliness of psychiatric reports;
- access to better information and advice about local mental health services, in order to make better use of community disposals; and
- better links to liaison and diversion services where they are available.

"Sentencers can only act positively if they are provided with full information about the offender and their circumstances – which is very often not the case."

Extract from submission to the review from the Magistrates' Association, 29 February 2008

Recommendations

- **The judiciary should undertake mental health and learning disability awareness training.**
- **Liaison and diversion services (see Chapter 5) should form close links with the judiciary to ensure that they have adequate information about the mental health and learning disabilities of defendants, and concerning local health and learning disability services.**

Specialist courts/problem-solving courts

Introduction

The USA has seen a growth in mental health, drug, community and domestic violence courts since the first drug court was created in 1989, and they have spread internationally to countries such as Australia, Ireland and Canada.[115]

Specialist courts or problem-solving courts shift the focus from processing cases to improving outcomes for victims, communities and defendants. Their principal characteristic is using court authority to:

> "forge new responses to chronic social, human and legal problems that have proven resistant to conventional solutions. They seek to broaden the focus of legal proceedings, from simply adjudicating past facts and legal issues to an early intervention into the behaviour of litigants."[116]

England and Wales currently have 124 specialist domestic violence court systems, 2 drug court pilots and 2 community justice courts, plus a further 11 community justice initiatives. The review took the opportunity to visit an example of each of these specialist courts and speak directly to those involved in running them.

Drug courts

Research from other countries suggests that where offenders misuse drugs, an approach by the courts that addresses all their needs can increase engagement with treatment, improve chances of successful completion of treatment and so reduce drug use and related offending.

The Dedicated Drug Court (DDC) framework for England and Wales provides for specialist courts which exclusively handle cases relating to drug-misusing offenders from conviction through sentence to completion (or breach) of a Community Order with a Drug Rehabilitation Requirement. Two magistrates' courts have been piloting the DDC model in England and Wales since 2005: Leeds Magistrates' Court and West London Magistrates' Court. The pilot was extended in early January 2009 to the magistrates' courts in Barnsley, Bristol, Cardiff and Salford.

The Ministry of Justice commissioned a process report[117] on the first two drug courts, which examined their process and structure, and provided an indication of their costs and benefits, and of their implementation. One of the key elements of drug courts that is fundamental to their success is the continuity of the judiciary. The report suggests that there is strong evidence that when an offender has continued contact with the same magistrates or judges, this has a significant impact. For example, greater continuity of magistrates is associated with offenders being less likely to miss a court hearing, more likely to complete their sentence and less likely to be reconvicted. Evaluation of the pilot courts found qualitative evidence that continuity was in place in both pilot sites (albeit via different models), but that challenges still exist in achieving continuity, in particular across review and breach hearings.

I was disappointed to find that despite the strong evidence to suggest that there are high numbers of individuals with dual diagnosis, there is no mention of the need for supporting mental health services in the body of the Ministry of Justice report.

Review visit to drug court

My visit confirmed the excellent work being undertaken to support offenders with drug problems and I was impressed by the enthusiasm and drive of individuals involved. However, given what we already know about the high prevalence of mental health problems among those with drug problems, I was disappointed to learn that there was no formal provision of mental health services to the drug court. This raises a question about how such courts can address the issue of dual diagnosis, particularly when there are also plans to set up separate mental health courts. The particular court I visited did not have a liaison and diversion scheme in place; it would perhaps be sensible to look at how a combination of a drug court and a mental health liaison and diversion scheme might help to address the dual diagnosis issue.

Some of the other issues the visit raised were as follows:

- **Referral criteria**: there were concerns that these were not accurately reflecting the local community, and the known make-up in relation to black and minority ethnic (BME) groups. In other words, despite the fact that there were large numbers of people from BME groups within the local offending community with drug problems, they were very poorly represented in the group being referred to the drug court.
- **Funding**: despite having been in place for some time, the funding had not been embedded into mainstream budgets and the court was still running on a pilot basis.

Recommendation

- **The Ministry of Justice should examine how individuals with a dual diagnosis are served in drug courts.**

Domestic violence courts

This specialist court programme is a co-ordinated community response to domestic violence that combines both criminal justice interventions (e.g. dedicated domestic violence prosecutors) and non-criminal justice interventions (e.g. independent domestic violence advisors). Together they form a multi-agency response that creates greater victim safety and brings perpetrators to account.

The programme has identified 11 core components (now increased to 12) that each area setting up this court system should consider. For the system to work effectively,

close co-ordination of all these components is required and key individuals need to be identified and held to account for the delivery of their section of the service. The components include the following:

- multi-agency partnerships with protocols;
- multi-agency risk assessment and risk management procedures for victims, perpetrators and children;
- identification of cases;
- specialist domestic violence support services;
- trained and dedicated criminal justice staff;
- court listing considerations;
- equality and diversity issues; and
- performance management.

Key issue from visit to the Domestic Violence Court, Wigan

This domestic violence court represented an excellent model of a court that can address all an individual's needs, taking account of the fact that people appearing at the court may have many different problems. I was particularly impressed with the emphasis on multi-agency partnerships and risk assessments.

Mental health courts

The mental health court model provides a problem-solving approach to dealing with mentally disordered offenders. It seeks to address the underlying issues associated with their criminal behaviour, aiming to reduce re-offending rates and the 'revolving door' syndrome, while securing timely access to health services. It builds on experience developed by HMCS in targeting other problem areas, such as anti-social behaviour, domestic violence and drugs, and adopts elements of the specialist domestic violence court and DDC models.

Key features of the model include:

- enhanced psychiatric services at court so that mentally disordered offenders are identified at an early stage and appropriately assessed;
- increased interaction between criminal justice agencies and health providers to speed up the delivery of assessment and court reports;
- clustering of cases on a particular day at sentence, review and breach stage;
- judiciary specially trained on mental health issues;
- availability to sentencers of the Community Order with supervision or mental health treatment requirement for mentally disordered offenders; and
- regular review of orders by the same magistrate/district judge or offender manager to monitor progress and encourage compliance.

I know that the Government is planning to roll out similar pilots in this country shortly. Although on the face of it this seems a way of successfully dealing with offenders with mental health problems, my visit to a mental health court in North America raised some concerns that should perhaps be explored before importing the idea as it stands.

Key issues from visit to the Bronx Mental Health Court, North America

- Although the scheme was extremely effective for those selected to go through the courts, there was a very limited number of places available. Places were allocated on the basis of identified services being available for that individual.
- Although the court was badged as 'mental health', the cases were overwhelmingly dual-diagnosis, with alcohol being a particular problem.
- The court had been running for some time; however, it was still being run on a pilot basis. It had not been integrated into mainstream services and the mental health court only sat on certain days of the week.

I would also question the value of such courts if the role of liaison and diversion services is to be developed as recommended (see Chapter 5). Of the list of key features outlined above, the majority could be met by effective liaison and diversion services which would eventually be available to all courts, rather than just a small proportion.

As with the drug courts, the mental health courts will also need to consider how they will tackle the issue of dual diagnosis, and what the links will need to be with substance misuse services.

Community courts

Community justice is part of the Government's agenda to tackle anti-social behaviour and the crime associated with it. Community justice brings the justice system and the community together to solve problems, reduce crime and build public confidence. The eight key principles of community justice are:

- courts connecting to the community;
- justice being seen to be done;
- cases handled robustly and speedily;
- a strong, independent judiciary;
- solving problems and finding solutions;
- working together;
- repairing harm and raising confidence; and
- re-integrating offenders and building communities.

Evaluations[118] of the first two community courts in England and Wales (North Liverpool and Salford) show that the full impact of these community justice projects may take years to assess.

The early evidence is that they are making progress towards many of their original objectives. The objectives of North Liverpool are as follows:

- Reduce low-level offending and anti-social behaviour.
- Reduce fear of crime and increase public confidence in the criminal justice system.
- Increase compliance with community sentences.

- Increase victims' and witnesses' satisfaction with the criminal justice system.
- Increase the involvement of the community in the criminal justice system.
- Reduce the time from arrest to sentence.

There are now 11 new community justice projects under way. One example is the Birmingham project, which encourages partnership working between all the criminal justice agencies as well as the local judiciary and magistrates, local authorities, Victim Support, community safety partnerships and many other services such as housing associations and drug and alcohol services.

Visit

Community Justice Centre, North Liverpool

The centre is a unique initiative, bringing justice into the heart of the community, tackling crimes and anti-social behaviour that affect the quality of life of people living in the local authority wards of Anfield, County, Everton and Kirkdale in North Liverpool.

The first of its kind in England and Wales, the centre aims to work closely with local people to understand and tackle the causes of anti-social behaviour and crime as well as crime itself. It combines the powers of a courtroom, run by Judge David Fletcher, with a range of community resources, available to residents, victims and witnesses as well as offenders. It also organises and supports activities involving local residents and, in particular, young people.

Other criminal justice agencies on Merseyside, including the police, the Crown Prosecution Service and the probation and youth offending teams, have advice and support teams located at the centre, enabling a joint approach to dealing with local offences.

The Community Resource Team provides a range of free and confidential services for anyone living in North Liverpool, including:

- **support for victims and witnesses;**
- **legal advice on housing, debt and benefits;**
- **help for those with drug and alcohol problems;**
- **help with education and employment; and**
- **individual support through its mentoring scheme, Side by Side, which uses local volunteers.**

Key issues from visit to the Community Justice Centre, North Liverpool

As with the domestic violence courts, this was an excellent model of a court that was able to address the multiple needs of offenders.

During my visit to the Community Justice Centre, I saw the effectiveness of its approach in addressing a wide range of complex offender needs. This raised a question for me about the establishment of specialist courts that only address single specific issues, such as drugs or mental health. As this report clearly sets out, offenders vary rarely have problems that can be isolated in this way. Not least, drug and alcohol misuse are very often linked with mental health problems, and yet two specialist court models have been developed to deal with these issues separately.

"It would be better to provide mainstream court staff with training to foster an understanding and awareness of mental health and substance misuse issues."

Comment on specialist court from stakeholder submission to the review[119]

Stakeholder views on specialist courts

The views expressed by stakeholders on the development of specialist courts were decidedly mixed. Half of the stakeholders who responded on this issue were against the idea, feeling that it might encourage stigmatisation of individuals attending certain specialist courts that could lead to further social exclusion. They also felt that the development of specialist courts might detract from ensuring that all courts have some expertise and resources to deal with the needs for which such courts are proposed. Those that responded in favour supported the opportunity for offenders to build up a relationship with the judiciary, and commented on how this contributed to successful rehabilitation.

Recommendations

- **All courts, including current specialist courts, should have access to liaison and diversion services, in order that specialist courts are seen as an addition to a comprehensive liaison and diversion service.**
- **Her Majesty's Courts Service and the Department of Health should investigate how defendants with a dual diagnosis of mental ill health and drug/alcohol misuse are currently served by all courts, including specialist courts.**
- **A study should also be undertaken to evaluate how community justice centres impact specifically on people with mental health problems or learning disabilities.**

Liaison and diversion schemes

Introduction

I have referred to liaison and diversion schemes at many points of the report so far, and discussed the role that they can serve in relation to offenders with mental health problems or learning disabilities. The focus of interventions for this population has historically been at the court stage and so I feel that this is an appropriate point at which to examine these schemes in more detail.

Key facts

- There is no agreed definition of what constitutes a liaison and diversion scheme, and there is no national list of schemes.
- Due to the lack of a national list, there is no official figure of the number of liaison and diversion schemes in operation, although a recent publication[120] suggests that there are between **100** and **110** in England. Others[121] suggest that, including schemes in Wales, the number could be as high as **143**.
- The majority of schemes are funded by health services.
- The majority of schemes are based at magistrates' courts.
- **16%** of schemes operate three days a week or less.

"Services have evolved rather than been planned."

Delegate at Yorkshire & Humber and North East Stakeholder Event, 1 October 2008

Context

In 1990, the idea of court liaison and diversion was promoted by the Home Office.[122] This idea was further supported by the 1992 Reed Report[123] which recommended the following:

> "There should be nationwide provision of properly resourced court assessment and diversion schemes and the further development of bail information schemes. ... The longer term future of many schemes is not yet assured but experience increasingly suggests that, where diversion schemes became established, these come to provide a broader multi-agency focus which, of itself, can make effective disposals easier."

The absence of a centralised strategy over the intervening years has meant that schemes have developed at different rates, or not at all, with many pilot schemes being set up with insecure funding arrangements that are not embedded into the health service or criminal justice infrastructure. Current opinion among stakeholders is strongly in favour of continuing to develop schemes, and during the course of the review it became clear that if effectively run, liaison and diversion schemes could become the basis for interventions for people with mental health problems or learning disabilities across the offender pathway.

The aim of the early schemes was to focus on diversion, in the sense of moving someone away from the criminal justice system to hospital. Diversion was originally focused at the court stage, but many schemes have since developed to provide services at other points of the criminal justice system. Many schemes now also

operate what is essentially a triage service at police stations and courts, and sometimes at other sites such as probation and bail hostels. However, there has been no consistency in this development, and as a consequence there are a variety of models of scheme which have different responsibilities and fulfil many different functions. They are broadly represented by the following examples,[124] or a combination of them:

- **Diversion schemes**: these schemes work to increase the identification of mental illness and facilitate and accelerate transfer to hospital where appropriate.
- **Assessment schemes**: assessment schemes have more of a focus on identifying and assessing people appearing before the courts, in order to assist magistrates with disposal options. They can reduce the time taken for magistrates to obtain advice by assessing the defendant at court rather than while they are on remand in prison.
- **Liaison schemes**: these schemes have a wider role – rather than diverting people out of the criminal justice system into the health service, they offer support and liaison both to people with mental health problems and to the agencies involved with them, so as to ensure they are treated appropriately. Their role may include processing people through the criminal justice system as well as dealing with their mental health problems.
- **Panel schemes**: mentally disordered offender (MDO) panels formally bring together a range of agencies – police, health, social care and probation – to put forward a co-ordinated package of care for the courts or Crown Prosecution Service (CPS) to consider. They also co-opt other agencies and organisations, such as third sector organisations, housing services and drug services.

Aside from these core functions, schemes also see their role as assisting where there are problems with information sharing, effectively becoming the conduit for the exchange of information between different agencies. A number also assist in the training of criminal justice practitioners on mental health awareness, risk assessment and risk management.

We are in effect the interface between two big organisations (the health service and criminal justice system) that don't really understand each other.

Sheffield Diversion Scheme worker, 1 October 2008

Learning disabilities

The vast majority of liaison and diversion schemes do not currently have learning disability expertise. Just three of 64 schemes (out of a total of 143) that responded to a survey in 2005[125] included learning disability workers. This is despite the Reed Report's recommendation in 1992 that "court diversion and assessment schemes should develop effective links with local learning disability teams and, where possible, team members should be encouraged to contribute to schemes."

National criminal justice mental health team audit

The national picture of services provided by liaison and diversion schemes has been unclear; there has not even been common agreement about how many actually exist and what services they provide. Up to this point, information on schemes has only been available through the efforts of the voluntary sector, for example from the regular surveys of schemes conducted by NACRO.[126]

In 2005, the Office for Criminal Justice Reform[127] commissioned the first of two literature reviews[128] to establish the characteristics of effective practice in mental health delivery for those in the criminal justice system. Through these literature reviews, the Mental Health Effective Practice Audit Checklist (MHEP-AC) was developed. The checklist entailed the examination of seven key areas: screening, assessment, facilitating access to mental health support, information exchange, multi-agency work, liaison, and data collection and analysis. This assessment tool was used to undertake, for the first time, a centrally commissioned audit[129] of schemes across England. The aim of the Department of Health-commissioned audit, using the MHEP-AC tool, was to:

- identify the profile of delivery of mental health services in criminal justice mental health teams;
- identify the characteristics of schemes with effective mental health practice; and
- identify aspects which facilitate or constrain effective mental health practice.

The audit reported its findings directly to this review and I have drawn on some of its material in this chapter. The audit has been extremely timely as it gives us a baseline picture of services. The full report of the audit will be published alongside this review.

> **“You’re OK if you’re mentally ill on a Tuesday.”**
>
> Comment on local diversion schemes, delegate at London event, 4 March 2008

General findings

In total, 101 criminal justice mental health schemes and teams in England were audited. These represent the majority of schemes in operation in England at the time of the audit (March–May 2008).

Funding arrangements

Of the schemes audited, 66% were reported to be health-funded; 29% were jointly funded by health and other monies, such as funding from the local authority, the Probation Service, the police or social services; and 4% were fully funded by the local authority. The funding that was put in place to start a scheme might not be from the same source as the funding to sustain it. In addition to formal funding arrangements, schemes may receive benefits in kind from other organisations, such as the use of facilities.

Jointly funded schemes outperformed schemes funded solely by health monies, and rarely achieved any weak scores. They were six times more likely to receive excellent scores than purely health-funded schemes.

Availability

Some 5% of the schemes were open more than five days a week; 80% were open on weekdays and 16% on three days a week or less. In some regions arrangements with crisis assessment or crisis intervention teams were in place for out-of-hours cover.

During the course of the review I was able to visit several schemes, and one of the key difficulties seemed to be that schemes were often not sufficiently well resourced to provide coverage across the whole week. In one example I visited, the scheme was only in place for one day a week, with the adverse effect that potential clients who arrived at court on other days were remanded back to prison until the day of the scheme.

Setting

Some 34% of schemes operated exclusively at one or more magistrates' courts; 14% operated exclusively at police stations and often served several stations; 24% of schemes operated in both police and court settings; and 28% were multi-site and operated over at least three locations, usually a court, a police station, and a prison or probation premises.

The courts referred to in the audit are magistrates' courts. Schemes have not generally provided services to cover the Crown Court; the vast majority of cases are heard through magistrates' courts, and most people appearing at Crown Court will have been through a magistrates' court first. However, since the start of this review, services to the Crown Court have begun to be piloted. The example detailed below provides a valuable service to the court it serves and reinforces the view that there should be access to such services at every point of the criminal justice system.

Visit

Crown Court pilot scheme

Early in the review, I visited the Central Criminal Court in London to learn about its proposed pilot liaison and diversion scheme which was due to be implemented. The scheme was to have a mental health senior nurse available at court at all times with a visiting consultant psychiatrist, who would hold one or two sessions a week and would take referrals from any source.

The scheme, as well as providing support to individuals, was also to be available to provide advice and information to those working in the court, such as members of the CPS and solicitors.

The scheme is now in operation. Primarily, it has enhanced the flow of communication between stakeholders and the agencies concerned, leading to improved health outcomes and more efficient use of court time. An independent evaluation has begun and it is hoped that the pilot will be extended for another year.

Staffing

Some 19% of schemes were reported as operating with a single staff member, 28% were operated by two people and 37% of schemes were between three and five people strong, with the remaining 17% of schemes having more than five people. In addition, 77% of schemes had at least one nurse as part of the team and 32% had a psychiatrist. Other schemes, however, indicated that they could access a psychiatrist when required, even though they were not team members. 44% of teams included a social worker.

Some 19% of schemes had a multi-agency component to their staffing, with representation from, for example, the Probation Service, psychology, the voluntary sector and drugs and alcohol services. However, BME groups and housing services had limited recorded representation. 54% of schemes reported having an active steering group and 58% reported that they had a clear development plan.

Workload

Some 20% of schemes saw up to 100 clients annually, 41% reported seeing between 101 and 300 clients and 40% saw more than 300.

Successful characteristics

The findings from the profiles of schemes were checked against the audit checklist scores in order to establish the characteristics that demonstrate excellent practice. Some of the identified key characteristics for effectiveness were as follows:

- Larger teams performed better than smaller teams. In addition, teams that saw fewer than 100 clients a year never achieved an excellent score.
- Court-only teams were more likely to score 'limited' or 'weak' in all categories than police-station-only teams or teams that operated on multiple sites.
- Jointly funded schemes outperformed schemes funded solely by health monies and rarely achieved any weak scores.
- An active steering group was an important quality assurance factor.
- A development plan was a good indicator of excellence.

Barriers to an effective service

The report also looked at key barriers to an effective service, which included the following:

- Information exchange generally worked well, but more often than not this was because schemes had been in existence for a long time and informal links had been formed between professionals from different agencies.

- Multi-agency work continued to be an area that schemes found problematic and there were few schemes which reported positive relationships with all their multi-agency partners.
- Housing provision and the presence and absence of probation hostels were unevenly distributed. Being able to offer secure housing is an important factor in reducing the risk of re-offending and can influence a criminal justice disposal.
- Most schemes collected data but many of them stated that there was no reporting structure into which this data could be fed.
- The overwhelming majority of clients had dual diagnosis, many with substance misuse as a primary diagnosis, and very few of the schemes had any dual diagnosis protocols in place.

“Diversion schemes should not be based merely on people with an interest or people with a will – they should be based on a strong strategic direction.”

Angela O’Rourke, Chair of Yorkshire & Humber, and North East Region Stakeholder Event, 1 October 2008

Liaison and diversion for women

A 2007 evaluation of criminal justice liaison and diversion schemes[130] looked specifically at how successful schemes were at supporting and diverting women offenders with mental health problems. It reached the following conclusions:

- Only half of the schemes looked at described their screening as proactive. This is cause for concern as women have been described as less vocal and more withdrawn in their presentation.[131]
- Women offenders were in the minority as clients, and gender-specific services at the point of contact were few.
- There was very rarely an opportunity for same-sex screening, as only a small proportion of the schemes examined by the study had female staff.
- There were relatively poor links with women’s prisons, partly due to the geographical dispersal of the women’s estate, and infrequency of contact.
- Lack of gender-specific training, particularly in relation to guidance on dealing with eating disorders or sexual abuse.

The study was unable to draw conclusions in relation to outcome due to the poor quality of data.

The recommendations made by the study follow a similar pattern to the more general recommendations for improving the performance of liaison and diversion schemes, for example around resources, proactive screening, improved links with community-based services, partnership working, performance monitoring and publicising schemes. Those that are gender-specific relate to availability of female staff and to improving working relationships with women’s prisons. I am confident that the recommendations from my review, as they address general improvements to schemes, will go a long way towards supporting a better service for women in the criminal justice system.

I am pleased to note that the Government is committed to making improvements to alternatives to custody. The Ministry of Justice has just announced, as part of its response to Baroness Corston’s report,[132] that it intends to provide £15.6 million of

new funding to invest in the provision of additional services in the community for women offenders and women at risk of offending.

Summary

In summary, the criminal justice mental health scheme audit report concludes that strong and sustainable schemes are larger, have a secure budget over the long term, an active steering group and a development plan, and see larger numbers of clients.

There are currently only 13 such schemes that regularly secure excellent scores and rarely achieve weak scores. The fragility of many schemes and their failure to operate to full effectiveness following the initial start-up often appears to be linked to the dependence of teams on personality rather than protocols, weak management, limited opportunities for continuous professional development and insecure funding.[133]

I have been greatly impressed by the many examples of liaison and diversion schemes in different settings that I have come across during the course of my review. Although it is easy enough to be critical of schemes for their shortcomings, it must be remembered that they have developed despite the lack of national drive and investment. Many schemes owe their existence to the enthusiasm and dedication of individual members of staff, and although the work of such individuals is to be applauded, it is no basis on which to rely for such an important service. This issue is further addressed in Chapter 5, where I set out my recommendations for delivering change.

References

99 Judiciary of England and Wales, 2008, *The Lord Chief Justice's review of the administration of justice in the courts*

100 Ministry of Justice, 2007, *Judicial and court statistics 2006*

101 Shaw J et al, 1999, Prevalence and detection of serious psychiatric disorder in defendants attending court, *Lancet*, Vol 353, pp 1053–1056

102 Kebell M et al, 2001, People with learning disabilities as witnesses in court: What questions should lawyers ask? *British Journal of Learning Difficulties*, Vol 29, pp 1–5

103 www.justice.gov.uk/publications/populationincustody-2008.htm

104 Department of Health, 2008, *Refocusing the Care Programme Approach: Policy and positive practice guidance*

105 Department of Health, 2007, *Getting through: Access to mental health services for people who are homeless or living in temporary or insecure accommodation*

106 Prison Reform Trust, 2008, *Bromley briefings*

107 www.fawcettsociety.org.uk

108 Home Office, 2007, *The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*

109 Hatfield B et al, 2004, The mental health of residents of approved premises in the Greater Manchester probation area: A cohort study, *Probation Journal*, Vol 51, pp 101–115

110 HM Inspectorate of Probation, HM Inspectorate of Prisons and HM Inspectorate of Constabulary, 2008, *Joint inspection of approved premises*

111 National Probation Service, 2007, *Probation bench handbook*

112 Winstone J and Pakes F, 2006, *Mental health literature review: Effective practice*

113 Home Office Strategic Policy Team, 2006, *Report on mentally disordered offenders*

114 Tribal, 2008, *Financial support to the Bradley review*

115 Center for Court Innovation, 2007, *Don't reinvent the wheel: Lessons from problem-solving courts*

116 Department for Constitutional Affairs, 2005, *Review of the effectiveness of specialist courts in other jurisdictions*

117 Ministry of Justice and Matrix Knowledge Group, 2008, *Dedicated drug court pilots: A process report*

118 www.communityjustice.gov.uk

119 Offender Health Research Network, 2008, *Independent evaluation of responses to the review*

120 Winstone J and Pakes F, 2008, *Report on national criminal justice mental health team audit (England)*

121 NACRO, 2009, *NACRO directory of criminal justice mental health liaison and diversion schemes in England and Wales*

122 Home Office, 1990, *Provision for mentally disordered offenders*. Home Office Circular 66/90

[123] Department of Health and Home Office, 1992, *Review of health and social services for mentally disordered offenders and others requiring similar services (The Reed Report)*

[124] NACRO, 2006, *Liaison and diversion for mentally disordered offenders*

[125] NACRO, 2005, *Findings of the 2004 survey of court diversion/criminal justice mental health liaison schemes for mentally disordered offenders in England and Wales*

[126] www.nacro.org.uk/mhu/index.cfm

[127] www.homeoffice.gov.uk/about-us/organisation/directorate-search/ocjr/

[128] Winstone J and Pakes F, 2008, *Provision of mental health services to individuals passing through the criminal justice system: A qualitative literature review*

[129] Winstone J and Pakes F, 2008, *Report on national criminal justice mental health team audit (England)*

[130] Hunter G et al, 2007, *Evaluation of criminal justice liaison and diversion schemes: A focus on women offenders*

[131] NACRO, 2008, *Criminal justice liaison and diversion schemes: A focus on women offenders*. Mental health briefing

[132] Home Office, 2007, *The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*

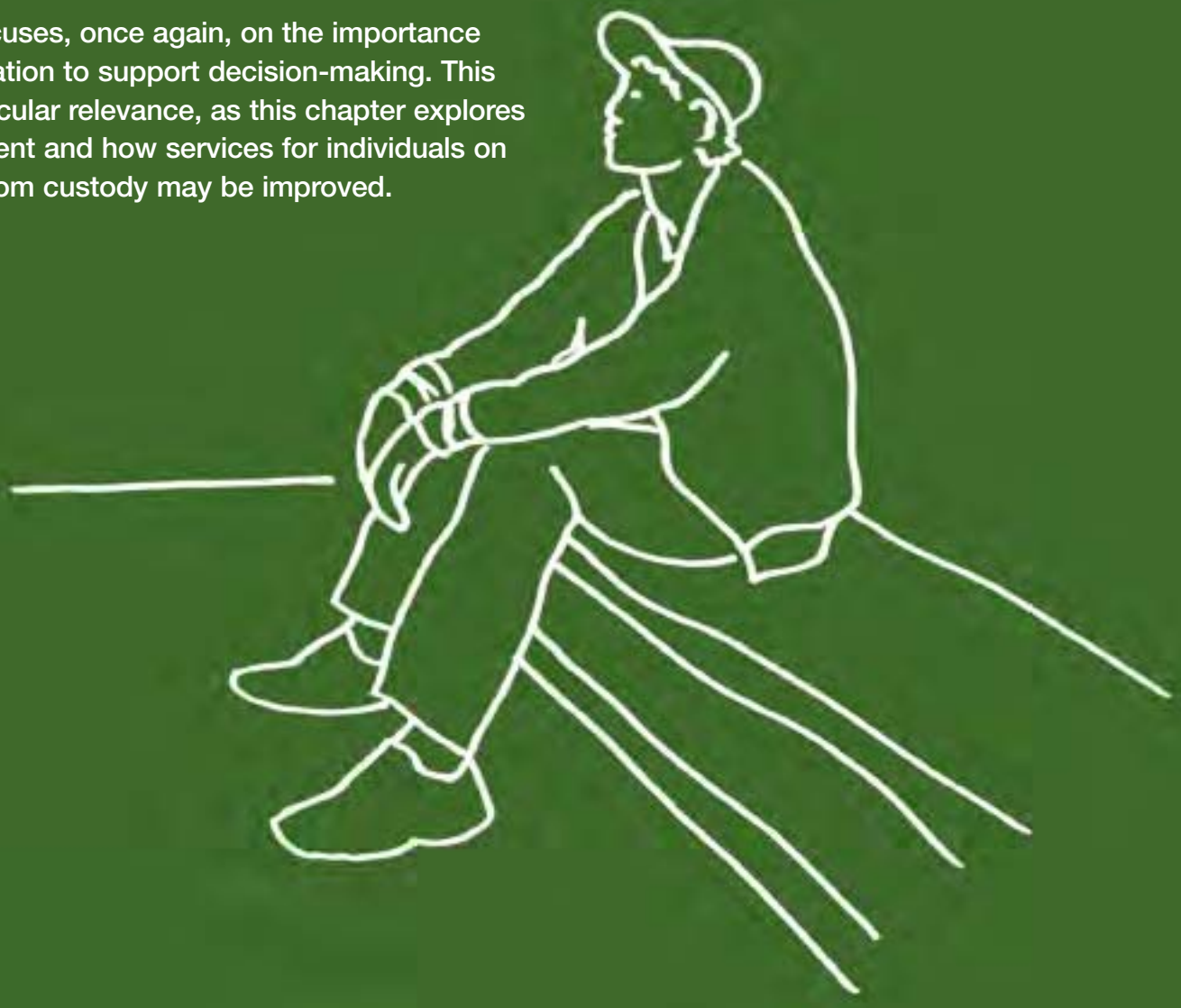
[133] Winstone J and Pakes F, 2008, *Report on national criminal justice mental health team audit (England)*

4

Prison, community sentences and resettlement

This chapter looks at the options of custodial and community sentences available to the judiciary, the impact of these options on individuals with mental health problems or learning disabilities and what services are necessary to support them.

It also focuses, once again, on the importance of information to support decision-making. This is of particular relevance, as this chapter explores resettlement and how services for individuals on release from custody may be improved.



Introduction

Alternatives to custody are available to judges and magistrates when sentencing individuals found guilty of a crime. Prison does not always have to be the default position for many offences; where used appropriately, community sentences can provide safe and positive opportunities for offenders with mental health problems or learning disabilities to progress with their lives, as well as receiving a proportionate sanction from the court.

For some individuals, a custodial sentence will be necessary. Where this is the case, they should have access to appropriate treatment, rehabilitation and resettlement services.

Many issues and problems exist in ensuring that individuals receive the most appropriate disposal and treatment following conviction. We have heard in previous chapters how information may be gathered and shared so that the right decisions can be made about the use of community or custodial sentences. This chapter provides an opportunity to examine custodial and community sentences in more detail and to look at the services, for people with mental health problems or learning disabilities, necessary to support these sentences.

Equally important is the continuation on release of any treatment started in custody. The second part of this chapter looks at the current arrangements in place for resettlement following release from custody and how these may be improved.

Community sentences

Key facts

- Community sentences accounted for **196,400** sentences in 2007, **13.9%** of all sentences; this represents an increase of **3.8 percentage points** from 1997.[134]
- For indictable offences, the community sentence rate was **33.8%** in 2007, down from **34.2%** in 2006 and lower than in 2004 and 2005.
- In 2006, **137,260** community sentences were started under the supervision of the Probation Service.
- During 2006 the courts gave **121,690** Community Orders.
- **50%** of Community Orders starting in 2006 had one requirement, **35%** had two requirements, **14%** had three requirements and **1%** had four requirements. A table listing all the requirements is set out on the following page.
- In 2006, only **725** of the **203,323** requirements commenced under Community Orders were mental health treatment requirements (MHTRs).[135]
- In a review of 302 offender case files, 17 (**6%**) included an MHTR.[136]
- Only **164** of the **60,185** requirements commenced under Suspended Sentence Orders in 2006 were MHTRs.

Context

The Criminal Justice Act 2003 introduced a new Community Order which gives a choice of 12 different requirements that an offender can be ordered to complete as part of a community sentence. Courts are able to choose different elements to make up a bespoke Community Order, which relates to a particular offender and the crime(s) they committed.

One of the 12 requirements is the MHTR. With the offender's consent, the court may direct them to undergo treatment by or under the direction of a medical practitioner and/or a chartered psychologist, with a view to the improvement of their mental condition. Treatment under this requirement may be as a resident patient of a care home or hospital (but not in hospital premises where 'high security' psychiatric services are provided), as a non-resident patient of such an institution, or under the direction of a medical practitioner and/or a chartered psychologist. Where the proposed treatment is residential, then the offender must be asked for their consent. These MHTRs are normally combined with a Supervision Requirement to support and reinforce rehabilitation and provide additional support.

An offender with learning disabilities who is convicted of an offence can also be given a Community Order if the offence fits the appropriate criteria.

Criminal Justice Act 2003 – requirements for Community Orders			
Requirement	**Level of seriousness**	**Length**	**Main purpose(s)**
Unpaid work	Low Medium High	40–80 hours 80–150 hours 150–300 hours	Punishment Reparation Rehabilitation
Supervision	Low Medium High	Up to 12 months 12–18 months 12–36 months	Rehabilitation
Programme (accredited)	Medium High	Stated number (or range) of sessions	Rehabilitation
Drug rehabilitation (offender must consent)	Low Medium High	6 months 6–12 months 12–36 months	Rehabilitation
Alcohol treatment (offender must consent)	Low Medium High	6 months 6–12 months 12–36 months	Rehabilitation
Mental health treatment (offender must consent)	Medium High	Up to 36 months	Rehabilitation
Residence	Medium High	Up to 36 months	Rehabilitation Protection
Specified activity	Medium High	20–30 days Up to 60 days	Rehabilitation Reparation
Prohibited activity	Low Medium High	Up to 24/36 months for Suspended Sentence Order/Community Order	Punishment Protection
Exclusion	Low Medium High	Up to 2 months Up to 6 months Up to 12 months	Punishment Protection
Curfew (typically up to 12 hours a day)	Low Medium High	Up to 2 months 2–3 months 4–6 months	Punishment Protection
Attendance centre	Low	12–36 hours	Punishment

Issues regarding community sentences

In 2008, the National Audit Office (NAO) published a report[137] that examined how well the National Probation Service manages Community Orders, and in particular how well these orders have been implemented and whether they are meeting sentencing objectives.

Only 17 of the 302 cases reviewed for the report (6%) included an MHTR. In all of these instances, the offender was already in receipt of treatment before the order began and the treatment was incorporated into the order. The NAO found no instances in the sample of mental health treatment being initiated as part of the Community Order.

In addition, the report identifies that in some cases an order requirement was later removed as being unsuitable for an offender, for example where an offender was unable to complete their paid work due to mental health issues. This example underlines the importance of sentencers having full information about an offender's needs in order to be able to judge the suitability of particular requirements and their ability to comply with them.

The NAO also commissioned a literature review[138] on the effectiveness of Community Orders in reducing re-offending. This review found that for a number of community-based interventions, including mental health treatment, the evidence was inconclusive regarding their effectiveness in reducing re-offending as they have not been subject to thorough evaluations. This is attributed to both the limited amount of research in the area and the low quality of research design in existing studies. The literature review highlights the need for more rigorous research, recommending randomised trials of the requirements that constitute Community Orders.

It could be argued that it would be difficult to determine the effectiveness of MHTRs in relation to reducing re-offending because they are normally combined with other requirements, such as a supervision requirement. It is also difficult to compare one MHTR with another because they depend on the particular mental health problems of the individual concerned and the treatment required to address them.

When I spoke to service users during the course of my review, they were clear that they supported the concept of community sentences but recognised that there were still some issues to be addressed. These included:

- agreement that potential risk to the individual or other members of the community must be overriding factors;
- a lack of consistency in implementation across the country;
- a need for better engagement with service users and carers to ensure the best treatment for the individual;
- an unwillingness for defence lawyers to recommend a Community Order to their client should the order period exceed that of a custodial disposal; and
- a need for a better understanding of these orders by sentencers.

"We have long stated that such offenders should not receive custodial sentences if there are appropriate community penalties available."

Extract from submission to the review from the Magistrates' Association, 29 February 2008

This last point is echoed in the recent report by the House of Commons Justice Committee,[139] which makes the recommendation that sentencers would benefit from better guidance on their options with regard to people requiring different levels of mental health support, including MHTRs as part of a community sentence. It suggested that this guidance should be provided as soon as possible. In my opinion it is important for both sentencers and probation staff to have access to clear guidance on the use and availability of MHTRs in order to alleviate the current confusion.

Case study

A service user was issued with a Community Order with an MHTR. However, when it was issued nobody within the court knew who was responsible for setting up the treatment required. The judge thought it should be the defending solicitor, which the defending barrister challenged. The judge asked the probation officer, who said it was not his responsibility to do this. In the end, the judge adjourned the case, which allowed the individual to ask his new GP to refer him to a psychiatrist.

The recent report on MHTRs by the Sainsbury Centre for Mental Health (SCMH)[140] highlights additional barriers to their usage. This report argues that MHTRs are only suitable in particular cases, as one of the prerequisites to an offender receiving one is that, on the evidence of a registered medical practitioner, their mental condition is such that it requires and may be susceptible to treatment, but does not warrant the making of a Hospital Order or Guardianship Order within the meaning of the Mental Health Act 1983 (now 2007). SCMH argues that as a result some offenders may not legally be eligible for MHTRs because of the nature of their mental health problems. A further piece of work by SCMH is under way; it is currently in the process of conducting more in-depth research to explore the MHTR, its usage, delivery and impact across nine London boroughs.

To support my review, I commissioned a cost/benefit analysis[141] to examine the impact on prison places should there be an increase in the use of Community Orders for people with mental health problems and learning disabilities. While there were problems with available data, early indications suggest that there are significant cost savings to be made for the criminal justice system by increasing the use of community sentence alternatives for individuals with mental health problems or learning disabilities.

Cost/benefit analysis – community sentences

If one takes into consideration the proportion of individuals who receive short sentences who may be experiencing mental health problems and may possibly be eligible for a community sentence, then it is estimated that as many as **2,000** prison places per year could be saved.

Set against an increase in the cost of community sentences, the savings for the Criminal Justice System may possibly reach (in the best case scenario) **£40m** per year.

Even if one takes into account the increase in spending necessary by mental health services to support these individuals, a net saving is still feasible.

Tribal – *Financial support to the Bradley review*, November 2008

These early findings are supported by separate research undertaken by SCMH on the cost benefits of diversion. The report,[142] which I have referred to in earlier chapters, concludes that there is a particularly strong case for diverting offenders away from short sentences in prison towards effective treatment in the community. I am of the opinion, however, that a centrally commissioned, more in-depth study needs to be undertaken to verify these initial findings.

I also recognise that there are significant qualitative benefits in ensuring that, where appropriate, individuals receive a community rather than a custodial sentence. These include improvements in clinical outcomes (due to timely and appropriate treatment being made available and access to mainstream mental health services), in well-being and in support (due to the individual being kept within their own community environment). I explore the implications of custody on people with mental health problems or learning disabilities later in this chapter.

Recommendations

- **The Department of Health and Her Majesty's Courts Service should commission further research on the use of mental health treatment requirements.**
- **A service level agreement between Her Majesty's Courts Service, the Probation Service and the NHS should be developed to ensure the necessary mental health provisions for Community Orders are available.**
- **The Department of Health and Her Majesty's Courts Service should issue clear guidance for sentencers and probation staff regarding the use of mental health treatment requirements.**

A crucial point is that NHS-funded alcohol and mental health treatments are not available in all probation areas across the country. This is because these were new provisions under the Criminal Justice Act 2003,[143] and as a result delivery is still being established in some areas. Sentencers are unable to sentence offenders to a requirement that is not available locally, which the NAO concluded could limit the effectiveness of an order if offending behaviour could not be addressed.

Recommendation

- **The Department of Health, the NHS and other relevant government departments must work with voluntary organisations to ensure the adequate provision of alcohol and mental health treatment services across the country.**

Custodial sentences

Key facts

- Since June 1995, the prison population in England and Wales has increased by **60%**, and current projections indicate that it will continue to increase.[144]
- In January 2009 the total prison population was **82,240**.[145]
- In July 2008 there were **4,619** prisoners serving Indeterminate detention for Public Protection (IPP) sentences.
- Women make up approximately **5%** of the prison population. Women prisoners tend to suffer from higher rates of mental disorder than men.
- Almost **14%** of the prison population is aged under 21, with a fifth of these being only between 15 and 17 years old.[146]
- The prevalence of psychiatric disorder is even higher among young offenders and juveniles, with **95%** suffering from mental disorder, substance misuse problems, or both.
- The prison suicide rate in England and Wales was **114** per **100,000** prisoners in 2007.[147] The suicide rate for the general population is **8.3** per **100,000**.[148]
- Around 30% of offenders have engaged in some form of self-injurious behaviour during their custody.[149]
- Prisoners have significantly higher rates of mental health problems than the general public (see table below).

	Prisoners	General population
Schizophrenia and delusional disorder	8%	0.5%
Personality disorder	66%	5.3%
Neurotic disorder (e.g. depression)	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%
Source	Singleton et al (1998)[150]	Singleton et al (2001)[151]

- The Office for National Statistics (ONS) study showed **78%** of male remand prisoners with personality disorder, **64%** of male sentenced prisoners and **50%** of female prisoners. Anti-social personality disorder had the highest prevalence of any category of personality disorder.
- Estimates of prevalence of learning disability among offenders in the UK range from **1%** to **10%**.[152]
- **20–30%** of offenders have learning difficulties or learning disabilities that interfere with their ability to cope within the criminal justice system.
- **8%** of the general population scores within the learning-disabled or 'borderline' group.
- Prison-based studies of dyslexia generally agree on a rate of about **30%**, though rates of serious deficits in literacy and numeracy (often defined as abilities below the age of an 11-year-old[153]) in general reach up to **60%**.
- People from black and minority ethnic (BME) communities with mental health problems represent about **10%** of the UK BME population, but in prison this rises to approximately **20%**.[154]

Context

Since April 2006, the NHS has commissioned health services in public sector prisons. All future new build non-public prisons will also have their healthcare commissioned by the local primary care trust (PCT), and in the few prisons where healthcare is commissioned privately, common NHS standards are applied. This approach strongly embeds the ethic of the 'equivalence' of services available to individuals in prison with those available to all other NHS patients, taking into account any security considerations.

We know that the numbers of people with mental health problems who go to prison are high. Even if all the diversion opportunities described in this report were fully utilised, there would still be individuals with mental health problems for whom prison would be the appropriate disposal. We also know that among prisoners the range of conditions and illnesses that fall into the 'mental health problems' category is broad. It represents a similar range of mental health problems to that suffered by people living in the community (although the proportions are different) and so requires a similar range of services to treat them effectively.

However, evidence gathered for this review suggest that prisons are currently struggling to provide this, and in particular that certain elements of the prison population with mental health problems are not receiving any treatment at all. The next few sections briefly explore the types of mental health treatment that are available in the prison setting.

The impact of imprisonment on mental health

It is widely accepted that the impact of prison on mental health is far from positive. The prison environment, with its rules and regimes governing daily life, can be seriously detrimental to mental health.[155] In addition to the actual experience of prison, many prisoners lose their own accommodation after starting a prison sentence, presenting a major difficulty in resettling them after release. Like accommodation, jobs are frequently lost after starting a prison sentence, and a criminal record is a significant barrier to finding employment after release. Losing access to family and close support is also a significant factor.

This last point is particularly pertinent to women prisoners. As the overall number of women's prisons is small and their geographical locations spread out, women tend to be located further from their homes than male prisoners, to the detriment of maintaining family ties, receiving visits and resettlement back into the community. These are some of the issues explored in more detail by Baroness Corston's report.[156]

We know that prisoners are a socially excluded population, often with very complex needs, and bring existing vulnerabilities into prison with them. This phenomenon led to the coining of the term 'imported vulnerability', denoting the social and health inequalities that prisoners bring with them into custody.

Given the significant impact of imprisonment on an individual's mental health, early and accurate assessment is vital. By the time someone comes into reception at prison, they should already have been assessed for mental health problems or learning disabilities at least once, by the police and possibly the courts. They may also have been in contact with health services in the community prior to entering the criminal justice system.

Prisoners sentenced to an indeterminate sentence of IPP have no automatic right to be released. They must serve a minimum period of imprisonment known as the 'tariff', and will not be released until the tariff period has been served in full; even when it has expired, release is not automatic. The Parole Board, which controls release, has to be satisfied that the risk the prisoner poses to the public is acceptable.

Recently, there have been several reports[157, 158, 159] critical of the impact that IPP sentences have on prisoners, particularly on their mental health, and on those with existing mental health problems or learning disabilities. The studies show that the mental health needs of IPP prisoners are high: for example, Offender Assessment System (OASys) assessments suggest that IPP prisoners have more mental health problems than other prisoners and that both IPP prisoners and lifers have a raised risk of self-harm and suicide (37%) compared to other prisoners (23%).

> **"A significant number of prisons receive people who have a serious mental illness and for whom prison is not a suitable environment. Caring for these people places intolerable strains on prisons, and exhausts disproportionate amounts of resources and staff time."**

Quote from Prison Reform Trust Independent Monitoring Board report[160]

> **"Admission procedures in individual receiving prisons can be good, but if information from the community or sending prisons is poor or non-existent then the healthcare professional has to rely on information given by the prisoner. This could be scant or misleading due to the stigma attached to mental health issues."**

Quote from Independent Monitoring Board Chair, Prison Reform Trust report[161]

There are several distinct issues in relation to IPP sentences:

- the impact of an indeterminate sentence on the mental health and well-being of an individual, as a result of the emotional distress brought about by having no set release date;
- the difficulty of access to offender behaviour programmes for prisoners with mental health problems or learning disabilities: prisoners whom staff consider to be unsuitable to participate because of mental illness or emotional instability are often excluded entirely. However, offender behaviour programmes are often necessary to reduce an individual's risk, and thereby help them towards release; and
- the high levels of pre-existing need identified in the IPP and detention for public protection (DPP – used for children and young people) populations and the high impact this has on demand for mental health services in prisons, in particular on the services of the prison mental health in-reach teams.

Recommendation

- **A study should be commissioned to consider the relationship between imprisonment for public protection sentences and mental health or learning disability issues.**

The impact of imprisonment on people with learning disabilities

The No One Knows programme, led by the Prison Reform Trust, has been an invaluable source of information for this review. A report published in 2007 as part of the programme graphically illustrates the difficulties people with learning disabilities face within the prison environment.[162] The report indicates that the general prison regime (i.e. reception, induction, transfer and release) does not cater for the needs of prisoners with learning difficulties or learning disabilities. Prison terminology and complex rules and regimes mean that people with learning disabilities or learning difficulties, including difficulties with speech, language or communication, will have trouble coping with the demands of the prison environment. The report provides many such examples, two of which are reproduced opposite:

Case study

One person was assessed with comprehension equivalent to age 11 and speaking and listening skills well below average for his age (9th percentile). He had limited non-verbal communication skills and had difficulty interpreting non-verbal cues. The result was that he had difficulty coping with psychological interventions aimed at his offending and was aggressive and confrontational with both staff and other inmates.

A young offender frequently misused his cell bell and repeatedly kicked his door. Earlier assessment by the speech and language therapist had identified this young man as having Asperger's syndrome. He had difficulties reading large amounts of information and differentiating between objects, which are characteristics of deficits in sentence processing and auditory memory.

Reception screening and assessment

Theoretically, there should be a whole wealth of information on an individual's health needs that can be made available to prison reception to inform and support their assessment. However, as we have seen in previous chapters, identification of mental health problems and learning disabilities is poor at earlier points of the pathway and so assessments are often not taking place until an individual arrives at prison reception.

Because of the short time available at reception, the health screen currently in use has a first part developed to identify quickly any immediate needs as someone enters prison. The second, more in-depth part of the screen is supposed to be undertaken away from the constraints of the reception environment. Although the general consensus is that it the current screen is an improvement on previous ones, there is concern that it is not being properly implemented, particularly the second part, and so is still not identifying all those with mental health problems.

There is also criticism that the screen does not contain a learning disability element, and HM Chief Inspector of Prisons,[163] among others, has called for this to be amended.

It is clear that there are still improvements to be made to the prison health reception screen; in fact, an evaluation and review of its use is currently under way. However, prison reception should not be the point at which health needs are being identified. Rather it should be the next point in the criminal justice system at which information can be added to an individual's file, and information from community, police or court assessments should already be available. The presence of liaison and diversion services at these points would assist in this flow of information.

Recommendations

- An evaluation of the current prison health screen should be undertaken in order to improve the identification of mental health problems at reception into prison.
- Urgent consideration should be given to the inclusion of the identification of learning disabilities as part of the screen.

Primary care mental health services

A large study of a local adult prison found that 55% of those with diagnosed mental health problems could be adequately and safely treated within primary care.[164] This correlates with the results from the general community where it is estimated that 80% of mental health issues are treated without recourse to secondary services.

The findings of this particular study indicate that, in order properly to address the mental health needs of the population, current services need to be reconfigured away from a reliance on the provision of mental health inpatient care and towards the development of robust models of primary mental health services. The majority of the care delivered by these services would be focused on those with mood, anxiety and adjustment disorders and be delivered through wing-based interventions.

Other recent studies support this view; in particular, where the focus is on the in-reach teams to provide services for those with severe mental illness, they struggle to do so if there is inadequate provision for prisoners with common mental health problems.[165] The mental health thematic review undertaken by Her Majesty's Chief Inspector of Prisons emphasised this issue.

The thematic review also concluded from interviews that many GPs who are responsible for primary care in prisons lack specialist training in the care of prisoners or their complex mental health needs. The inadequacy of primary care services has, in turn, had a negative impact on the mental health in-reach teams.

One of the other key issues to come out of the report was the importance of a holistic approach to mental and emotional health. This was made apparent by the responses from prisoners when asked what contributed to improving mental health problems: they cited a range of non-health activities, such as reading, painting, going to the gym, and receiving support from others. It is important to remember that health services need support from the rest of the prison to ensure that "the whole environment of a prison… supports emotional wellbeing".[166]

"For those whose mental health was non-severe they just didn't get the appropriate or necessary levels of treatment."

Peer support worker, the Griffins Society, at DrugScope event, 15 October 2008

"Secondary need was being prioritised over primary, and… the in-reach resource (primarily focused on severe and enduring mental health need) had made less impact on the bulk of prisoner need associated with psychological distress and lack of emotional wellbeing."

Extract from HMIP thematic review on mental health

Recommendations

- Robust models of primary mental health services should be developed, ensuring an appropriately skilled workforce to assess and treat those with mild to moderate conditions.
- Primary mental health care must include a range of non-health activities to support well-being in prison.

"IAPT services should be available and effective for both men and women who come into contact with the criminal justice system, as well as those who are at risk of offending."

Quote from Department of Health guidance, 2009[169]

Improving Access to Psychological Therapies

Improving Access to Psychological Therapies (IAPT) is a key initiative from the Department of Health to improve the lives of people living with anxiety and depression.

We already know that prevalence of depression is much higher in prisoners than in the general population (see page 97), so it is extremely important that prisoners and, more widely, offenders are included in this programme.

I am extremely pleased to note that just before I completed my report, a positive practice guide on implementing access to psychological therapies for offenders[167] was published. This includes specific advice on offenders at all points of the pathway, including on how to remove barriers to access and how to engage with the offender population.

Mental health in-reach

Mental health in-reach teams were established in prisons alongside the transfer of health services from the Prison Service to the NHS. They were originally set up to treat people with severe and enduring mental illness (SMI), although practice has since broadened to include a whole range of mental health problems, as already noted.

Since the inception of these teams and the initial planning of staff levels, the prison population, and therefore potentially the level of health need, have increased rapidly. Recent evaluations of the service recognise that the teams are no longer able to focus on the people they were set up to serve, but have through necessity also taken on those who are not receiving appropriate treatment from other services.

My review was fortunate to receive the results of the first formal national evaluation of in-reach services,[168] which produced valuable input on this issue. As part of its work, the evaluation produced a breakdown of the clinical composition of in-reach caseloads to demonstrate where teams were directing their resources:

- The most prevalent disorders reported were psychosis **(22%)** and major depression **(20%)**.
- **60%** of prisoners on in-reach caseloads did not have a diagnosis of current SMI.
- Of the 60% of in-reach clients who had no diagnosis of SMI:
  - **41%** had personality disorder;
  - **34%** had minor mental illness;

- **42%** did not currently have either a minor mental illness or personality disorder;
- **70%** had substance misuse problems;
- **62%** had a history of prior contact with community mental health services; and
- **76%** had a history of previous contact with mental health services in prison.

These figures clearly show how in-reach teams have moved away from their original intention of serving those with SMI. Many of the teams covered by the evaluation noted that their role had moved beyond involvement with those with SMI to encompass assessment of and intervention with prisoners who self-harmed, those who had personality disorder and even those with primary mental health needs. Other roles included consultancy to other staff, giving advice and information, linking prison and NHS services and providing clinical leadership and training.

The findings of the study indicate that the vast majority of prisoners with SMI are not identified by prison in-reach services:

- Only 23% of prisoners in the study with a current SMI were assessed by in-reach services.
- Only 14% of prisoners in the study with a current SMI were accepted onto in-reach caseloads.

Further, 85% of in-reach team leaders stated that their teams were not sufficiently well staffed to meet the needs of prisoners. This view has been supported by many other studies that have taken place since in-reach teams were created, some of which have pointed to lack of resourcing of in-reach teams as the key failing. The evaluation report seems to indicate that what needs attention may be the poor resourcing of other mental health services in prison, and poor links to drugs and alcohol services, so that in-reach teams are enabled to focus on providing services for those with SMI as originally intended.

Recommendations

- **The Department of Health should examine the current role of mental health in-reach teams and explore how they can be refocused on providing services for those with severe mental illness. This should include the development of liaison and diversion services to undertake some of the current non-clinical activities.**
- **NHS commissioners should seek to improve the provision of mental health primary care services in prison.**
- **The involvement of non-health agencies, including statutory and third sector providers, should be urgently considered in order to improve the support for prisoners with mental health problems or learning disabilities.**

Transfers to hospital

Prisoners cannot be sectioned under the Mental Health Act and remain in prison. Prisons, and even their healthcare wings, are not recognised as hospitals under the Act, so when someone is suffering from a mental illness that is so severe that if they were in the community they would be sectioned, they are transferred to hospital.

Historically, transferring prisoners to hospital for treatment of an acute mental illness has been problematic, and prisoners have had to endure lengthy waits. For example, in 2006 London in-reach teams reported difficulties in locating NHS secure beds for prisoners with marked mental health problems, and also in finding acute psychiatric beds where these were deemed appropriate. Participants said that there were not enough appropriate secure beds available.[170]

When someone needs transfer to a specialist unit within the NHS, any delay is unacceptable. Delay can cause significant distress to the patient, their family, and the people charged with their care. This issue was recognised by the Department of Health in its guidance document *Procedure for the Transfer of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act 1983*, and the Department also undertook an audit.[171] The results indicated that at any one time across the prison estate there are on average 282 prisoners awaiting initial psychiatric assessment by a psychiatrist. The lack of availability of specialist beds and the absence of timely provider assessments accounted for two-thirds of the delays.

There has been progress over recent years and a reduction in transfer delays has occurred, but it is still the case that a number of patients have to wait for long periods of time. Identified barriers contributing to delays include:

- communication breakdowns within and between prisons and hospitals;
- difficulties in obtaining the required paperwork held within different departments across the criminal justice system;
- lack of administrative support in prisons;
- lack of bed availability and, on closer inspection, lack of through-care/step-down facilities to provide fluidity and movement between different levels of security;
- problems establishing responsible PCT commissioners and getting PCTs to accept responsibility for payment for prisoners' treatment;
- disputes over the level of security required for the prisoner; and
- different attitudes and perceptions of prison and hospital staff towards mental illness and offenders.

The Department of Health has piloted a 14-day waiting target. This has yet to be fully evaluated, although there appears to be strong support from stakeholders for such a target to be rolled out nationally.

I am pleased to note that this issue has been addressed in this year's central mental health contract. Although not mandated in the contract, there is a suggestion that transfer waiting times should be reduced to a minimum, with an expectation that this be included in local contracts. This is an encouraging start; however, if we are to make real progress in this area this issue must become a higher priority and be made one of the mainstream requirements.

I am aware that there have been some concerns raised about the security of some NHS-commissioned secure services for prisoners transferred under the Mental Health Act.

A number of absconds and a few rare escapes have highlighted the importance of ensuring that receiving secure services have an appropriate level of physical, procedural and relational security so that the public can feel fully confident in the diversion of acutely mentally ill patients from prison custody.

Recommendations

- **The Department of Health should develop a new minimum target for the NHS of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting.**
- **This new target should be included as a mandated item in the Central Mental Health Contract and included in the next edition of the Operating Framework.**
- **The Department of Health should expedite planned work on assessing the quality of security at low- and medium-security mental health facilities in order to retain public confidence in the diversion of prisoners with mental health problems to these facilities.**

Services for people with a dual diagnosis

Drug and alcohol issues are a major problem among the prison population and dual diagnosis (mental health problems combined with alcohol or drug misuse) is common. Mental health services and substance misuse services in prisons do not currently work well together; national policy is developed separately for mental health and for substance misuse, and this is reflected on the ground, where dual diagnosis is used as a reason for exclusion from services rather than supporting access.

Sadly, this reflects what is often the case for services in the community: those with substance misuse problems are often excluded from mental health services, and those with significant mental health problems from substance misuse treatment. This frustration was strongly echoed by respondents to my review who work in substance misuse services.

This issue was also reflected in the recent visit by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment,[172] which called for improvement in prison healthcare, identifying that substance misuse and mental health services were fragmented and not properly integrated within primary healthcare services.

I welcome the planned publication of guidance for commissioners, service providers and practitioners on the management of dual diagnosis within prisons[173] and hope this will support a move to closer integration and co-ordination of mental health and substance misuse services. This guidance also integrates the new mental health Care Programme Approach (CPA),[174] stressing that individuals with dual diagnosis should have their care co-ordinated within the CPA process. I have made reference throughout my report to the CPA process, underlining its vital role in the continuity of care of individuals with mental health problems and its relevance to our target population. I address this issue in more detail on page 110.

I am also aware of, and very much support, the establishment of a cross-departmental prison drug treatment review group, chaired by Professor Lord Kamlesh Patel, and I look forward to his report next year. I hope that Lord Patel is able to make use of the information provided in this report to support his review, particularly around the issue of services for people with a dual diagnosis.

Recommendation

- **Improved services for prisoners who have a dual diagnosis of mental health and drug/alcohol problems should be urgently developed.**

Personality disorder services

As we have seen, a large proportion of the in-reach caseload is taken up with people with personality disorder. There is currently no formal provision of services for people with personality disorder in prison, despite the fact that such services are available in the community.

Studies show that prevalence of personality disorder is high; an ONS study[175] conducted in 1998 showed 78% of male prisoners on remand with personality disorder, 64% of male sentenced prisoners and 50% of female prisoners. Anti-social personality disorder had the highest prevalence of any category of personality disorder. Ten years on, the in-reach evaluation[176] study showed that:

- 42% of in-reach team service users had a dual diagnosis of SMI and either personality disorder or substance misuse; and
- 17% had personality disorder alone.

A review of psychiatric morbidity in the general population suggested that the incidence of personality disorder could be of the order of 10–13%. By contrast, a study of psychiatric morbidity in the prison population found personality disorder to be present in approximately 63% of the population. The Prisoner Cohort Study found that in offenders who had committed violent and sexual offences, the rates of personality disorder were higher still.[177]

These studies underline the fact that personality disorder is very common in prison populations and would seem to suggest that in the spirit of 'equivalence of services' some development of personality disorder-specific services would play a significant role in improving prison mental health services.

The current availability of personality disorder-appropriate services within mainstream or specialist mental health services is limited. However, changes to the Mental Health Act establish the principle that personality disorder, as a mental disorder, is now a mainstream condition requiring equal and appropriate consideration for assessment and treatment. This change, coupled with new National Institute for Health and Clinical Excellence (NICE) guidance on borderline and anti-social personality disorders,[178, 179] means that access to assessment and appropriate treatment for personality disorder should improve.

Visit
HMP Grendon

HMP Grendon is a specialist centre for the treatment of personality disorder, particularly as it gives rise to serious offending. Five therapeutic communities within the prison offer intensive group psychotherapy and social therapy. There is a strong emphasis on multi-disciplinary working and each team consists of a forensic psychologist, prison officers, a probation officer and psychodynamic a psychotherapist. Through exploring the past and present, clients can begin to make sense of the cycle of abuse, and through forming reparative relationships with staff over a period of years can turn away from violence.

The one aspect of offenders' personality disorder that is currently being addressed is the severe end of the spectrum. The Ministry of Justice and the Department of Health currently run a dangerous and severe personality disorder (DSPD) programme.[180] The programme comprises the following pilot service development projects: two high-security prisons (HMP Frankland and HMP Whitemoor), two high-security hospitals (Broadmoor and Rampton Hospitals), a pilot in an integrated wing of the women's prison HMP Low Newton, three medium-security hospitals with community residential services and three community case management teams.

The assessment of DSPD needs to show the presence of:

- a severe disorder of personality;
- a more-likely-than-not risk of further offending that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover; and
- a link between the two.

Across all the pilots, over 350 assessment and treatment places are now available; however, there are suggestions that this may not be sufficient to meet current needs. Further, concerns have been expressed that this programme is not fully integrated with other work programmes around personality disorder. My view is that there is currently not a coherent and agreed inter-departmental approach to the management of personality disorder within the criminal justice and health systems. This is a complex issue, often overlaid with factors relating to individuals' co-existing mental illness, substance misuse and behavioural difficulties, which have long-standing causes and consequences in terms of offending behaviour and management in health services.

Recommendations

- **An evaluation of treatment options for prisoners with personality disorder should be conducted, including current therapeutic communities in the prison estate.**
- **An evaluation of the dangerous and severe personality disorder programme should be conducted, to ensure that it is able to address the level of need.**
- **In conjunction with other government departments, the Department of Health, the National Offender Management Service and the NHS should develop an inter-departmental strategy for the management of all levels of personality disorder within both the health service and the criminal justice system, covering the management of individuals with personality disorder into and through custody, and also their management in the community.**

The Care Programme Approach

Over the period of this review, it has become clear to me that effective case management is the key to ensuring that individuals receive timely, effective and responsive services to meet their needs. Within mental health in the wider community, the Care Programme Approach (CPA) has been developed as the fundamental process for ensuring co-ordination and continuity of care for people with mental health problems. Such an approach is vital within the prison environment, and then through release and into resettlement. The original report *The future organisation of prison health care*[181] recommended that the NHS take responsibility for health services in prison, and also made specific recommendations with regard to mentally ill prisoners, including that mechanisms should be put in place to ensure the satisfactory functioning of CPA within prisons.

Nearly 10 years on this is still not the case: the evaluation of in-reach services found that only 27% of in-reach clients were on the enhanced level of CPA.[182] In-reach team leaders described significant barriers to the implementation of CPA, including:

- prisoners not having an address on release;
- problems liaising with external agencies;
- geographical distance between prison and planned area of release;
- prison bureaucracy; and
- IT difficulties.

It has been widely reported that in-reach teams have faced difficulties in getting community mental health teams to engage with patients who are about to be released. There are additional concerns that the fluidity of the prison population and problems around information sharing and confidentiality may make effective implementation and co-ordination of CPA problematic.[183] This concern is reflected in recent guidance issued by the Department of Health[184] that usefully re-emphasises the use of CPA for those in the criminal justice system.

Recommendations

- **Offender managers should be aware of their role in the Care Programme Approach process, and the new Department of Health guidance *Refocusing the Care Programme Approach* should be fully implemented in prisons as a matter of urgency.**
- **Prison mental health teams must link with liaison and diversion services to ensure that planning for continuity of care is in place prior to a prisoner's release, under the Care Programme Approach.**
- **Improved continuity of care for prisoners subject to the Care Programme Approach should become a mandatory item in the standard NHS contract for mental health.**

Mental health awareness training

Mental health services are still reliant on non-mental health trained staff, i.e. prison officers, to refer clients to them. Prison officers have the most contact with prisoners on a day-to-day basis, and as such often act as their primary carers. Mental health awareness training is currently available for wing-based prison officers, for whom a three-day training package has been developed which includes an introduction to mental health, self-harm and suicide awareness, skills training and mental health awareness.

An evaluation of the implementation of this training[185] concluded that roll-out has been disappointing. It also found several factors which hindered the effectiveness of the training, including:

- a perceived lack of coherence between Her Majesty's Prison Service Assessment, Care in Custody and Teamwork suicide awareness training and mental health awareness training;
- self-directed learning, without the opportunity for peer support and discussion, which has proved to be a less effective method of learning; and
- difficulties in ensuring that senior managers prioritise the issue and so free front-line staff for training.

The issue of poor implementation was echoed by Her Majesty's Chief Inspector of Prisons' 2007 mental health thematic review,[186] which reported that only about a quarter of prison officers interviewed had received mental health training, although most wanted it or wanted more.

Recommendations

- **Awareness training on mental health and learning disabilities must be made available for all prison officers.**
- **Where appropriate, training should be undertaken jointly with other services to encourage shared understanding and partnership working. Development of training should take place in conjunction with local liaison and diversion services.**
- **The training programme must be developed in conjunction with service users.**

Resettlement

Key facts

- At magistrates' courts, the average sentence length for sentences of immediate custody in 2007 was **2.5** months.[187]
- Only those sentenced to a year or more receive supervision from the Probation Service on release.
- In 2006, a total of **235,029** people were being supervised by the Probation Service.
- In the same year, a total of **193,580** people started Probation Service supervision.[188]
- **45%** of offenders (as registered on OASys)[189] can be identified as having problems with 'emotional well-being'[190] (although this is not the same as formal psychiatric diagnosis or mental illness).

Context

The majority of people released from prison are not subject to supervision from the Probation Service; only those sentenced to a year or more or who are under the age of 21 receive supervision. Offenders serve custodial sentences partly in prison and partly in the community on licence; 30% of a probation officer's caseload will be made up of offenders released from prison on licence. The licence will have standard conditions such as staying out of trouble and staying in touch with probation, plus some possible additional elements such as residency or curfew requirements. Breach of licence can result in a return to custody.

Many of those released from prison will also leave directly from court, having previously been on remand – either because they have received a shorter sentence than the time they have already spent on remand or because they have been found not guilty.

Remand prisoners have higher rates of mental disorder than sentenced prisoners. It is therefore currently impossible accurately to estimate the prevalence of mental health problems in those leaving prison and so be able to assess the level of service that might be needed in the community, but we can only surmise that need is currently being underestimated.

> **"Meet them at the prison gate, and don't lose them for even a day and you have offered the right support."**
>
> Comment from DrugScope focus group, 15 October 2008

Continuity of care

Where people have been accessing treatment in prison, it is important to ensure that the engagement continues once they leave the prison gate. Feedback from stakeholders tells us that if prisoners get the support they need inside prisons they are more likely to engage with services outside prison. However, as most sentenced prisoners serve less than a year in custody they have limited time and opportunity to engage with prison programmes,[191] so extra effort will be necessary to ensure that they engage with services on release.

When the new offender management system was implemented in 2005, its aim was to impact on the re-offending rates by ensuring that offenders were offered the best possible opportunity to change their offending behaviour. However, those with sentences of less than 12 months in custody do not receive offender management and so receive no supervision from probation on release. Some services are provided to this group via voluntary or third sector organisations, but they are inconsistently commissioned and remain isolated examples of good practice that do not meet the needs of all offenders.

A similar perspective in relation to the importance of ensuring effective follow-up after discharge was brought up during the review by the Rethink Service User Focus Groups on 11 November 2008. This specifically concerned the follow-up after discharge of individuals who had been released from NHS or independently provided secure accommodation, whether they were returning to prison or discharged directly into the community following step-down treatment in other NHS or independent facilities. Wherever discharge or release occurs, it is important to ensure that responsibility for care is passed on to the relevant services, and that they are engaged well in advance of discharge. This will help people to continue with their treatment in the community.

Recommendation

- **The National Offender Management Service, in partnership with the Department of Health and the NHS, should develop a national strategy for rehabilitation services for those leaving prison with mental health problems or learning disabilities who are not subject to supervision from the Probation Service.**

Additional problems with continuity have been created by the new early release scheme, the End of Custody Licence (ECL), which was introduced in 2007. The ECL allows eligible prisoners to be released up to 18 days earlier than would otherwise be the case. A recent study by the Sainsbury Centre[192] suggests that this can be problematic in terms of planned resettlement support being disrupted, as release dates are often given to support workers at very short notice.

Practice example
HMP Wormwood Scrubs

A first phase pilot scheme based in HMP Wormwood Scrubs was launched in 2005, when a dedicated resettlement wing was established. Individuals in the pilot are housed on the resettlement wing to enable a process of multi-agency intervention in preparation and planning for discharge back to their local community. Prisoners can begin to develop relationships with different community services while still in custody, and these will be continued after release.

Resettlement responsibilities

Social care

Primary responsibility for the resettlement process, in particular the completion of the resettlement plan, falls on the Prison Service and the National Probation Service, although a prisoner's responsible local authority can and should be involved. Local authorities have a statutory duty to assess an individual's need for services identified in the resettlement plan. If the need for these services is there, there is a duty to provide them. For adults, this assessment is also the gateway to assessments by other agencies. If, during the assessment process, it appears to the local authority that there may be a need for the provision of health or housing services, the local authority has a responsibility to notify the relevant PCT or housing department and require it to assist in the making of the assessment.

It is in the interests of a local authority with a prison in its catchment area to identify vulnerable prisoners proactively well in advance of their release, and to identify their responsible local authority. The authority where the prison is located can then ensure that the 'home' local authority takes responsibility for the prisoner before their release, rather than picking up the pieces after the prisoner has been released and presents themselves as homeless to its local housing office.

At the time of release, a prisoner may find themselves in a different part of the country to that in which they were resident at the time of sentence or arrest. Different rules for establishing responsibility for different services mean that prisoners may have a responsible local authority in one area and a responsible PCT in another. This can lead to disputes between agencies concerning who is responsible for assessing a prisoner and providing them with health, housing and community care services. Resolution of these disputes can be lengthy, hence the need for early identification of those who may be 'in need' and of who is responsible for them.

Healthcare

Funding responsibility for healthcare in England falls to the PCT for the area in which a person is registered with a GP or, if they are not registered, the area in which the person is 'usually resident'. In the case of prisoners this will generally be the PCT in which the prison is situated. However, once a person is released, healthcare responsibility reverts to their home PCT, until they register with a new GP or formally move to a new area. This is important in terms of ensuring continuity of care and access to services, as prisoners are not always released into their home PCT.

Primary healthcare is often a gateway to other services, so failure to register or engage with a GP can have wide-ranging consequences. A report in 2002[193] estimated that around half of prisoners had no GP before they came into custody. However, this may now be less of an issue. A more recent study[194] suggests that the situation may have improved, as the majority of prisoners interviewed were registered with a GP in the community. The advent of new GP-led health centres as advocated

by Lord Darzi[195] will also allow better access to treatment, potentially without registration. In his final report,[196] Lord Darzi announced that every PCT will commission comprehensive well-being and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations.

Lord Darzi's review and subsequent development of primary care services provides a significant opportunity for offenders with mental health problems or learning disabilities, thanks to its emphasis on addressing health inequalities and improving access to primary care. This will build on the excellent examples of work already under way in individual PCTs and GP practices.

Our efforts must be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving sexual health and improving mental health.

Quote from Lord Darzi's NHS Next Stage review

Practice example

The Quays GP Practice, Hull

During the development of the primary care service for the socially excluded in Hull, it was decided to enable the prison to send all unregistered Hull residents leaving the local prison to register with a local GP practice. In addition, many clients of the drug service are met on release at the prison gate by the local Drug Interventions Programme to support them in engaging with their service, following their treatment initiated in prison. The practice will respond to prisoners who are released and will provide treatment even where it is not planned. Although young men are still moving back through the criminal justice system, local police leaders have commented favourably on the apparent effect of this initiative on local crime.

As liaison and diversion services often hold valuable information concerning an offender's mental health problems or learning disabilities, they are well placed to identify those that will require resettlement support at a very early stage. Along with my other recommendations around the development of liaison and diversion services, set out in detail in Chapter 5, I believe that these services should be responsible for ensuring that arrangements for resettlement for those with mental health problems or learning disabilities are in place prior to release. In particular, it will be important for these services to build up strong working relationships with the community mental health teams to ensure that they are alerted to offenders as they are released from prison.

Recommendations

- It will be a key role of developed liaison and diversion services (see Chapter 5) to liaise with prison mental health in-reach teams to ensure that planning for continuity of care for prisoners on release is in place. Once a prisoner has been released, the liaison and diversion services will continue to act as a point of information and support for probation and third sector staff and other organisations involved in resettlement.
- Further work should be undertaken to ensure better implementation of the Care Programme Approach for people with mental health problems in prisons, to ensure continuity of treatment through the prison gate.

Substance misuse services

A national framework for continuity of care, comprising throughcare and aftercare, has been set up to deliver an end-to-end approach for the needs of drug-misusing offenders. This involves the Drug Interventions Programme (DIP), the National Treatment Agency and the National Offender Management Service (made up of prison and probation services). The framework sets out arrangements to ensure continuity of care of clients between the criminal justice integrated teams who deliver DIP in the community, the drugs teams based in prisons, offender managers and treatment providers.

Although the programme accepts that drug treatment plays only one part in supporting rehabilitation and re-integration, stakeholders have informed the review that the link between the DIP and mental health services is simply not being made.

Effective work with offenders with dual diagnosis and complex need depends on better assessment and information sharing between various agencies involved with an individual's care, so as to get a complete picture of their needs.

> **"Unless there are specialist drug workers in mental health teams and vice versa I don't see how we will get beyond what happens now."**
>
> Stakeholder at DrugScope focus group, 15 October 2008

Recommendation

- Joint care planning between mental health services and drug and alcohol services should take place for prisoners on release.

Addressing multiple needs

If mental and physical health problems are inadequately treated while people are in prison, it can become more difficult for them to make the best use of other opportunities such as education and training, which can help to reduce re-offending.[197] The Social Exclusion Unit report recognised the key elements known as pathways which, if not resolved, would contribute to re-offending. The seven identified elements to be tackled were:

- accommodation, including supported housing;
- education, training and employment;
- health;
- drugs and alcohol;
- finance, benefit and debt;
- children and families; and
- attitudes, thinking and behaviour.

The needs of released prisoners are complex, and many of these elements are interlinked. For example, if mental health problems are not resolved, an individual may have difficulty gaining and keeping employment, or problems in maintaining accommodation which in turn may impact on their chances of employment. There is a need to ensure that people coming out of prison have access to a range of services to tackle these issues. Liaison and diversion services will play an important role in facilitating access to these services.

Practice example

Her Majesty's Young Offender Institution Brinsford

Her Majesty's Young Offender Institution Brinsford has a primary mental healthcare team focused on a holistic assessment tool which identifies not only the primary mental health needs of prisoners, but also issues relating to social exclusion. Isolation, homelessness, unemployment and fatalistic attitudes are actively addressed. Those individuals without GPs are registered prior to release and full discharge packages are arranged in conjunction with the mental health charity Rethink. This may include referral to the local community mental health team, GP appointments, befriending, telephone helplines, drop-in centre arrangements or contacts with voluntary work.

A key concern is having a place to live and social security benefits on release. Securing either can often require the completion of considerable paperwork six weeks ahead of release. Service users told me that if these issues are not dealt with, there is an increased risk that someone leaving prison will resort to criminal behaviour in order to obtain money.

Mentoring

There has been a significant amount of recent interest in the influence of mentors in increasing the success of individuals who are at risk of re-offending.[198] Studies have shown that mentoring can reduce re-offending by between 4% and 11%. The mentor can provide both direct assistance (e.g. helping to fill in job applications or locate appropriate housing) and indirect support (e.g. encouragement or acting as a positive role model).

This support is already effectively in operation and available for individuals leaving a number of prisons. Charitable organisations are proactively engaging with offenders prior torelease and connecting them with services on the outside. In many cases this means preparing the client for discharge and physically meeting them at the prison gates. They will then take the client to the relevant organisations to continue their care, or to engage with services.

There have been many evaluations and studies into the potential benefits that mentoring may offer. These have found that some mentoring programmes are more effective than others. Those more successful in reducing re-offending are those where the mentor and beneficiary spend more time together at each meeting and meet at least once a week. Mentoring is most effective when it is only one of a number of supporting interventions that are available.

Feedback from service users or carers suggests that ex-offenders work well as mentors as they understand the problems involved and are easier to relate to. However, it can be problematic to recruit ex-offenders, and security is often used as a reason for not ensuring that this support is offered in a systematic or sustained way. There is currently no information available specifically on how effective mentoring schemes are for those leaving prison with mental health problems or learning disabilities.

A good example of such a service is one currently provided by Supporting Others through Volunteer Action (SOVA). SOVA works with offenders preparing to return from custody to their community. Support continues after their release to ensure a smooth return to society and help reduce re-offending. Trained volunteer mentors regularly meet offenders and ex-offenders to help address resettlement needs such as housing, basic skills, training, employment, budgeting, benefits, health, family and any other issues likely to impact on successful resettlement.

There are many other local and regional initiatives that are making a significant difference to offenders as they leave custody and return to the community. The way in which the success of such services is measured has been varied; without formal evaluation, it is fair to say that not all schemes are able to show demonstrable successes. But feedback from stakeholders, from individuals who have been through the system, and from those who have become mentors themselves, makes it clear that the mentoring model has value and can make a significant impact on an individual's life. On this basis, it is certainly a model worth pursuing.

> **"What they really want and need is one-to-one support, ideally from ex-offenders or at least people who have been through the system."**
>
> Mentor from the Griffins Society, at DrugScope focus group, 15 October 2008

Practice example

West Midlands Connect Project

This project has provided a mentoring service for a number of years and is focused on prisoners receiving sentences of less than 12 months. In the latest analysis, in the West Mercia area, only 56% of those going through a mentoring programme were found to have re-offended within two years (compared with the national average for this group of 73.4%). The project is managed by West Mercia Probation and delivered throughout the West of Midlands Region (Warwickshire, Staffordshire, West Midlands and West Mercia). Partners include the local probation boards and most prisons in the region.

Recommendation

- A comprehensive mentoring programme for people leaving custody with mental health problems or learning disabilities and returning to the community should be established.

References

134 Ministry of Justice, 2008, *Sentencing statistics, 2007: England and Wales*

135 Seymour L and Rutherford M, 2008, *The Community Order and the mental health treatment requirement*

136 National Audit Office, 2008, *The supervision of Community Orders in England and Wales*

137 National Audit Office, 2008, *The supervision of Community Orders in England and Wales*

138 Davis R et al, 2008, *A synthesis of literature on the effectiveness of community orders*

139 House of Commons Justice Committee, 2008, *Towards effective sentencing: Fifth report*

140 Seymour L and Rutherford M, 2008, *The Community Order and the mental health treatment requirement*

141 Tribal, 2008, *Financial support to the Bradley review*

142 Parsonage M et al, 2009, *Diversion: A better way for criminal justice and mental health*

143 www.opsi.gov.uk/acts/acts2003/ukpga_20030044_en_1

144 Ministry of Justice, 2007, *Lord Carter's review of prisons: Securing the future – Proposals for the efficient and sustainable use of custody in England and Wales*

145 www.hmprisonservice.gov.uk/assets/documents/100044D4Monthly_Bulletin_jan09.doc

146 www.justice.gov.uk/publications/populationincustody-2007.htm

147 www.justice.gov.uk/news/newsrelease010108a.htm

148 National Institute for Mental Health in England and Care Services Improvement Partnership, 2008, *Mental health digest*

149 Brooker C et al, 2002, Mental health services and prisoners: A review for the Department of Health

150 Singleton N et al, 1998, *Psychiatric morbidity among prisoners in England and Wales*

151 Singleton N et al, 2001, *Psychiatric morbidity among adults living in private households, 2000: Technical report*

152 Loucks N, 2007 *The prevalence and associated needs of offenders with learning difficulties and learning disabilities*

153 Bryan K, 2004, *Speech and language therapy provision for young people in prison: Third project report, May 2004–October 2004*

154 Rickford D and Kimmett E, 2005, *Troubled inside: Responding to the mental health needs of men in prison*

155 Birmingham L, 2003, The mental health of prisoners, *Advances in Psychiatric Treatment,* Vol 9, pp 191–199

156 Home Office, 2007, *The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*

157 Prison Reform Trust, 2007, *Indefinitely maybe? How the indeterminate sentence for public protection is unjust and unsustainable*

158 Ministry of Justice, 2007, *Service review: Indeterminate sentence prisoners (ISPs)*

159 Rutherford M et al, 2008, *In the dark: The mental health implications of Imprisonment for Public Protection*

160 Prison Reform Trust, 2009, *Too little, too late: An independent review of unmet mental health need in prison*

161 Prison Reform Trust, 2009, *Too little, too late*: *An independent review of unmet mental health need in prison*

162 Loucks, N, 2007, *The prevalence and associated needs of offenders with learning difficulties and learning disabilities*

163 HM Inspectorate of Prisons, 2007, *The Mental Health of prisoners: A thematic review of the care and support of prisoners with mental health needs*

164 Senior J, 2005, *The development of prison mental health services based on a community mental health model*

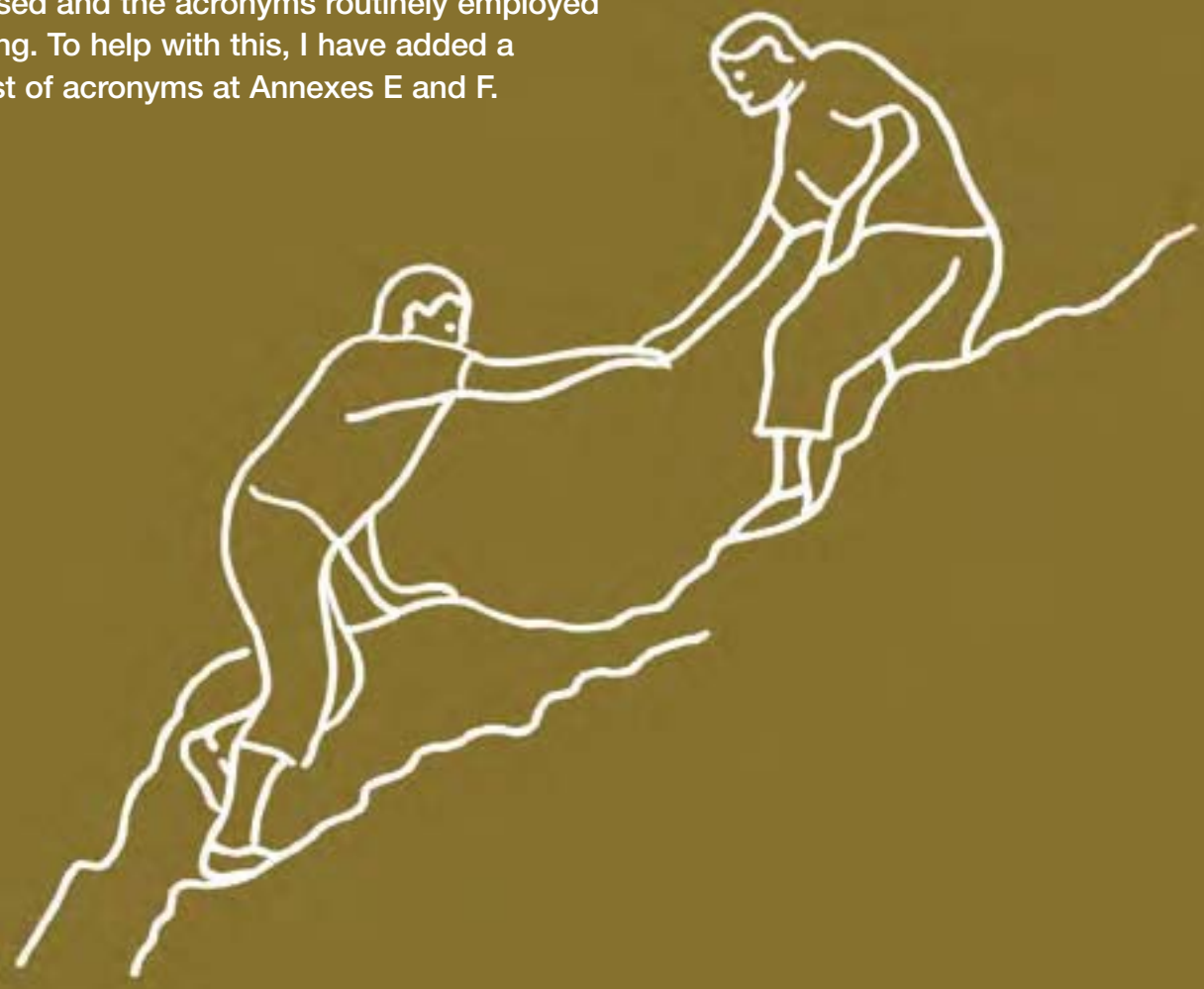
165 Brooker C et al, 2005, *An evaluation of the prison in-reach collaborative*

[166] HM Inspectorate of Prisons, 2007, *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs*
[167] Department of Health, 2009, *Improving Access to Psychological Therapies: Offenders – Positive practice guide*
[168] Shaw J et al, 2008, *A national evaluation of prison mental health in-reach services*
[169] Department of Health, 2009, *Improving Access to Psychological Therapies: Offenders – Positive practice guide*
[170] Durcan G, 2006, *London's prison mental health services: A review*
[171] Department of Health, 2005, *Prison mental health transfers audit report*
[172] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2008, Statement, 1 December
[173] Department of Health, 2009, *A guide for the management of dual diagnosis for prisons*
[174] Department of Health, 2008, *Refocusing the Care Programme Approach: Policy and positive practice guidance*
[175] Singleton N et al, 1998, *Psychiatric morbidity among prisoners in England and Wales*
[176] Shaw J et al, 2008, *A national evaluation of prison mental health in-reach services*
[177] Coid et al, 2007, *Predicting and understanding risk of re-offending: The prisoner cohort study*
[178] National Institute for Health and Clinical Excellence, 2009, *Borderline personality disorder*. NICE Guidance CG78
[179] National Institute for Health and Clincial Excellence, 2009, *Antisocial personality disorder*. NICE Guideline CG77
[180] www.dspdprogramme.gov.uk
[181] HM Prison Service and NHS Executive Working Group, 1999, *The future organisation of prison health care*
[182] Department of Health, 2008, *Refocusing the Care Programme Approach: Policy and positive practice guidance*
[183] Brooker C et al, 2008, *Short-changed: Spending on prison mental health care*
[184] Department of Health, 2008, *Refocusing the Care Programme Approach: Policy and positive practice guidance*
[185] Brooker C, 2007, *An evaluation of the roll-out of the self-directed 'Mental Health Awareness' workbook in custodial settings*
[186] HM Inspectorate of Prisons, 2007, *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs*
[187] Ministry of Justice, 2008, *Statistics bulletin: Sentencing statistics 2007*
[188] Ministry of Justice, 2007, *Offender management caseload statistics 2007*
[189] National Probation Service, 2003, *OASys: The new offender assessment system*. www.probation.homeoffice.gov.uk/files/pdf/Info%20for%20sentencers%203.pdf
[190] House of Commons Justice Committee, 2008, *Towards effective sentencing: Fifth report*
[191] Stewart D, 2008, *The problems and needs of newly sentenced prisoners: Results from a national survey*
[192] Keil J et al, 2008, *On the outside: Continuity of care for people leaving prison*
[193] Social Exclusion Unit, 2002, *Reducing re-offending by ex-prisoners*
[194] Keil J et al, 2008, *On the outside: Continuity of care for people leaving prison*
[195] Lord Darzi, 2007, *Our NHS, our future: NHS Next Stage Review – Interim report*
[196] Lord Darzi, 2008, *High quality care for all: NHS Next Stage Review – Final report*
[197] Social Exclusion Unit, 2002, *Reducing re-offending by ex-prisoners*
[198] DuBois D et al, 2002, Effectiveness of mentoring programs for youth: A meta-analytic review, *American Journal of Community Psychology*, Vol 30, pp 157–197

5

Delivering change through partnership

My report ends with a chapter dedicated to the delivery of change. It sets out my recommendations for service improvement, leadership and governance arrangements that will support change. As with many complex systems, the language used and the acronyms routinely employed can be confusing. To help with this, I have added a glossary and list of acronyms at Annexes E and F.



Introduction

Up to this point, I have tried to set out a comprehensive picture of the offender pathway, highlighting some of the key issues that relate to offenders with mental health problems or learning disabilities at specific points along the way. In addition, there are broader, more far-reaching areas that span the pathway and require us to take a more strategic view when considering change. The related recommendations I have made so far are strongly based on the considerable contributions I have received from a wide range of stakeholders.

I will now look, therefore, at how my proposals should be taken forward. I will first consider the governance arrangements, levels of responsibility and mechanisms that will be necessary to ensure effective implementation. I will then explore my recommendations for the development of liaison and diversion services and how they will act as a catalyst for a range of short-, medium- and long-term changes required to improve services. I will also look at some of the key service improvements that need to take place to underpin the development of liaison and diversion services.

Lastly, I will set out some preliminary timescales for implementation of my recommendations.

Building partnerships

In Chapter 1, I explained the reasons why I believe that certain changes have taken place since the Reed Report was published in 1992, which would allow this agenda to now move forward. One of the main problems with previous policy development has been the piecemeal approach that it has taken; government departments, agencies and organisations working independently of one another, developing policies and practice in isolation, addressing one problem or one part of the system at a time. One of the most common phrases repeated to me by stakeholders time and again over the course of the last year has been of people and organisations 'working in silos'. There is no one organisation that can be held responsible for making changes for this population; it is the joint responsibility all the government departments, agencies and organisations that I have discussed in this report to drive through improvements by working closely in partnership with one another.

National partnerships

If we are not to repeat the mistakes of the past few years, as exemplified by the rather uncoordinated approach to the implementation of liaison and diversion services, it will be vital to ensure that there is a clear, visible, national focus on this agenda that transcends all the traditional governmental and organisational boundaries. My review has been a starting point for this, by providing an independent focus for discussion on many of the issues in relation to mental health, learning disabilities and offending, and generating an enthusiasm and momentum among stakeholders to drive this agenda forward.

One of my key objectives has been to produce a report to start off a process of change that would really make a difference to individuals with mental health problems or learning disabilities in the criminal justice system, and to front-line staff working in the services that support them. Key to achieving that objective will be ensuring that there are robust governance arrangements in place that will follow through the implementation of my recommendations.

With both these aims in mind, I make the following Recommendation.

Recommendation

- **National accountability for this agenda will be via a new Programme Board, which will bring together all the relevant government departments, covering health, social care and criminal justice. The National Programme Board will develop a clear, national approach to mental health/learning disability for offenders.**

The strategic agenda will ultimately be owned by Ministers, and the Programme Board will be directly responsible to them for this programme of work. However, I believe that it would greatly assist progress of the work if there was an independent challenge to its development.

Throughout, I have been struck by the wide range of stakeholders that have an interest in this agenda; their range of views and perspectives has been invaluable to me in understanding the complexity of this subject. Further, as my review was independent of government, there has been a great willingness from stakeholders to engage in frank discussion about developing new policy initiatives. I strongly believe, therefore, that such stakeholders should continue to play a vital role in the implementation of my recommendations. I therefore make the following Recommendations.

Recommendations

- A National Advisory Group should be set up to support Ministers and the Programme Board. The role of the Advisory Group will include:
  - provision of independent, evidence-based advice to Ministers and the Programme Board on the developing agenda;
  - acting as an independent challenge to the development and progress of the work programme; and
  - highlighting examples of good practice and commissioning in-depth studies in areas of particular interest.
- An independent Chair should be appointed for the Advisory Group.
- The Advisory Group will incorporate service user/carer experience into its work.

I envisage that such a Group will be a small, non-statutory body, led by an independent Chair. Both the Programme Board and the Advisory Group will be supported by a cross-government implementation team (see the following Recommendation). However, the Advisory Group should have the authority to intervene where it has evidence that insufficient progress is being made by the Programme Board. It follows that the Chair of the Advisory Group needs to have access as necessary to Ministers; and to have the expertise necessary to take a cross-sector approach to managing this agenda.

Recommendation

- The National Programme Board and Advisory Group will be supported by a small, cross-government implementation team that will draw together all the key agencies needed to deliver this agenda.

Regional and local partnerships

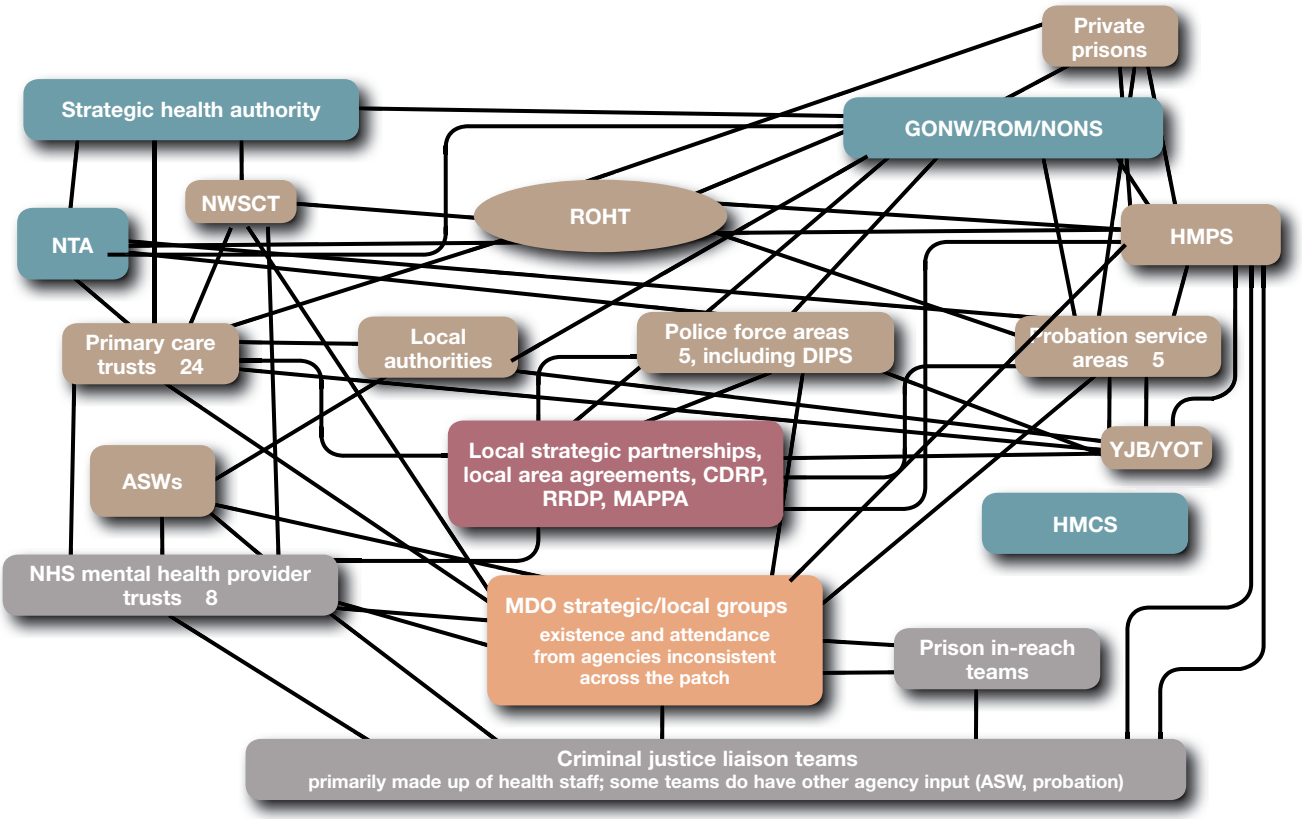
Ultimately delivery of this agenda will be via partners at a regional and local level, building on existing structures and relationships. Throughout this review, through my visits and stakeholder events, I have seen excellent examples of effective partnership arrangements, at both regional and local level. Where they have worked best, they have been locally structured and locally determined to reflect local circumstances.

Considering the manner in which policy in relation to this agenda has historically been formed, the development of partnerships at a local and regional level has led to a whole range of complex relationships, working at different levels, with different accountabilities and responsibilities. This is compounded by the fact that there is little co-terminosity between the boundaries of strategic and local level organisations in

relationship to the key agencies such as health, police and local authorities. In this scenario, one single agency can potentially be a member of a variety of working groups or boards set up with responsibility for, or with an interest in, offender issues.

This complexity was graphically illustrated to me by a report submitted from the North West region. As one of the regions that I visited very early on in my review, I asked the North West Offender Health Team to conduct a scoping exercise to map the working relationships that had been formed across the region to support work about offenders with mental health problems or learning disabilities. Although the following diagram represents the current arrangements for multi-agency liaison in the North West region, the complexity and confusion that it represents are not specific to the North West but in fact tell a familiar story that is repeated across other regions.

North West multi-agency liaison map



Key

- Main strategic bodies
- Main agencies involved
- Mental health providers
- Statutory obligation for agencies to participate
- Groups/network meetings (non-compulsory)

Given some of the inherent difficulties in aligning regional structures, and the fact that each 'region' will have within it any number of diverse localities requiring different approaches, I will not attempt to prescribe in detail how each of these regional and local partnerships should be developed, but they will need to take into account the different needs and demands presented in each area. For example, needs within rural communities may be different to those in large inner-city areas with greater population densities, higher concentrations of crime and differing social and health needs.

However, I have found that during the course of this review that the existing structures of Regional Offender Health Teams already provide an excellent focal point for co-ordinating all the relevant agencies, and are co-terminous with strategic health authority regions and prison service areas. I understand that this structure will have responsibility at a regional level for the implementation of the forthcoming Offender Health and Social Care Strategy that is currently in development by the Government. I do not intend to replicate a structure that is already there, so would recommend that the current Regional Offender Health Teams act as the basis for delivering this agenda at a regional strategic level.

One of the key responsibilities for regional teams will be the development of strategic regional delivery plans. Some examples of key components of such plans might be:

- establishing effective local partnership boards to cover all local criminal justice and health and social care services across the region;
- developing partnerships between community mental health teams, criminal justice system agencies and prison in-reach teams that may improve the management of challenging behaviour, continuity of care and information sharing;
- making provision more cost-effective, including improved flows between different levels of secure hospital, prison and community through stronger financial incentives to provide step-down accommodation, and the development of model cost and volume contracts to improve efficiency and effectiveness; and
- developing aligned commissioning of services.

At a local level, I propose that, while local partnership boards should contain the key criminal justice organisations, health, social care, third sector providers and service user representation, their boundaries should again be determined locally.

I have set out in further detail on page 129 what I consider to be some of the key responsibilities of the national, regional and local partnership arrangements.

Leadership

The effectiveness of the new arrangements I propose will require the support of leaders in all the organisations involved in this agenda. The offender population has not always been a priority for leaders of health-related departments and organisations, and similarly offenders with mental health and learning disabilities may not have been a priority for criminal justice agencies.

What many of the services related to offenders with mental health problems or learning disabilities have been dependent on in the past have been individual champions on the front line with the drive and enthusiasm to set up pilots or schemes, and to keep them going. As I have already made clear, however laudable the aims of the individual, this is no basis on which to run any service.

In an environment of increasingly tight resources and competing priorities, leadership will be crucial for moving this agenda forward. This includes leadership at all levels, national, regional and local. Where we particularly need champions is among the senior leaders of the key partner agencies in order to drive this agenda forward and ensure that services are supported with sufficient resources to make change happen. I have been heartened to have met many such senior leaders during the course of this review who have expressed to me their commitment to this agenda. I was pleased to see many of them participate in my stakeholder events. I see part of the role of the Advisory Group, and in particular the Chair, as being to act as a National Champion for this agenda and to inspire and develop leadership at all levels.

The key implementation responsibilities at national, regional and local partnership level

	Key activities	Commissioning	Performance, inspection and regulation	Patient and public involvement	Information management	Capacity and resources
National Programme Board	- Oversight of the national programme, its management and priorities - Maintain links between all government departments and key stakeholders involved in the programme - Report on progress of the programme to Government - Co-ordinate response to Advisory Group recommendations	- Link the programme to national commissioning strategies and future commissioning developments	- Maintain direct links to all relevant national inspectorates - Support the development of national standards	- Ensure effective representation of patients and the public in policy and service development	- Link to national information management and technology developments in the criminal justice system and health and social care - Develop a programme monitoring scheme	- Support policy development of resource transfer/ pooling - Full impact assessment of policy proposals
Regional Strategic Partnerships	- Develop and monitor regionally focused strategies to deliver the programme - Manage partnerships across the region - Use regional resources more effectively	- Provide programme links to regional commissioning strategies, activities (such as needs assessments) and commissioning groups - Support the joint commissioning of secure accommodation	- Integrate the programme into the existing regional performance framework - Support service improvement and development	- Integrate the regional strategy into existing regional stakeholder involvement programmes	- Link to regional information and technology groups, supporting an improvement in data quality, information sharing and infrastructure delivery - Implement national programme performance management	- Monitor the use of resources across the region, to support the programme - Develop plans to ensure efficiency and effectiveness of service provision
Local Partnership Board	- Commission services locally - Manage service performance - Provide feedback to the regional group on progress of the delivery programme	- Develop local commissioning plans - Support local needs assessments	- Support the development of service monitoring and improvement plans - Monitor individual service performance	- Develop local stakeholder engagement plans/ communication strategy - Ensure all services link into Local Involvement Networks (LINks) and Patient Advice and Liaison Service (PALS) frameworks	- Implement information-sharing protocols across agencies and teams - Support improvements in data quality and information management at a team level	- Ensure that resources are used most effectively, based on local determination of need - Identify where service provision may be shared across agencies

Delivering change

I will now describe the new model of liaison and diversion services in Criminal Justice Mental Health Teams, their component functions and how they will form the mechanism for current and future change to services.

Development of liaison and diversion services

A constant thread throughout the offender pathway chapters of this report has been the potential improvements that better coverage of liaison and diversion services can bring. Although currently not without their problems, what liaison and diversion schemes can offer is a framework on which a more effective model can be built. This framework, if properly developed, could carry many of the functions currently needed to support improvements for people with mental health problems or learning disabilities across the criminal justice system.

Recommendations

- **The National Programme Board will oversee the development of a national model of Criminal Justice Mental Health Teams with agreed common elements, and its roll-out across the country. The core elements of this work will be the development of the following:**
  - **Core minimum standards for each team**
  - **National network**
  - **Reporting structure**
  - **National minimum dataset**
  - **Performance monitoring**
  - **Local development plans**
  - **Key personnel.**

Recommendations

- The development of Criminal Justice Mental Health Teams will be informed by the recent Mental Health Effective Practice – Audit Checklist recommendations in addition to further evaluation work. It is anticipated that some of the core elements will include:
  - Liaison with local community services
  - Screening and assessment
  - Coverage of police custody and courts, with links to prison mental health in-reach services and resettlement to ensure continuity of care
  - Management of information concerning an individual's needs throughout the criminal justice system and back into the community
  - Direct involvement and input to Multi Agency Public Protection Arrangements (MAPPA)
  - Standardised assessment processes
  - Joint training for criminal justice and health and social care staff
  - Active service user involvement
  - Access to learning disability expertise.
- Schemes should also consider how they can best serve the interests of particular groups within the offender population, for example:
  - People with learning disabilities
  - Women
  - Children and young people
  - People from black and minority ethnic groups.

  The requirement for Criminal Justice Mental Health Teams is currently included in the standard NHS contract for mental health and learning disabilities on a non-mandated basis. This should be included in the contract as a mandated item and reflected in the next edition of the NHS Operating Framework.

Roles and responsibilities

Although the detail of how liaison and diversion services function will obviously need to be determined at a local level, according to local circumstances, there are some specific areas that have clearly emerged that require a focus for development. These include:

- Focusing liaison and diversion services at the police station
- Managing continuity of care across the offender pathway
- Information sharing
- Data collection.

Focusing liaison and diversion services at the police station

As we know from the liaison and diversion scheme audit report,[199] discussed in Chapter 3, schemes serving only courts represent the majority, despite the fact that police station-only teams and teams that operate on multiple sites scored more highly in terms of effectiveness. As we also know, the police are the first point of contact and so provide a great opportunity for early assessment and engagement of appropriate services.

If we look back at Chapter 2, there is a strong case for ensuring that screening and assessment take place at the earliest possible opportunity – at the police station. This is not only to inform the police in their risk assessment and handling of an individual, but also to inform charging and prosecution decisions by the police and Crown Prosecution Service (CPS) and further decisions at subsequent stages of the criminal justice system.

A study undertaken in 2000[200] looked at a scheme set up at a police station in London and compared it with similar schemes based at court. The report argued that a service at a police station was not duplicating that of existing court diversion schemes but tended to identify those accused of more minor offences, which may never even reach the court stage. The police-based scheme allowed offenders to be signposted to local services, with a view to supporting them at an early stage in their offending career, rather than merely dropping out of the criminal justice system with no further support. The report concluded that intervention at the police station may contribute to the prevention of more serious offending in the future.

Another issue that this report explored is the role of the Forensic Medical Examiner (FME) in relation to assessing individuals for mental health problems at the police station. In Chapter 2, I touched on the issue of how well equipped FMEs are for coping with the high prevalence of mental health problems in offenders at police stations. This report found that the role of the FME, which has traditionally provided health services in police stations, tended to be focused on making judgements in terms of 'fitness to be detained' and 'fitness to be interviewed'. In contrast, where community psychiatric nurses were based at police stations they were attached to the local community mental health and social services teams, and had immediate access to the local forensic service for advice and support. It concluded that a full assessment by an experienced community psychiatric nurse, with their links to mainstream mental health services, may be more effective at identifying need for hospital admission than a brief interview by an FME.

> **"Court diversion schemes cannot be the solution to the problem of mentally disordered cases who are filtered out of the system at an earlier stage and therefore do not reach court. If any service were to be provided for the mentally ill who had committed minor offences, then this had to be located at the police station."**
>
> James, 2000, Study of London police diversion scheme

Visit

Dorset Custody and Liaison Service

A partnership between Dorset Police and Dorset Healthcare NHS Foundation Trust set up this service to screen detained people in order to ascertain mental fitness for detention and interview. Other functions include liaison with relevant agencies for those currently in treatment and fit to be dealt with, diversion to mental health services for those too unwell to go through the judicial process, and advice on accessing appropriate services for those not in the mental healthcare system.

Managing continuity of care across the offender pathway

When we talk about continuity of care in relation to this population, what we mean is the co-ordination of care received by an offender over time and across the multiple health, social care and criminal justice agency boundaries that make up the offender pathway. Continuity can be greatly compromised by the number of different agencies that the offender may need to pass through.

The importance of ensuring continuity of care should not be underestimated.

The 2007 mental health thematic report by HM Inspectorate of Prisons[201] found significant failings throughout the offender pathway in relation to continuity of care. I have extracted the following points from the report as they provide a useful example of the range of consequences of a breakdown in continuity:

- Increased risk of suicide and self-harm incidents for new transfers and receptions into prison.
- Reassessment of individuals upon transfer between prisons rather than using and building on existing assessments.
- Incomplete or inadequate assessments failing to identify an individual's range and complexity of need.
- Individuals who were already receiving care prior to reception into prison not receiving it in prison, thus increasing the likelihood of a deteriorating mental health state.
- Individuals not being picked up within three months on release from prison, resulting in disruption in treatment regimes, re-referral and reassessment by community services, and subsequent deterioration in a person's mental state.
- Poor compliance by patients with resettlement and treatment regimes, resulting in possible re-offending.
- In some cases, no involvement by patients in their resettlement planning, compounding compliance issues and access to appropriate services.
- Increased risk to practitioners and the wider community.

The Department of Health attempted to address problems of continuity for this population by publishing its *Offender mental health care pathway*.[202] This document sets out in a series of key phases the actions and activities, service involvement and key issues for consideration in addressing the needs of individuals with mental health problems. It lays down a best practice template to guide providers and commissioners of mental health services for those involved in the criminal justice system. The key focus within the document is the effective use of the Care Programme Approach (CPA) to ensure continuity. While this represents the ideal way in which continuity should be implemented, we know that the CPA is not currently being undertaken for people while they are in prison.

The key elements of continuity in this context have, in part, been managed by liaison and diversion schemes where they exist. However, we know that provision is patchy and, in order to be fully effective, the role needs to cover the whole of the criminal justice system, and have links with all the agencies both inside and outside the criminal justice system. My proposals for building liaison and diversion arrangements into Criminal Justice Mental Health Teams would provide just such a role. In a similar way that currently both the CPA and social care case management models operate, this team could identify and follow an offender with mental health problems or learning disabilities along their criminal justice system pathway, regardless of final location. The role of this team with regard to continuity would be to:

- act as a central co-ordinating point for all enquiries and information regarding a person's health and social care status;
- act as the reference point for all other health and social care professionals involved in a person's care;
- manage a high-level, centrally co-ordinated 'care plan' for an individual (distinct from the day-to-day care plan) which would ensure that they were accessing the appropriate services; and
- be a central contact point for the individual and their family, when necessary, to facilitate contact with the other professionals involved in their care.

The starting point of this process would be at the initial identification and assessment stage. Assessment should be an iterative process, developing and being continuously added to. Service users currently report a degree of frustration about undergoing similar assessments at each stage of the criminal justice system, rather than having an initial assessment which is subsequently built on. Additional problems exist when assessments are undertaken in stressful situations, such as transition points within the criminal justice journey. An oversight role for Criminal Justice Mental Health Teams could ensure that assessments are completed at the first appropriate point and then augmented as the individual travels along the pathway.

"I believe that the provision of a system that encompasses the whole of the criminal justice system, and is not solely court-based, could play an enormous part in alleviating [those] problems, and so improving the overall situation."

Excerpt from submission to the review by Lord Ramsbotham, 11 March 2008

Recommendation

- **Criminal Justice Mental Health Teams will be responsible for ensuring continuity in an individual's mental health care when they are in contact with the criminal justice system.**

The role of the Criminal Justice Mental Health Team will not take the place of the local CPA care co-ordinator, case manager or key worker role where they are in place. It will operate with an oversight responsibility, to ensure that those key elements are there, drawing together all the complex threads of a person's care from a diverse range of agencies (including criminal justice system and voluntary sector sources). The team would also have an overview, through periodic reviews of a person's case, to identify potential gaps in service provision.

"If you can sort out the holy grail of information sharing it makes life much easier for practitioners on the ground to operate effectively."

Delegate at Eastern Region Stakeholder Event, 9 September 2008

Information sharing

A single, consistent theme has been apparent throughout this review, regardless of organisation, activity and environment, which is the importance of managing information effectively. Appropriate information sharing is key to ensuring continuity of care and delivery of services throughout the criminal justice system and on release back into the community. In addition, sharing data between health and criminal justice practitioners and organisations is vital for ensuring the protection of both the public and the offender.

However, there are certain barriers to effective information sharing, including issues relating to confidentiality and privacy, organisational and cultural differences, legislative requirements and data security. There is a whole wealth of legislation, guidance, codes of practice, protocols, advice and position statements for professional groups (such as the Royal Colleges) within the criminal justice and health and social care systems to draw upon, but problems still remain. I do not intend, as a product of this review, to add to this by issuing further guidance on the sharing of information, but I do want to draw attention to this issue and urge practitioners to implement the existing frameworks much more effectively and collaboratively.

The following paragraph is drawn from the Information Commissioner's guidance.[203]

"Data protection law reinforces common sense rules of information handling, which most organisations try to follow anyway. It is there to ensure that organisations manage the personal information they hold in a sensible way. Organisations must keep the information accurate and up to date, they must only keep it for as long as they need it for a specified purpose and they must keep it secure. Some organisations understandably err on the side of caution and do not release information when they could do so. Unfortunately, some organisations continue to use the Data Protection Act 1998 as an excuse not to do something, rather than seeing it as good business sense to treat their customers and their information with respect."

The consequences of not sharing information appropriately are well known, as I have also explored in the section on continuity of care. Independent inquiries into violence and homicide involving people with mental health problems commonly highlight a lack of effective information sharing across agencies, making specific recommendations about the need to adopt collaborative approaches in terms of communication, record keeping and shared care management.

As with the previous section on continuity of care, there is a central role for Criminal Justice Mental Health Teams here. With their links to community mental health services throughout the offender pathway, and health staff making up part of the team, the issue of health information flowing between the different stages of the criminal justice process should be eased. The teams are able to act as the central co-ordinating point for information, which means that other parties will always know where to go, and who to ask for appropriate information. On a wider basis, the value of agreed protocols for information sharing between agencies should also be recognised and these should be implemented.

During the lifetime of this review, we were fortunate to find that a comprehensive review by Sir Ian Magee of criminality information was under way, which would cover many of the issues of relevance to this population. The specific focus of his review (Review of Criminality Information – ROCI) was the recording and sharing of information on criminality for the purposes of public protection. There is a complex variety of organisations involved in public protection ranging from some whose core function it is – such as police and prisons – to others whose contribution may be less obvious, and less central to their own core purpose – such as social, health and education services.

Sir Ian's review identifies that current information sharing arrangements mean that front-line professionals may inadvertently put the public or themselves at risk for lack of information which is 'in the system' somewhere but which is either inaccessible or unknown to them at the point when a decision is required.

The review concluded that sharing is not the most natural process for some front-line staff, who may be focused on using and protecting the data they assemble for their own purposes. Where there is a lack of understanding about what shared data is being used for, this will inhibit willingness to share. The following summarises the key points coming from the review:

- Criminality information across the public protection network as a whole is often a low management priority – except in a crisis.
- A presumption not to share information, in some cases for fear of criminal penalties for doing so.
- Confusion about legal provisions.
- A focus on information owned by a single organisation – or part of it – and designed for its specific purposes.
- A lack of understanding from those entering data about its fundamental purpose – public protection.

"It generally works well but more often than not this is because schemes have been in existence for a long time and informal links have been formed between professionals from different agencies."

Winstone and Pakes, 2008[204]

With specific reference to the sharing of health information, Sir Ian's review concluded that the health sector was possibly the most sensitive sector as healthcare staff have a duty of confidentiality to their patients. Yet, there may be occasions when absolute adherence to that duty may place individuals in particular or the public in general at unnecessary risk. In addition, he concluded that the limited mental health information recorded in the Offender Assessment System (OASys) is not regarded as fit for purpose by many mental health practitioners.[205] OASys was introduced in 2003, and following a recent strategic review of offender management, plans are currently under way for its replacement.

Recommendation

- **This review supports the Review of Criminality Information report recommendation that mental health professionals be engaged in the development of the planned replacement for the Offender Assessment System (OASys).**

MAPPA is an excellent example of how agencies can work together on a formal basis, sharing information for mutual benefits. MAPPA aims to ensure that information is shared by individual agencies to support a risk management plan drawn up for the most serious offenders. Health is one of the agencies that has a duty to co-operate with the MAPPA Responsible Authority (police, probation and prison services).

During the course of the review, stakeholders often cited this as an example of how information sharing can work between these particular agencies, and stressed that there was a need for something similar for less serious offenders as well, or a 'sub-MAPPA' arrangement. In addition, many liaison and diversion schemes currently act as a point of information for local MAPPA.

Recommendations

- **A responsibility of the Criminal Justice Mental Health Teams will be to ensure that appropriate information is shared between all the agencies that are responsible for caring for an offender with mental health problems or learning disabilities.**
- **The Criminal Justice Mental Health Teams should have direct involvement with and input into local Multi Agency Public Protection Arrangements (MAPPA).**

Data collection

As we have seen throughout this report, there is a paucity of reliable information available about this population at both national and local level. A great deal of effort throughout this review period has been consumed attempting to get accurate, up-to-date and relevant information to support the review and the analysis of potential recommendations, often with very little success. I have been particularly surprised at the lack of available co-ordinated data about this population in both the criminal justice and health and social care domains.

Currently data is not routinely collected in relation to offenders' health needs at every stage of the criminal justice system, and therefore it is difficult to estimate the full scale of need. This in turn makes it difficult to inform the commissioning and planning of appropriate services. For criminal justice agencies it is essential that they move forward significantly on systematic and robust data gathering to inform local commissioning across health and social care. Information is particularly poor in relation to those on remand or serving very short sentences, due to the fact that they are not subject to the current offender management system and OASys. The recording of information on all offenders as they progress through the criminal justice system is important in building a picture that will assist with healthcare and risk assessment and identify wider needs.

"A national minimum dataset needs to be developed in order to improve the very poor state of current data collection and analysis."

Winstone and Pakes, 2008[206]

As already discussed, at national level, the main source of information relating to psychiatric morbidity of offenders for this review was studies undertaken over 10 years ago. This information related only to individuals in prison and not those managed in the community. A small number of excellent cohort studies have helped to illuminate the situation but the use of proxies for mental illness (such as 'emotional well being' from OASys) further dilutes the clinical value. Given the expansion of the offender population, the shift in its demographic profile and advances in assessment and diagnosis of mental health and learning disabilities, a repeat of the Office for National Statistics study should be commissioned.

Recommendations

- **A new study should be commissioned which repeats the 1997 Office for National Statistics survey of the psychiatric morbidity of prisoners to provide new baseline data. In addition, the Government should explore the feasibility of adding to the study the psychiatric morbidity of offenders at other stages of the criminal justice system.**
- **A similar study should be undertaken to establish the prevalence of people with learning disabilities in the criminal justice system.**

The audit of Criminal Justice Mental Health Teams showed that most schemes currently in operation collect data but many of them state that there is no reporting structure into which this data can be fed. Additionally, there is no broad consensus

on the form of collecting data or compatibility of operating systems for analysing data both within and between schemes and their multi-agency partners.

Better collection of information on numbers of people with mental health problems and learning disabilities, their specific needs and subsequent management is vital for informing some of the key functions of commissioning and delivering services and allowing for appropriate performance management.

Recommendation

- **A minimum dataset should be developed, for collection by Criminal Justice Mental Health Teams, to provide improved information to assess need, plan and performance manage services, and inform commissioning decisions.**

Summary

Liaison and diversion services were originally intended to cover the courts, and where they exist, they are generally placed at that stage of the criminal justice system. Where they have been developed to include services at police custody, liaison and diversion can improve the identification and assessment of mental health problems and learning disabilities at an earlier stage. This assists in identifying those eligible for diversion at a very early stage, and obtaining information that can be shared along the criminal justice pathway.

However, it is clear that an absence of a centralised strategy has meant that schemes have developed differently and inconsistently. Problems range from differences in the size and workload of schemes, to diverse aims and objectives. A lack of follow-up data on cases makes it difficult to ascertain what the impact of these services has been on mental health outcomes, or on reducing re-offending rates.

Many of the functions of the teams have been proven to be very effective in ensuring that court processes can be made more efficient and timely, in particular by linking the court with local health and social care services and ensuring that court staff and the judiciary are trained and informed in relation to mental health needs. This in turn enables the judiciary to make fully informed decisions about appropriate further assessments, and appropriate disposals. In addition, the teams have the function of acting as an interface between the health and criminal justice systems and can improve the efficacy of processes in both.

Recent studies provide us with information about the characteristics of such schemes that make their operation effective. Taking that information, and information gained from stakeholders in the course of this review, I have identified the elements and functions that I believe are necessary in a scheme to provide an optimum service to offenders, to the criminal justice system, to the health service and to many other agencies and individuals. I now present a summary of the key roles and relationships of Criminal Justice Mental Health Teams and the expected outcomes of their interventions, although this list is by no means exhaustive.

Summary of key roles, relationships and outcomes for Criminal Justice Mental Health Teams

	Community	Police custody	Courts	Prison/community sentence	Resettlement
Role	- Link to Safer Neighbourhood Teams - Provide support for existing mental health and primary care services - Act in advisory capacity to community services - Support prevention initiatives from the Youth Justice System including liaising with the Youth Offending Teams - Support the promotion of mental health well-being/ mental health education, in varied environments - Advise service commissioners about offender mental health - Support evidence collection for Joint Strategic Needs Assessment - Provide training and support for third sector organistations working with offenders with mental health problems	- Screen and assess detainees - Provide direct advice to police officers about individual cases - Support the collection, collation and appropriate management of clinical information from this and previous mental health contacts and its transfer to appropriate parties further along the criminal justice pathway - Provide knowledge of and links to local services - Provide information to CPS - Provide training for police and CPS - Provide signposting to other services for prisoners following disposal other than custody - Provide advice for NHS commissioners about mental health requirements within custody suites - Provide follow-up in Section 135 and 136 cases - Advise police about most effective use of custodial facilities for individuals with mental health problems - Provide advice and support to the police service in the case of dispute with other providers - Facilitate transfer arrangements to other service once diversion decisions made - Provide support and advice to Appropriate Adults	- Identify early the need for psychiatric court reports - Commission proportionate reports - Provide information for sentencing decisions - Provide general advice to judiciary and solicitors - Provide information on capacity to plead - Provide advice and information to sentencers relating to the range of community services/ facilities available to them - Liaise with external providers of mental health facilities and services - Support the collection, collation and appropriate management of clinical information from this and previous mental health contacts and its transfer to appropriate parties further along the criminal justice pathway - Provide training and support to sentencers, CPS and court officials relating to mental health and learning disability awareness - Provide links back to previous liaison activity within police custody and forward to the prison service or community services where a custodial sentence is not given - Provide signposting to community facilities where an individual is discharged by the court	- Provide information relating to previous contacts, assessments and treatment in progress, on reception into prison - Provide signposting to services for individuals who receive a community sentence - Liaise with mental health and learning disability services, third sector organisations and social services, in support of those receiving a community sentence - Provide advice, support and assessments where necessary to offender managers - Provide support for MAPPA when requested	- Assist in release planning for those in custody - Provide support for MAPPA when requested - Provide signposting to community facilities where appropriate - Advise and support approved premises - Support the client to re-engage with community services post discharge - Provide advice and support to third sector resettlement organisations - Provide support to offender managers - Liaise with mental health service providers, social services and primary care services in support of the resettlement of the offender

	Community	Police custody	Courts	Prison/community sentence	Resettlement
Who is involved	- Primary care services - Community mental health teams - Social care organisations - Criminal justice agencies, including youth offending services - Third sector providers - Commissioners of health services - Educational establishments - Health promotion and public health departments - Substance misuse services	- Police - Community mental health services - Primary care services - Forensic Medical Examiners - CPS - Third sector providers (in police stations) - Independent healthcare providers (in police stations)	- Magistrates - Crown Court judges - CPS - Solicitors and barristers - Court officials - Mental health service providers - Third sector agencies - Police	- Prison staff - Probation officers/ offender managers - Probation staff in approved premises - Mental health service providers - Primary care services - Third sector organisations - Social services	- Probation staff - Mental health service providers - Police - Social services - Educational establishments - Substance misuse services - Employment and training services
Outcomes	- Greater community understanding of mental health issues and offending behaviour - Improved access to mental health services - Reduction in the number of people with mental health or learning disabilities arrested and taken into police custody - Improved partnership working between criminal justice system and health/ social care and third sector providers	- Better informed police and CPS charging decisions - Information available to pass to courts - Speedy diversion of seriously ill offenders to hospital where appropriate - Decreased risk and improved management of individuals in custody suites - Improved representation for people with mental health problems or learning difficulties - Improved co-ordination of Section 135 and 136 activity - Increase in satisfaction with police services - Improved police/ community relations	- Improved use of remand - Savings in court time and resources - Better informed sentencing decisions - Increased use of community sentences - Reduction in the number of individuals in custody as final sentence - Improved access to community facilities - Improved information flows - Improved satisfaction with court service	- Reduction in sentence breaches - Improved information flows - Improved continuity of care - Improved risk management - Improved service commissioning/ planning - Reduction in serious incidents due to poor treatment follow-up - Improved partnership working	- Reduction in non-attendance at follow-up appointments following release - Reduction in re-offending rates for people with mental health problems or learning difficulties - Increase in third sector involvement in resettlement - Improved commissioning of services

Supporting change

The model of Criminal Justice Mental Health Teams that I have set out in the preceding pages is intended to act as the key mechanism for change to services for offenders with mental health problems or learning disabilities. Aside from the services that such teams will provide directly both to offenders and to other criminal justice and health staff, there are far broader implications to some of their activities that will support and inform service development for our target population in the medium and longer term.

I believe that my report has demonstrated that services, and the capacity of those services, are currently being commissioned without the benefit of accurate information on what the demand for them is. Apart from some areas where local needs assessments are undertaken, there has not been an opportunity to properly address any of these issues either strategically or at a national level. The second part of this chapter will look at some of the areas of broader service development that will need to be addressed and how I believe that Criminal Justice Mental Health Teams will start a process whereby a regional and national picture of health needs can be developed with a view to seeking more strategic solutions to meeting them.

“This situation, where there are courts with a range of models of court diversion allied to courts with no model/resource at all, raises serious issues of equality and diversity.”

Submission from HM Courts Service, London, 28 February 2008

Improved use of resources

The findings of the liaison and diversion audit report[207] show that schemes are currently being provided through existing resources with the majority being funded by healthcare services. However, concerns were regularly expressed about how improved quality and coverage of liaison schemes would be resourced in the future. Many felt that offenders are still not a priority for the NHS and there is a fear that by developing diversion services at the police/court stage, funding will be redirected locally from commissioning services in prisons. Stakeholders report that in some cases, when mental health in-reach services were introduced to prisons, money that was then funding liaison and diversion schemes was re-routed to finance in-reach services. There is a suggestion that there is one finite pot of money for offenders that is moved around according to the current priority area identified by the Government.

In order to realistically assess what resources might be necessary to support the development of such schemes, it is clear that further detailed work will need to be undertaken. The current collection of data is poor in this area in terms of outcomes, and it is difficult to provide evidence on whether such schemes provide value for money.

However, we do know that schemes have developed despite the lack of national investment. This client group does not represent new numbers of people, and it is possible to make better use of the resources that are already available for them from the various agencies involved in their care.

Visit

Manchester Mental Health Criminal Justice Liaison Service

Manchester Primary Care Trust (PCT) recently set up this service and it reflects, in practice, the suggested broader range of responsibilities and settings for schemes. The mental health criminal justice liaison service in Manchester provides a city-wide, community-based, culturally sensitive service to meet the requirements of those people who traditionally have been excluded from services due to having a mental health problem and an offending history or behaviour.

The service provides a single point of access for this client group, regardless of their status on the offending pathway (for example, police custody suite, court or prison) with a single point of contact for all agencies for people who require a mental health criminal justice liaison service.

It aims to provide integrated and intensive evidence-based mental healthcare to male and female offenders who are residents of the city of Manchester and have a probable diagnosis of mental illness and/or co-morbidity with substance misuse (including drugs and alcohol), or those who have a personality disorder and high-risk behaviours.

The Trust has produced a detailed service specification that sets out in detail what the service will provide.

The Manchester Mental Health Criminal Justice Liaison Service has recently been developed from an original service that was provided to the courts. It now covers people at all points of the offender pathway and provides a comprehensive service as set out above. It serves a wide area and has broad criteria for its client group. The estimated running cost of such a service is £500,000 per year, partly funded by the courts and partly by the local PCT. This level of investment obviously represents a response to a dense, urban area where there is a high prevalence of offenders with complex needs, including mental health problems and learning disabilities. Although the Manchester service does represent a good example of a service that is close to my recommended model, it is clearly not an example of the level of investment that might be necessary across the country. The recent report by the Sainsbury Centre for Mental Health on the cost/benefit analysis of diversion[208] suggests that (based on current functions) an average scheme costs around £80,000 per year.

> **“Diversion schemes can promote cost savings in the criminal justice system in a variety of ways.”**
>
> Quote from Sainsbury Centre for Mental Health report

From my discussions with stakeholders and the preliminary financial work undertaken for my review and by other organisations, there are strong indications that there are efficiency savings to be made in the current system in return for this level of investment. Some examples are as follows:

- Improved assessment at police custody, allowing early diversion where appropriate and ensuring better informed decisions by the CPS and the courts regarding prosecution and disposal (**Chapter 2**).
- Improved efficiency in the provision of court reports, leading to potential savings in remand time and court time (**Chapter 3**).
- Providing better quality information to enable sentencers to make better use of community sentences, with potential for more efficient use of prison places (**Chapter 4**).
- Links to prison mental health in-reach teams (**Chapter 4**), so that information gathered on an offender follows them into custody, and links are made to services in the community.
- Through links with prison mental health in-reach teams, and links to community mental health services, improved resettlement in relation to health issues and a contribution to reducing re-offending rates (**Chapter 4**).

The Sainsbury Centre for Mental Health report suggests that additional potential sources of savings include the following:

- Reductions in the number of arrests
- Reductions in the number of prosecutions
- Reductions in the number of ineffective court hearings and other causes of delay in the administration of justice
- Reductions in the number of prison sentences.

This list is not exhaustive, but in accordance with feedback received during the course of this review, the report recognises that the current dearth of information collected by schemes, particularly in relation to outcomes such as a reduction in re-offending, means that it is not yet possible to quantify all potential savings, but such information as there is suggests that they may be more far-reaching.

The recommendations presented in my report will undoubtedly have an impact on the way resources are managed across the offender pathway. I am well aware of the current and likely future financial constraints placed on Government, commissioners and service providers. However, as I have already stated, analysis of the potential impact of a number of my recommendations raises the possibility of monetary savings being realised for the criminal justice system. While further work does need to be done to draw out actual cost savings, initial analysis is positive.

Developing capacity

For diversion to be introduced effectively, there needs to be sufficient capacity in mainstream services, as well as confidence in those services for those making decisions about offenders.

For example, there has been significant feedback from stakeholders on the lack of beds available in mental health facilities and a suggestion from some stakeholders that this may be due to bed-blocking in secure units due to a lack of step-down facilities in the community. Whether this is the case, and to what extent, it is hard to estimate given that current data does not allow us to calculate any shortfall between demand and supply. It will only be through improved and ongoing collection of appropriate data, through Criminal Justice Mental Health Teams, that the full picture can emerge of what level of development will be necessary for mainstream mental health and learning disability services. Such changes will of course be incremental and it will be necessary to first get teams in place and then to start evaluating the level of demand for services.

The independent and voluntary sector has shown that it can make an important contribution to increasing capacity, patient choice and service innovation.[209] Third sector partners (from national and local charities to community and local voluntary groups) have a crucial role in helping to shape services that people value, as well as delivering them directly. Crucially, the third sector can exercise this role both at national and local level.[210] The independent and voluntary sectors have a good track record of providing services to offenders and supporting criminal justice colleagues in meeting their duty of care to clients. They also work well in environments where services cross boundaries, e.g. in court settings where there is a need to work across probation, court, police, health and social care services. For example, I have already discussed the potential for third sector and peer support schemes in helping prisoners with mental health problems in prisons, and also how the third sector contributes considerably to the rehabilitation of offenders when they are released from prison.

“Offenders are part of the population and not separate to it.”

Dr Simon Tanner, Regional Director of Public Health, South East Region, London event chair – 24 September 2008

Improving commissioning

Having set up Criminal Justice Mental Health Teams, it will be a priority to ensure that they are running efficiently and to start to evaluate the costs incurred and benefits realised by the service. The input of improved data will in turn influence incremental change in resource allocations across health services and the criminal justice system.

It is vital that commissioning of mental health services is not done in isolation from other key elements of care and treatment for offenders. Many services that support offenders, for example drug treatment and mental healthcare, are more effectively delivered if partners work together to plan, commission and provide such services. Together, partner organisations must consider the potential for aligning commissioning and pooling of resources to ensure that effective services are available.

There are a number of existing mechanisms already in place, such as Local Criminal Justice Boards that co-ordinate the work of criminal justice agencies, which can provide crucial input to ensure effective commissioning. In addition, health, social care and criminal justice agencies have a range of levers and incentives already in place to develop services in partnership, for the benefit of their local communities. Public Service Agreements,[211] Local Area Agreements[212] and Joint Strategic Needs Assessments[213] are key tools for enabling commissioners and providers, along with other local partners, to effectively identify and prioritise the health and well-being needs of their local populations.

Those PCTs that have prisons in their area will already be more familiar with our target population; however, anecdotal evidence suggests that some PCTs are still struggling to understand commissioning services for them. In terms of improving commissioning at a local level, under World Class Commissioning,[214] it may be appropriate for there to be a nominated PCT within a local area that could build up the relevant expertise.

Recommendations

- **Primary care trusts (PCTs) and partners should jointly plan services for offenders to ensure effective commissioning and delivery of services.**
- **Consideration should be given to a lead PCT commissioning offender mental health and learning disability services on behalf of a cluster of local PCTs in each area.**

The NHS Operating Framework[215] is one of the key levers for driving improvements in the area of health and social care services for those with mental health problems and learning disabilities who are in contact with the criminal justice system. It would be helpful if the next framework could recognise that offenders and those in contact with the criminal justice system are not a distinct population, but are part of existing socially excluded groups already covered by the framework.

Recommendation

- **The Department of Health should include explicit reference to the needs of offenders with mental health problems or learning disabilities in future NHS Operating Framework documents.**

There are also a range of measures resulting from the NHS Next Stage Review that are designed to improve the quality of services in the NHS. One example of these is the Commissioning for Quality and Innovation (CQUIN) framework, which gives greater recognition for innovative work being developed. I welcome the development of approaches that incentivise innovation and suggest that further examination of CQUIN and other initiatives is undertaken to find new opportunities for improving services for the offender population.

Patient and public involvement

The NHS has for some time been developing mechanisms for patients and the public to feed back on the services they receive. This includes a duty[216] to consult on service planning and operation, and in the development of proposals for changes to services. I know from talking to stakeholders that the offender population is very often not included in the patient and public involvement agenda. The benefit this review gained from the insight and experience of those who had been through the system was invaluable; and it is vitally important that such a group, historically hard to engage with services, is able to have its voice heard.

An example of these mechanisms is Local Involvement Networks (LINks). Based in local authorities, LINks are currently being developed as the key mechanisms for local patient and public involvement. LINks will aim to:

- provide everyone in the community with the chance to say what they think about local health and social care services;
- give people the chance to influence how services are planned and run; and
- feed back to services what people have said so that things can be improved.

Recommendation

- **The NHS must engage offenders with mental health problems or learning disabilities with current patient and public involvement mechanisms.**

Inspection and regulation

Inspection and regulation for the criminal justice system are currently undertaken by inspectorates for each of the sectors: police, courts, prison and probation. For health, responsibility for this currently falls to the Healthcare Commission. Later this year, the Healthcare Commission will merge with the Commission for Social Care Inspection to become the new Care Quality Commission. This represents a significant opportunity to ensure that the needs of offenders with mental health problems or learning disabilities are on the agenda of this new organisation.

It will also be important to explore whether existing arrangements with HM Inspectorate of Prisons (via the current Memorandum of Understanding) can be continued and strengthened to include the other criminal justice inspectorates, so that offenders' health needs, in particular mental health, can be scrutinised at each stage of the offender pathway.

Recommendation

- **Inspectors and regulators involved in the criminal justice system in partnership with the new Care Quality Commission should determine how they will ensure quality assurance for services provided to offenders with mental health problems or learning disabilities, with a particular focus on joint inspections.**

The benefit of undertaking joint inspections should not be underestimated. There is ample evidence, from work undertaken by HM Inspectorates of Prisons, Probation, Court Administration and Constabulary, that by working together, inspectorates can obtain a unique perspective and understanding of complex situations that would have been impossible working in isolation.

IT infrastructure

If we are expecting stakeholders to improve the way in which information is shared, they must be supported in this by provision of the necessary IT infrastructure. The Connecting for Health[217] project is intended to deliver a National Programme for IT to give electronic access to the NHS National Care Records Service (NCRS), including access by prison-based healthcare staff. Further adaptation of the NCRS would be required to allow access by health workers in Criminal Justice Mental Health Teams located at police stations, courts and other criminal justice settings.

Currently, health information regarding mentally disordered offenders can be accessed locally within the NHS and within prisons, on electronic and/or paper-based records systems. However, these systems have been developed locally and are not generally nationally compatible, which makes it very difficult for other organisations to obtain the information they require. This has a particular impact on the rehabilitation of offenders with mental health problems or learning disabilities, as they are routinely difficult to engage with services on release and follow-up is often missed.

My report identifies the importance of transferring and sharing information between each stage of the criminal justice system to ensure that continuity of care is maintained and unnecessary delay or risk is avoided. This could not be effectively achieved without the use of an electronic information system, such as that being deployed by Prison Health IT. It is now important for the programme to consider how health records might be transferred electronically in and out of prison to include the wider NHS and police, courts, and probation services.

Recommendation

- **Connecting for Health, primary care trusts and strategic health authorities should work together to roll out integrated information systems to health services provided in all criminal justice settings.**

Conclusions and next steps

As we have seen, the current prison population represents a huge diversity of individuals with a range of very complex needs, including a high number who are suffering from mental health problems or learning disabilities. The first step to the effective management of offenders is the existence of good early identification and assessment of problems, which can inform how and where they are most appropriately treated.

I believe that, over time, the establishment of Criminal Justice Mental Health Teams will have a significant impact on this chain of events. By ensuring early identification and assessment, along with improved information sharing, there will be better informed charging, prosecution and sentencing decisions. In the longer term, the impact may be that more offenders can be treated in the community, ensuring that those individuals who must be in prison can receive targeted, effective care while they are there.

This report sets out a direction of travel, and it recognises that the implementation of my recommendations will have different timescales. However, the crucial first step is to establish the governance arrangements at a national, regional and local level to set this work in progress. The National Programme Board will be key to ensuring that this work is consistently implemented across the country. Further, it will be important to set up the Advisory Group to ensure not only that these recommendations are carried forward, but also that further consideration of the many complex issues can start immediately. The regional partnerships will ensure that all the key organisations work strategically to deliver this agenda, and local partnerships will develop appropriate services to meet the diverse needs of our target population.

Measuring progress will be vitally important in maintaining the momentum of this work. I recognise that some of my recommendations will take longer than others to implement, but many can be implemented quickly. I would expect, therefore, that in the first six months following publication of my report there will be in place:

- a clear national strategic direction;
- the new governance arrangements at a national, regional and local level; and
- a fully costed national delivery plan for all my recommendations, and progress on their implementation under way.

Finally, there will also be regular reports to Parliament, both by the National Programme Board and the Advisory Group, to ensure that wider stakeholders and the public are informed of the changes that have been introduced, and of the assessment that has been made of their effectiveness.

References

199 Winstone J and Pakes F, 2008, *Report on national criminal justice mental health team audit (England)*

200 James D, 2000, *Police station diversion schemes: Role and efficacy in central London*

201 HM Inspectorate of Prisons, 2007, *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs*

202 Department of Health, 2005, *Offender mental health care pathway*

203 www.ico.gov.uk/upload/documents/library/data_protection/introductory/data_protection_myths_and_realities.pdf

204 Winstone J and Pakes F, 2008, *Report on national criminal justice mental health team audit (England)*

205 Magee I, 2008, *The review of criminality information*

206 Winstone J and Pakes F, 2008, *Report on national criminal justice mental health team audit (England)*

207 Winstone J and Pakes F, 2008, *Report on national criminal justice mental health team audit (England)*

208 Parsonage M, 2009, *Diversion: A better way for criminal justice and mental health*

209 Department of Health, 2007, *The NHS in England: The operating framework for 2008/09*

210 Home Office, 2007, *Cutting crime: A new partnership 2008–11*

211 www.hm-treasury.gov.uk/pbr_csr07_psaindex.htm

212 www.communities.gov.uk/localgovernment/performanceframeworkpartnerships/localareaagreements

213 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_081097

214 Department of Health, 2007, *World Class Commissioning: Vision*

215 Department of Health, 2007, *The NHS in England: The operating framework for 2008/09*

216 Consolidated NHS Act 2006, Section 242 (was Section 11 of the Health and Social Care Act 2001)

217 www.connectingforhealth.nhs.uk

6

Annexes

List of annexes

ANNEX A

Reference group membership

Lord Bradley	Chair of the Review
Professor Louis Appleby	National Director for Mental Health, Department of Health
John Bashford	On behalf of Lord Kamlesh Patel, Prison Drug Treatment Review Group
David Behan	Director General of Social Care, Local Government and Care Partnerships, Department of Health
Richard Bradshaw	Director of Offender Health, Department of Health
Paul Cavadino	Chief Executive, NACRO
Deborah Clothier	On behalf of Chief Executive, NACRO
Frances Done	Chair, Youth Justice Board
Helen Edwards	Director General Criminal Justice, Ministry of Justice
Angela Greatley	Chief Executive, Sainsbury Centre for Mental Health
Roger Hill	Director of Probation, National Probation Service
Nick Lawrence	Deputy Director, Head of Alcohol, Drugs and Tobacco Policy, Department of Health
Peter Lewis	Chief Executive, Crown Prosecution Service
Juliet Lyon	Director, Prison Reform Trust
Joan Mager	Chief Executive, Richmond and Twickenham Primary Care Trust
Chris Mayer	Chief Executive, HM Courts Service
Erville Millar	Chief Executive, Kent and Medway NHS and Social Care Partnership Trust
Dr Janet Parrott	Chair of the Forensic Faculty, Royal College of Psychiatrists
Sarah Payne	South East Regional Offender Manager, National Offender Management Service
Baroness Joyce Quin	Chair, No One Knows Advisory Group, Prison Reform Trust
Jonathan Slater	Acting Chief Executive, Office for Criminal Justice Reform
Phil Wheatley	Chief Executive, National Offender Management Service
Susannah Nisbett	Review Secretariat
Dawn Anderson	Reference Group Secretariat

ANNEX B

Working group membership

Richard Bradshaw	Offender Health, Department of Health
Alan Brown	Policing Powers and Protection Unit, Home Office
Colin Dale	Offender Health, Department of Health
Sean Duggan	Sainsbury Centre for Mental Health
Catherine Elkington	HM Courts Service
Jane Forsyth	Offender Health, Department of Health
Mignon French	Offender Health, Department of Health
Savas Hadjipavlou	Health Policy and Strategy Unit, Ministry of Justice
Mark Johnson	Offender Health, Department of Health
Dave Knight	Offender Health, Department of Health
Elizabeth Moody	Mental Health Unit, Ministry of Justice
Patrick O'Dwyer	Offender Health Programme Team, London Regional National Offender Management Service
Derek O'Toole	Offender Health, Department of Health
Debbie Parkin	Offender Health, Department of Health
Robert Ritchie	Office for Criminal Justice Reform, Home Office
Susan Russell	Offender Health, Department of Health
Max Rutherford	Sainsbury Centre for Mental Health
Nigel Shackleford	Mental Health Unit, Ministry of Justice
Penny Snow	Mental Health Unit, Ministry of Justice
Elizabeth Stevens	Performance and Policy, NHS East Midlands
Glyn Thomas	Secure Policy, HM Courts Service
Caroline Twitchett	Offender Health, Department of Health
Susannah Nisbett	Review Secretariat
Dawn Anderson	Working Group Secretariat

ANNEX C

List of events, visits and meetings

Events

	Date
London Stakeholder Workshop	04/03/2008
No One Knows Workshop	13/05/2008
North West Regional Stakeholder Event	02/09/2008
NACRO Mental Health Conference	03/09/2008
Eastern Regional Stakeholder Event	09/09/2008
London and South East Regional Stakeholder Event	24/09/2008
East Midland Regional Stakeholder Event	30/09/2008
Yorkshire and the Humber and North East Regional Stakeholder Event	01/10/2008
South West Regional Stakeholder Event	14/10/2008
DrugScope Focus Group	15/10/2008
Association of Chief Police Officers, Birmingham	29/10/2008
Wales Stakeholder Event	10/11/2008
Rethink Service User Focus Groups	27/08/2008 07/10/2008 11/11/2008
Approved Social Worker Interest Group	27/11/2008

Visits

Health services

Approved Social Workers, Camden and Islington Mental Health and Social Care Trust, London

Dorset PCT

Northumberland, Tyne and Wear NHS Trust

Rampton Hospital, Nottinghamshire Healthcare NHS Trust

Section 136 Facility, Doncaster Adult Mental Health Unit, Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust

South West Yorkshire Mental Health NHS Trust

Police Service

Custody suite, St Ann's Road Police Station, Tottenham, London Borough of Haringey

Custody suite, Weymouth, Dorset

Courts Service

Brent Magistrates' Court

Bronx Mental Health Court, New York, USA

Central Criminal Court, London

Community Justice Centre, Liverpool

Domestic Violence Court, Wigan

South West Bristol Magistrates' Court

Victoria Law Courts, Birmingham

West London Drug Court

Prison Service

HMP Belmarsh

HMP Dovegate

HMP Grendon

HMP/YOI Holloway

HMP Liverpool

HMP/YOI Styal

HMP Wakefield

Probation Service, Approved Premises

Crowley House, West Midlands

Elliott House, West Midlands

Westbourne House, London

Meetings

Health services

Claire Barcham	National Co-ordinator, Approved Social Workers Network
John Boyington	Chair, NHS North West Commission on Mental Health Services
Mike Farrar	Chief Executive, NHS North West
Craig Harris	Head of Mental Health Joint Commissioning, NHS North West
David Hinchliffe	Non-executive Director, South West Yorkshire Mental Health NHS Trust
Erville Millar	Chief Executive, Kent and Medway NHS and Social Care Partnership Trust
Steve Shrubb	Director, Mental Health Network, NHS Confederation
Ted Unsworth	Chair, Strategic Review of Secure Mental Health Services in Wales

Police Service

Commander Ali Dizaei	Metropolitan Police, President, National Black Police Association
Tim Godwin	Assistant Commissioner, Metropolitan Police Service
Andrew Hunt	Acting Superintendent, West Midlands Police, and ACPO Mental Health Lead

Crown Prosecution Service

Sir Ken Macdonald	(then) Director of Public Prosecutions
Peter Lewis	Chief Executive, Crown Prosecution Service

Courts

Lord Justice Leveson	Senior Presiding Judge for England and Wales
Chris Mayer	Chief Executive HM Courts Service
Neil Ward	Interim Chief Executive, HM Courts Service
Judge Simon Hammond	Midland Circuit, Leicester Crown Court
Judge Justin Phillips	Northern Circuit, JSB Course Director, West London Drug Court
Judge David Fletcher	Northern Circuit, Sheffield Crown Court
Judge Richard Hone QC	South Eastern Circuit, Central Criminal Court for England
Judge Robert Atherton	Northern Circuit, Manchester Crown Court
Hank Steadman	Bronx Mental Health Court, New York, USA

Law Society's Criminal Law Committee

Criminal Justice Council

Prison Service

Phil Wheatley	Chief Executive, National Offender Management Service

Prison Officers' Association

Brian Caton	General Secretary, Prison Officers' Association

Probation Service

Roger Hill	Director of Probation, National Probation Service

Third sector and other organisations

Frances Crook	Director, Howard League for Penal Reform
Sean Duggan	Director of Prisons and Criminal Justice Programmes, Sainsbury Centre for Mental Health
Angela Greatley	Chief Executive, Sainsbury Centre for Mental Health
Juliet Lyon	Director, Prison Reform Trust
Fay Mansell	Chair, National Federation of Women's Institutes

CBI

No One Knows Advisory Group

Partnerships in Care

Revolving Doors Agency

Third Sector Forum

Tribal

Inspectorates

Dame Ann Owers	HM Chief Inspector of Prisons

MPs, Ministers and Peers

Baroness Scotland QC	Attorney General

Charles Clarke MP

Vernon Coaker MP	Minister of State responsible for policing, crime and security

Baroness Corston

Lord Darzi	Parliamentary Under Secretary of State, Department of Health
Maria Eagle MP	Parliamentary Under Secretary of State, Ministry of Justice
David Hanson MP	Minister of State, NOMS, Ministry of Justice
Phil Hope MP	Minister of State for Care Services, Department of Health, and Minister for the East Midlands

Lord Ramsbotham

Government Departments

Department of Health

Professor Louis Appleby	National Director for Mental Health
David Behan	Director General of Social Care, Local Government and Care Partnerships
Nick Benefield	Senior Policy Adviser, National Personality Disorder Team
Richard Bradshaw	Director of Offender Health
Mark Freeman	Primary and Social Care Policy Lead, Offender Health
Jo Leech	Head of Secure Services Policy
David Marteau	Section Head, Substance Misuse, Offender Health
Dr Mary Piper	Senior Public Health Consultant, Offender Health
Anne Richardson	Head of Offender Mental Health
Kathryn Tyson	Mental Health Programme Lead
Mark Williamson	Senior Medical Adviser, Offender Health

Ministry of Justice

Helen Edwards	Director General Criminal Justice
Savas Hadjipavlou	Head of Health Policy and Strategy Unit
Nicola Lowit	Head of Criminal Justice Women's Strategy Unit
Jonathan Sedgwick	Acting Chief Executive, Office for Criminal Justice Reform
Julie Taylor	Director of Offender Management Strategy
Mental Health Unit	
National Criminal Justice Board	
Women's Policy Team	
Women's Strategy Unit	

Home Office

Alan Brown	Head of Policing Powers and Protection Unit
Chris Sawyer	Business Consultant, ROCI (CUI)

Children's and young people's services

Professor Sir Al Aynsley-Green	Children's Commissioner for England
Frances Done	Chair, Youth Justice Board
Ellie Roy	(then) Chief Executive, Youth Justice Board
Rainsbrook Secure Training Centre, Rugby	

Royal Colleges

Jane Mckenzie	Learning Disability lead, Royal College of Psychiatrists
Professor John O'Grady	(then) Chair of the Forensic Faculty, Clinical Pharmacologist and General Physician, Royal College of Psychiatrists
Dr Janet Parrott	Chair of the Forensic Faculty, Royal College of Psychiatrists

Researchers

Dr Francis Pakes	Institute of Criminal Justice Studies, University of Portsmouth
Dr Alison Rose-Quirie	Consultant, Priory Group
Dr Jane Senior	Division of Psychiatry, School of Medicine, University of Manchester
Professor Jenny Shaw	Chair of Forensic Psychiatry, School of Medicine, University of Manchester
Jane Winstone	Prinicipal Lecturer, Institute of Criminal Justice Studies, University of Portsmouth

ANNEX D

List of respondents to the call for evidence

A

Archbishops' Council

Archway

Association of Black Social Workers and Allied Professionals

Association of Chief Police Officers

Avon Forensics, Bristol South

B

Birmingham and Solihull NHS Trust

Birmingham Magistrates' Court

Bishop of Liverpool/HM Prisons

Bishop of Ripon and Leeds

Bolton, Salford and Trafford NHS Trust (now Greater Manchester West Mental Health NHS Foundation Trust)

Bradford District NHS Trust

Brent Magistrates' Court

Brent Mental Health Services

Bridgend Probation Service (Wales)

Bristol Magistrates' Court

British Psychological Society

Bronx Mental Health Court, New York, USA

C

Calderstones NHS Trust

Campbell Taylor Solicitors

Central and North West London NHS Foundation Trust

Central Criminal Court, London

Clinks

Coast and Moors Voluntary Action

Confederation of British Industry

Coram Community Campus

Council for Disabled Children

Criminal Justice Alliance

Crowley House Approved Premises

Crown Prosecution Service

D

DANDA

Department of Health

Derbyshire Mental Health Services

Devon and Cornwall Police

Dudley PCT

Durham cluster of prisons

E

East London NHS Foundation Trust

Eastern Region Government Office

Elliott House Approved Premises

F

FACTS Team Court Liaison Service

First Step Trust

Foundation for People with Learning Disabilities

G

Gloucester Partnership NHS Foundation Trust

Gloucestershire Criminal Justice Liaison Team

Greater Manchester West Mental Health NHS Foundation Trust

Greenwich Teaching PCT

Gwent Forensic Mental Health Services

Gwent Probation

H

Harrow Mental Health Services

Her Majesty's Chief Inspector of Prisons

Her Majesty's Courts Service

Her Majesty's Courts Service, London

Her Majesty's Courts Service, South Wales

Her Majesty's Courts Service, Stratford

Her Majesty's Courts Service, West Lothian

Her Majesty's Inspectorate of Court Administration

Hertfordshire Probation Area

Hillingdon Mental Health Services
Home Office
Howard League for Penal Reform
HMP Belmarsh
HMP Birmingham
HMP Edmunds Hill
HMP Erlestoke
HMP Featherstone
HMP Foston Hall
HMP Garth
HMP Grendon
HMP Hull
HMP Liverpool
HMP Pentonville
HMP Preston
HMP Shrewsbury
HMP Usk/Prescoed
HMP Whatton
HMP Winchester
HMP Woodhill
HMP Wymott
HMP/IRC Haslar
HMP/YOI Holloway
HMP/YOI Styal
HMYOI Glen Parva
HMYOI Huntercombe
HMYOI Warren Hill
Humberside Probation

I
Independent Police Complaints Commission
Inquest
Institute of Psychiatry
Isle of Wight PCT

J
JD Spicer and Co Solicitors
Julian Housing
Justice Committee

K
Kent Probation
Kirklees Youth Offending Team

L
Lancashire Care NHS Trust
Lancashire Early Intervention Service
Law Society
Leeds PCT
Legal Services Commission
Leicester City Council CDRP
Leicester City Health and Well Being Partnerships
Leicester City PCT
Leicester Youth Offending Service
Leicestershire and Rutland Probation boards,
Leicestershire and Rutland Youth Offending Service
Leicestershire County and Rutland PCT
Leicestershire Partnership Trust
London Borough of Tower Hamlets
London Criminal Justice Bureau
London Development Centre
London Metropolitan Police
London Probation Service
London Regional Offender Management Service

M
Magistrates' Association
Manchester Learning Disability Partnership
MENCAP
MerseyCare Mental Health Trust
Merseyside Police
Merseyside Probation
Ministry of Justice

N
NACRO
National Audit Office
National Bench Chairman's Forum
National Children's Homes

National Probation Service
National Treatment Agency
NHS Confederation
Norfolk and Waveney Mental Health NHS Trust
North East London Mental Health Trust
North Hertfordshire Liaison Services
North Staffordshire Combined Healthcare NHS Trust
North Yorkshire and York PCT
North Yorkshire and York PCT MDO steering group
North Yorkshire Forensic Psychiatry Service
Northern Ireland Office
Northumberland and Tyne and Wear Mental Health Trust
Northumbria Probation
Northumbria University
Norvic Clinic
NSPCC

O

Office for Criminal Justice Reform
Office for Criminal Justice Reform Out of Court Disposals Team
Ontario Telemedicine Network
Oxleas NHS Foundation Trust

P

Park Royal Centre for Mental Health
Partnerships in Care
Policy Research Associates, New York City, USA
Portsmouth Collaboration
Priory Group
Prison Officers' Association
Prison Reform Trust
Prisons and Probation Ombudsman
Providence Row Housing Association

R

Rethink
Revolving Doors Agency
Royal College of General Practitioners
Royal College of Nursing
Royal College of Psychiatrists
Royal College of Speech and Language Therapists
Royal Courts of Justice

S

SADAS
Sainsbury Centre for Mental Health
St Mungo's
Salford Community Justice Centre
Sandwell Mental Health Trust
Sandwell Probation
Secure Healthcare
Serco
Sheffield PCT
Social Exclusion Task Force
Somerset PCT
South London and Maudsley NHS Foundation Trust
South Staffordshire and Shropshire NHS Foundation Trust
South View Approved Premises
South Wales Probation
South West London and St George's Mental Health Trust
Staffordshire County Council
Staffordshire Social Care and Health
Suffolk and Cambridgeshire Forensic Services
Suffolk Mental Health Services
Surrey Alcohol and Drug Advisory Service
Sussex Partnership Trust
Sustain

T

Tees, Esk and Wear Valley NHS Trust CAMHS
Telford Criminal Justice Liaison Scheme
Thames Magistrates' Court
Together Forensic Mental Health Practitioner Service
Together Women's Project
Transition Information Network
Turning Point

U

University of Cambridge
University of Lincoln

V

Victims' Voice

W

Wandsworth PCT
Welsh Office
Wessex Forensic Psychiatry Service
West London Drugs Court
West London Mental Health Trust
West Midlands CJB
West Midlands Probation
West Sussex County Council
West Yorkshire Police, Kirklees Division
Wolverhampton PCT
Women and Young People's Group

Y–Z

Youth Justice Board
Yorkshire and Humberside Probation Commissioner
Yorkshire and Humberside ROMS
Zito Trust

11 Million – the Children's Commissioner for England

Responses were also received from Members of Parliament, service users and private individuals. Names are not individually listed.

ANNEX E

Glossary

Appropriate Adult

The role of the Appropriate Adult is defined in the Police and Criminal Evidence Act 1984 (PACE), Code of Practice C. The role is "to support, advise and assist" detainees in a police station who are either juveniles under the age of 17, or adults who are mentally vulnerable.

Approved premises

Approved premises provide controlled accommodation for offenders under the supervision of the Probation Service. They provide a greater degree of supervision for offenders than is possible in other forms of housing.

Approved Social Worker (ASW)

Approved Social Workers are mental health social workers trained to enact elements of the Mental Health Act 2007. They receive specific training relating to the Mental Health Act 2007, usually lasting one year, and perform a pivotal role in the assessment and detention process of mentally ill people.

Assessment, Care in Custody and Teamwork (ACCT)

Care planning system used by the Prison Service. ACCT was designed to provide flexible multi-disciplinary support to prisoners at risk of harming themselves.

Crime and Disorder Reduction Partnership (CDRP)

There is a Crime and Disorder Reduction Partnership for each local authority in the UK. The Police, local authority, police authority, primary care trust and fire authority are statutory members of the CDRP and must be involved. CDRPs are encouraged to engage with as many local agencies and voluntary groups as possible in order to achieve a truly community-based multi-agency approach to crime reduction. Known as Community Safety Partnerships (CSPs) in Wales.

Criminal justice integrated teams (CJITs)

Community-based integrated drug teams, whose main functions are:

- assessment;
- case management and co-ordination;
- immediate access to structured motivational engagement;
- initial interventions with crack users; and
- facilitating immediate treatment requirements including prescribing services.

Community Order

The Community Order was introduced in April 2005 under the Criminal Justice Act 2003. It replaced all existing community sentences for offences committed from April 2005.

It allows magistrates and judges to customise a different sentence for each offender, based on their offences, by choosing from a range of 12 different requirements.

Care Programme Approach (CPA)

The purpose of the CPA is to improve the delivery of care to people with severe mental illness. It aims to identify who these people are and what their needs are. Services and resources can then be prioritised and allocated.

Care Quality Commission (CQC)

The Care Quality Commission was established by the Health and Social Care Act 2008 to regulate the quality of health and social care and look after the interests of people detained under the Mental Health Act.

It brings together the work of the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission. The CQC took on the role of regulation in April 2009.

Criminality information

Any information which is, or may be, relevant to the prevention, investigation, prosecution or penalising of a crime.

Forensic Medical Examiner (FME)

Forensic Medical Examiners (formerly known as Police Surgeons) are usually GPs who are self-employed, independent and individually appointed to provide their services to relevant police forces. Their role is varied and includes tasks such as offering care and forensic assessment of detainees in police custody, assessing suspects and alleged victims of crime, and interpreting findings for the police, courts and social services.

Indeterminate Detention for Public Protection (IPP)

The Criminal Justice Act 2003 created two new indeterminate sentences: the sentence of Indeterminate Detention for Public Protection for adults, and a parallel sentence of Detention for Public Protection (DPP) for children and young people under 18. They were to be imposed on those who committed specified serious violent or sexual offences and who were deemed to pose a significant risk of serious harm in the future.

Joint Strategic Needs Assessment (JSNA)

The Local Government and Public Involvement in Health Act 2007 requires primary care trusts and local authorities to produce a Joint Strategic Needs Assessment of the health and well-being of their local community.

Local Area Agreement (LAA)	A Local Area Agreement is a three-year agreement based on local Sustainable Community Strategies. It sets out the priorities for a local area agreed between central government, represented by the regional Government Office, a local area, represented by the lead local authority, and other key partners through Local Strategic Partnerships (LSPs).
Local Involvement Networks (LINks)	Local Involvement Networks aim to give citizens a stronger voice in how their health and social care services are delivered. Run by local individuals and groups and independently supported, the role of LINks is to find out what people want, monitor local services and use their powers to hold them to account.
Mens rea	Criminal intent or reckless state of mind that the prosecution must prove an accused had at the time of committing the offence to secure a conviction.
Mental health treatment requirement (MHTR)	This requirement of a Community Order can be issued to offenders who have an identified mental health problem, where treatment is readily available and when the offender has given their consent. The requirement can be set for up to three years. The order must be managed by an offender manager, and it must be conducted under the direction of an appropriate medical practitioner as described in statute.
Multi Agency Public Protection Arrangements (MAPPA)	Arrangements to protect the public from violent and sexual offenders who have been convicted of one or more specified offences and are now in the community.
Offender Assessment System (OASys)	A standardised assessment system used in the probation and prison services.
Parole Board	The Parole Board is an independent body which decides whether prisoners should be released early. Through a change brought in by the Criminal Justice Act 2003, the Parole Board now only makes decisions about the most serious and dangerous offenders and sentences relating to public protection issues.
Public Service Agreement (PSA)	Public Service Agreements set out the key priority outcomes the Government wants to achieve in the next spending period.
Summary offence	A criminal offence which is triable only by a magistrates' court.

Supporting Offenders through Volunteer Action (SOVA)	SOVA is a national volunteer mentoring organisation working with socially and economically disadvantaged people in England and Wales.
Youth Inclusion Programmes (YIPs)	Established in 2000, Youth Inclusion Programmes are tailor-made programmes for 8- to 17-year-olds who are identified as being at high risk of involvement in offending or anti-social behaviour.
Youth Inclusion and Support Panels (YISPs)	Youth Inclusion and Support Panels are multi-agency planning groups that seek to prevent offending and anti-social behaviour by offering voluntary support services to children aged 8 to 13 and their families where the children are at risk of becoming involved in anti-social behaviour and crime.

ANNEX F

Acronyms

ACPO	Association of Chief Police Officers
ASBO	Anti-social Behaviour Order
ASW	Approved Social Worker
BME	Black and minority ethnic group
CAMHS	Child and Adolescent Mental Health Services
CDRP	Crime and Disorder Reduction Partnership
CfH	Connecting for Health
CPA	Care Programme Approach
CPS	Crown Prosecution Service
CQUIN	Commissioning for Quality and Innovation
DDC	Dedicated Drug Court
DIP	Drug Interventions Programme
DSPD	Dangerous and severe personality disorder
ECL	End of Custody Licence
FIP	Family Intervention Project
FME	Forensic Medical Examiner
FNP	Family Nurse Partnership
HMCS	Her Majesty's Courts Service
HMP	Her Majesty's Prison
IPP	Indeterminate Detention for Public Protection
IPPC	Independent Police Complaints Commission
LINks	Local Involvement Networks
MAPPA	Multi Agency Public Protection Arrangements
MDO	Mentally disordered offender
MHEP-AC	Mental Health Effective Practice – Audit Checklist
MHTR	Mental health treatment requirement
MoJ	Ministry of Justice
MST	Multi-systemic therapy
NAO	National Audit Office
NCH	National Children's Homes – now named Action for Children
NCRS	National Care Records Service
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NOMS	National Offender Management Service
NPIA	National Policing Improvement Agency

NTA	National Treatment Agency
OASys	Offender Assessment System
ONS	Office for National Statistics
PACE	Police and Criminal Evidence Act 1984
PCT	Primary care trust
PER	Prisoner Escort Record
PND	Penalty Notice for Disorder
PSA	Public Service Agreement
PSR	Pre-sentence report
QUEST	Quality Improvement Evaluation for School Nurses and Teachers
ROCI	Review of Criminality Information
SCMH	Sainsbury Centre for Mental Health
SEAL	Social and Emotional Aspects of Learning
SHA	Strategic health authority
SMI	Severe and enduring mental illness
SoVA	Supporting Others through Volunteer Action
YOI	Young Offenders Institution
YOT	Youth Offending Team

294278 1p 2.5k April 09 (CWP)
Produced by COI for the Department of Health

If you require further copies of this title visit
www.orderline.dh.gov.uk and quote:
294278/The Bradley Report
or write to:
DH Publications Orderline
PO Box 777
London SE1 6XH
E-mail: dh@prolog.uk.com

Tel: 0300 123 1002
Fax: 01623 724 524
Minicom: 0300 123 1003 (8am to 6pm, Monday to Friday)

www.dh.gov.uk/publications