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Access to Justice: a review of the existing evidence of the experiences of adults with mental health problems

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Contents

Policy Briefing

- The review was based on systematic review methods and involved screening 7,890 research abstracts, and fully reviewing 41 studies.

- Although the review found evidence of the high prevalence of offending amongst adults with mental health problems, there was conflicting evidence about the severity of offences associated with this group.

- Adults with severe mental health problems, such as schizophrenia, are more likely to be victims of crime than the general population by as much as 23%.

- There is a lack of good quality research about the effects of interventions designed to improve access to both criminal and civil justice for those with mental health problems.

- 'Diversion schemes', such as specialist mental health courts, criminal justice-based mental health teams or compulsory out-patient admission, provide mixed evidence of their effectiveness – more research is needed.

- There is evidence that prejudicial attitudes towards people with mental health problems may result in unfair criminal justice outcomes for victims.

- In order to tackle the effects of stigma and discrimination on justice, lessons may be learnt from national strategies, for example to tackle racism and homophobia and from the joint working that was undertaken by police, Crown Prosecution Service and others to reduce domestic violence.

- Policy recommendations include:
  - work towards more integrated criminal justice and mental health systems;
  - develop strategic guidelines for integrating the goals of ensuring justice is done and providing effective treatment;
  - provide further training and awareness-raising to challenge prejudicial attitudes amongst civil and criminal legal service providers.

Summary

This review was undertaken to investigate the evidence base on how adults with mental health problems experience civil, family and criminal justice. The focus is on both formal justice systems and processes, such as civil and criminal courts and tribunals, and informal ones, such as advice and information. The areas of interest cover criminal, civil, family and employment justice and the research reviewed came from a broad range of academic disciplines and sources, provided they met with the quality criteria set out in advanced of the review.

The original questions of the review focused on the actual experiences adults with mental health problems have when attempting to access justice systems and processes. We were interested in individuals' interaction with these systems and processes and whether these were satisfactory or not. We were also interested in whether justice outcomes, such as criminal justice dispensations, tribunal results and resolution of disputes were less likely to be satisfactory for adults with mental health problems. However, limited information on formal justice systems and processes, particularly civil justice, emerged from the studies, especially on how these were experienced specifically by adults with mental health problems. The studies have therefore been analysed for evidence which highlights the prevalence of justiciable problems amongst adults with mental health problems in general and possible risk factors, thus providing some indication of the potential problems this group face in accessing justice. We also extrapolated information on evidence of effectiveness of interventions and services that adults with mental health problems may access when experiencing a justice problem – civil or criminal.

The four key research objectives were as follows:

1. To critically evaluate research relating to the experience of people with mental health problems in attempting to access civil, family or criminal justice or their experience as an offender.
2. To critically evaluate research assessing the effectiveness of interventions designed to improve access to justice for people with mental health problems.
3. To critically evaluate research from observational studies investigating the associations between mental health problems and the experience of justice and justice processes.
4. To suggest areas where there are gaps in research or knowledge and highlight issues with clear policy implications.

Findings

The main findings are as follows:

Associations and characteristics of adults with mental health problems

- Adults with mental health problems are over-represented in populations of offenders (Brekke *et al*., 2001; Sheldon *et al*., 2006; Weisman *et al*., 2004; Riches *et al*., 2006; James *et al*., 2002).
- One study found adults with mental health problems are less likely to be involved with violent crimes than offenders in general (Brekke *et al*., 2001).
- Adults with mental health problems are more at risk of crime victimisation than the general population, even after controlling for demographic variables (Teplin *et al*., 2005; Brekke *et al*., 2001; Fitzgerald *et al*., 2005; Burton & Sanders, 2006; Hamlyn *et al*., 2004; Guggisberg, 2006; Vostanis, 2001; Gale & Coup, 2005; Kilpatrick & Acierno, 2003).
- Adults with mental health problems are likely to experience higher rates of some civil justiciable problems, such as debt and relationship breakdown, compared to adults without mental health problems (Pleasence *et al*., 2004; Moorhead *et al*., 2006; Meltzer *et al*., 2002; Vostanis, 2001; Stuart, 2006; Buck *et al*., 2005; Marwaha, 2005; Alexander, 2006; Roeloffs *et al*., 2003; Powell & Clarke, 2006; Schulze & Angermeyer, 2003; Gaebel & Zäske, 2005).
- Risk factors[1] associated with mental health problems and victimisation include being 'symptomatic' and a lack of meaningful daily activity for adults with mental health problems (Brekke *et al*., 2001; Theriot & Segal, 2005; Sheldon *et al*., 2006).
- Risk factors associated with mental health problems and offending include homelessness, substance misuse and history of offending although these risk factors are also present for the general population (Theriot & Segal, 2005; Sheldon *et al*., 2006; Green & South, 2005; Swanson, 2001).

Services and agencies accessed by adults with mental health problems and their effectiveness

- There is inconsistent but mainly supportive evidence about the effectiveness of so called criminal justice 'diversion' schemes in terms of preventing offending or improving mental health for offenders, however, this may be due to differences in research designs (Boothroyd *et al*., 2005; Moore & Hiday, 2006; Steadman *et al*., 2005; Kisely & Preston, 2005; Swanson, 2001; Lamberti *et al*., 2004; Weisman *et al*., 2004; Kingham, 2005; James *et al*., 2002).
- Promising practice in criminal justice interventions for offenders with mental health problems includes holistic integrated models that link criminal justice, housing, mental health services and social services (Lamberti *et al*., 2004; Weisman *et al*., 2004).
- Some promising practice is emerging from civil justice advice projects aimed at adults with mental health problems, which targets civil advice at adults with mental health problems, although this area is under-researched (Alexander, 2006; Moorhead *et al*., 2006; Legal Services Commission 2005).

[1] A risk factor is understood throughout this report as a factor associated with an increased likelihood of certain outcomes being realised.

Experiences, barriers and potential barriers to accessing justice for adults with mental health problems

- There is evidence prejudicial attitudes within the criminal justice system may result in negative justice outcomes for adults with mental health problems and decisions being made based on an incorrect understanding of mental health problems (Mind, 2001; Watson *et al*., 2004).
- Discrimination and prejudice against adults with mental health problems may deter people from disclosing their mental health problems, seeking advice or support for fear of disclosure (Gee *et al*., 2006; Marwaha, 2005; Powell & Clarke, 2006; Roeloffs *et al*., 2003; Stuart, 2006; Schulze & Angermeyer, 2003; Gaebel & Zäske, 2005).

Potential areas for future research and policy

The review suggested some potential areas of future research and policy development including:

Research:

- More information and research is needed to determine which mechanisms are responsible for improvements in justice outcomes for offenders with mental health problems and in how these mechanisms interact with each other.
- Generally, there needs to be more research into the experiences and outcomes for adults with mental health problems in the domains of civil or non-criminal justice.
- Critical discourse analysis of language used in different legal contexts would help sharpen an understanding of the underlying perceptions of mental health held by the legal and associated professions.
- More research is needed on the interaction of the effects on certain mental health problems, symptoms and coping strategies with risks of offending and victimisation.

Policy:

- Working towards more integrated criminal justice mental health teams, which facilitate communication and information sharing between agencies and which can be pro-active if a client experiences problems.
- More strategic guidelines for integrating the conflicting goals of ensuring justice is done and providing effective treatment for local agencies are needed, particularly to facilitate and stimulate local multi-agency co-operation around mental health problems and offending.
- Further training and awareness-raising to challenge prejudicial attitudes amongst civil and criminal legal service providers should be implemented, for which valuable lessons can be learnt from the experience of anti-race discrimination practices and initiatives to tackle domestic violence.

1. Background

The Department of Constitutional Affairs (DCA), now the Ministry of Justice (MOJ), commissioned this review as part of the 2006 Research Programme. The Programme is intended to help summarise existing knowledge in priority areas of interest to MOJ and to indicate information gaps that may need to be addressed in future research. A priority for the 2006 programme was 'Access to justice particularly for vulnerable people' (DCA, 2006). The requirements of the DCA Research Programmes were as follows:

- examine people's understanding of their rights and responsibilities and barriers to accessing information, advice and assistance;
- highlight any evidence of multiple/complex problems;
- take into account future demographic trends; and
- focus on the key messages for policy makers of the experiences and outcomes for justice for vulnerable adults. **(DCA, 2006)**

This review focuses on one particular group of vulnerable people: adults with mental health problems and how they are able to access justice.

Government policy is increasingly focused on protecting the most vulnerable in society, to ensure that their rights to justice are respected and also to keep them free from harm. Examples of this are the adult protection guidance, *No Secrets,* issued by the Department of Health (2001). This document covers the protection of vulnerable adults, including those with mental health problems or disability, to ensure abuse is identified, prosecuted and prevented. Another example is *Speaking up for Justice* (Home Office, 1998) and the subsequent Youth Justice and Criminal Evidence Act 1999 which introduced 'special measures' for vulnerable victims and witnesses in courts, including those with mental health problems or disability.

A large number of adults in Britain suffer from mental health problems and those who are affected suffer from disproportionate levels of economic and social disadvantage therefore making them more likely to experience problems that are 'justiciable' (Lord Chancellor's Department & Law Centres Federation, 2001). The National Service Framework for Mental Health published by the National Health Service (NHS) in 1999, states around one in six people of working age have a mental health problem, ranging from more common conditions, such as depression to schizophrenia (NHS, 1999). The Social Exclusion Unit (SEU) estimates there are between 125,000 and 600,000 people in Britain with a 'severe

and enduring mental health problem' (Prime Minister's Office, 2006). It is also suggested that between 15 and 25% of the general population have a **common** mental health problem, defined as mild to moderate problems, at any one time (Seymour & Grove, 2005). People claiming Incapacity Benefit - the state benefit for people who are unable to work due to illness or disability – for **any** diagnosed mental health problem rose from 475,000 in 1995, to 848,000 in 2004 (SEU, 2004). This represents around 44% of all people claiming Incapacity Benefit (Seymour & Grove, 2005). In response to this, the Health and Safety Executive (HSE) published guidelines for employers to reduce stress in the workplace (HSE, 2001). Common mental disorders are responsible for the large majority of long-term sickness absence from work (British Medical Journal, 2005).

Economic and social deprivation affects adults with mental health problems disproportionately. A recent systematic review found consistent evidence of an association between a less privileged social position and higher prevalence of common mental disorders. The most consistent associations were with unemployment, less education and low income or material standard of living (Fryers *et al*., 2003). The Labour Force Survey shows us 24% of all people with mental health problems are employed, whereas only 8% of those who have experienced severe mental illness are in work (Department for Education and Skills, 2003). Research shows people with a range of mental health problems are more likely to be hired for unskilled, part-time and temporary jobs with high turnover and few benefits (Stuart, 2006). These disadvantages translate into justiciable problems: people with mental health problems are found to be nearly three times more likely to be in debt than other people; have higher rates of relationship breakdown (Meltzer *et al*., 2002); and more likely to be in rent arrears (Office of the Deputy Prime Minister, 2004).

The ability to access justice, to seek assistance to address problems or to be treated fairly in times of adversity is central to improving the lives of adults with mental health problems. 'Accessing justice' may mean a number of things. In this review we have taken a wide view of the concept and include criminal justice (for both victims and offenders) and non-criminal justice or 'civil justice' including family law, civil courts and tribunals. The types of problems that can potentially be remedied by justice processes, which are therefore referred to as 'justiciable' problems, also cover a wide range. They may include crime victimisation or offending, housing and debt problems, family or employment problems and discrimination.

Accessing justice is considered a means of addressing social exclusion and social injustice. Indeed, concepts of social justice and formal justice processes and systems have been linked:

> '…the infrastructure of civil justice today plays an important role in realising social justice'. **(Pleasence *et al*., Legal Services Commission (LSC), 2004, p. 1)**

The extent to which adults with mental health problems are able to navigate around justice systems and processes in order to address their problems says much, therefore, about their ability to address social exclusion. As the 2004 Social Exclusion Strategy states:

> '…the key to surviving adversity is a feeling of being in control which helps to develop confidence, skills and strategies to escape social exclusion'. **(SEU, 2004)**

It is important to note at this opportunity that definitions of 'mental health problems' vary depending on the nature of the enquiry. Recent interest has grown in the 'social model of disability' in which the social causes of ill health rather than individual pathology are the focus. The social model of disability proposes that barriers, prejudice and exclusion by society (purposely or inadvertently) are the real factors that define who is disabled or 'mentally ill' rather than simple biological or medical factors. The model recognises differences in physical ability or psychological functioning do not have to lead to disability unless society fails to accommodate and include them. Research framed by the social model would tend to see mental health as a continuum where good mental health and poor mental health are conceptually joined. Other research which uses set definitions of mental **ill** health, such as medical diagnoses, does not critique the notion of mental ill health, but, rather, would focus on the factual or empirical associations between mental health and other facts.

In either case, there is a lack of research to identify people most vulnerable to problems for which there may be a legal remedy, including those with mental health problems (Pleasence *et al*., 2004). It is hoped this review will be a step towards improving our understanding of how adults with mental health problems are able to access justice.

1.1 Aims of the review

This review was undertaken to investigate the evidence base on how adults with mental health problems experience civil, family and criminal justice. The focus is on both formal justice systems and processes and informal ones, such as advice and information. The purpose is to present the existing evidence as well as point out gaps in our knowledge.

There are four key objectives to the review:

1. To critically evaluate research relating to the experience of people with mental health problems in attempting to access civil, family or criminal justice or their experience as an offender.

2. To critically evaluate research assessing the effectiveness of interventions designed to improve access to justice for people with mental health problems.

3. To critically evaluate research from observational studies investigating the associations between mental health problems and the experience of justice and justice processes.

4. To suggest areas where there are gaps in research or knowledge and highlight issues with clear policy implications.

The aims were to find and review research across a broad range of disciplines including psychology, criminology, victimology, sociology, forensic psychology, law and criminal justice. Findings were merged from across the disciplines using the methodology set out below.

2. Methods

This review was conducted using systematic review methodology based on guidelines issued by the Centre for Reviews and Dissemination (CRD) (CRD, 2001). Systematic review is a specific technique promoted by organisations, such as the Campbell and Cochrane collaborations as well as the CRD. The technique is useful at ensuring an unbiased selection of research articles for review and establishes minimum standards for the scientific quality of the research. The use of standards allows findings of the research to be compared more easily. The CRD technical guidelines, issued as a handbook, are an easy-to-use tool for preparing the review and were chosen for this reason. However, the technique promoted in this document is consistent with other well regarded techniques. The systematic review process involves isolating search terms and using these to search databases of academic peer reviewed publications. Following the search, information from relevant studies is drawn together and described. An additional search of non-academic research or 'grey literature' was also undertaken through hand searches[2] of government and other organisations' websites and published papers.

2.1 Study advisory group

A meeting was convened with key policy makers and representatives from relevant agencies across the mental health support sector to advise on the development of the search terms used in the review. The meeting took place on 12 February 2007, before the final search strategy was decided.

2.2 Studies searched

Studies were identified using a search strategy defined and documented in appendix 2. Electronic databases of peer reviewed journals were searched to locate studies, using specific search terms. A list of databases searched is included at appendix 3.

2.3 Criteria for inclusion and exclusion of studies in the review

Studies were selected if they met specific criteria for inclusion and were excluded if they met exclusion criteria. A full list of inclusion and exclusion criteria is included at appendix 7. To summarise, studies were included if they were published from 2001 onwards, included populations that were 18 years or older, and focused on populations with justiciable

[2] A hand search involves reviewing all titles and abstracts, where necessary, of a given data source, for example a website.

problems **and** mental health problems. The cut off point in time for studies was decided upon in order to a) address the most up to date research, and b) to allow for any findings reported as a result of significant legal reforms introduced in 1999 by the Woolf reforms to be included. Although there have been many important studies in the field of justice and mental health, these have not been included. Studies were excluded if they did not meet this criteria and also if they were not published in the English language or focused exclusively on the application of the Mental Health Bill 2005.

2.4 Quality criteria

Studies were tested for the quality of their design. This was done using the Maryland Scientific Methods Scale (SMS), a measure of the robustness of scientific method used in the research design (see appendix 4). Studies that met the SMS level three and above were included for review. Qualitative studies were also included in the review provided they met all the quality criteria based on Popay and colleagues' list (CRD, 2001). The Popay criteria are shown at appendix 5.

It is worth noting that studies and articles which are reviews of existing literature or secondary analyses of primary data are not rated on the SMS scale and so are not given a quality rating. They are, however, included in this review provided they have demonstrated a systematic process of evidence collection, or referred to studies that also met the SMS criteria level three or above, or Popay criteria for qualitative research. The included studies are referred to throughout the report and in the list of references at the end of the report.

2.5 Results of the literature search

In total, 7,890 abstracts were screened initially. A total of 86 abstracts were selected and ordered for further investigation. A total of 41 studies met all the necessary inclusion criteria and are referred to in the analysis, including five studies that were identified in a search of the grey literature. The grey literature studies were high quality primary studies which were commissioned by government departments or sponsored organisations.

Organisation of the evidence

Once the search of databases was completed and studies selected for review, the information was extracted using specially designed data extraction sheets (a copy is attached at appendix 8). Analysis of the data was conducted using a specially designed thematic Excel database.

The information was selected and organised according to the review questions. These focused on the experience*s* that adults with mental health problems have when attempting to access justice systems and processes. We were interested in victims and offenders, defendants and claimants of civil legal processes, including civil, family and criminal proceedings. We were interested in individuals' interaction with these systems and processes; whether these were satisfactory or not. We were also interested in whether justice outcomes, such as criminal justice dispensations, tribunal results and resolution of disputes were less likely to be satisfactory for adults with mental health problems.

On examining the evidence from the initial abstract search, it quickly became apparent there was a lack of relevant, high quality studies. There was also a lack of relevant high quality studies that examine justice outcomes specifically for adults with mental health problems, especially for non-criminal justice.

However, evidence was found which highlighted the prevalence of justiciable problems amongst adults with mental health problems in general and possible risk factors, thus providing some indication of the potential problems this group face in accessing justice. Prevalence of justiciable problems and associated risk factors are described in chapter 3, which explores the characteristics of the studies' populations.

The studies also presented some evidence of effectiveness of different interventions, services and agencies which are either designed specifically for adults with mental health problems or that may be accessed by this group. However, studies were heavily concentrated around criminal justice interventions for offenders. There was a lack of high quality, relevant studies that explored effectiveness or potential good practice for other types of non-criminal justiciable problems. Chapter 4 sets out the evidence of effectiveness of the interventions.

The studies also pointed towards some potential problems and barriers that exist for adults with mental health problems in interacting with bureaucracy and authorities. This information provides salutary lessons for justice systems and services. This evidence is presented in chapter 5.

2.6 Analysis

Due to the heterogeneity of the studies identified it was not possible to synthesise the results of the studies through a meta-analysis as the samples included in studies and the objectives

of the research design varied considerably. Therefore, a narrative synthesis of the results has been provided. Narrative synthesis is appropriate for findings from multiple studies with diverse designs that do not focus specifically on impact data but on a wider range of questions. Narrative synthesis allows both evidence of impact and effectiveness as well as qualitative information and data on processes to be included (Popay *et al*., 2006).
The narratives in the research were first identified in the thematic Excel spreadsheet, which allowed common themes to be expressed; these were then put into prose form in the body of the report.

3. Associations and characteristics of adults with mental health problems

3.1 Introduction

This chapter sets out some key characteristics of adults with mental health problems included in the studies, or study 'participants'. Although synthesis of the data on these characteristics is not possible, due to the very diverse nature of the studies, key overall characteristics show some common vulnerabilities that adults with mental health problems face. A description of population 'sub-groups' is provided which indicates how different sections of the population are affected, for example by gender or ethnicity, where this was possible. Also attempted is an exploration of 'risk factors', which underlie the experiences of the population included in the studies.

3.2 General characteristics of study participants

The design and purpose of the studies included in the review varied as did the characteristics of the populations covered. Over 40,000 participants were included across 40 studies.[3] Studies were conducted in different countries including the USA, UK, Netherlands, Germany, Australia and New Zealand. The majority of studies were from the UK (23) and the USA (14), with the majority of evaluation studies, which examine criminal justice 'diversion' projects, being based in the USA.

Some general tendencies can be noted about participants. The age of participants included in the studies tended to be within the 30-40 year old age range. Participants tended to be evenly split between male and female, except for evaluation studies of criminal justice interventions, where there were more male participants. Studies varied in terms of the ethnic background of populations, with higher numbers of black peoples in studies set in urban centres and those which focus on interventions for offenders or alleged offenders.

As the studies were designed to answer different research questions and therefore have different designs, the measurement, criteria or description of mental health varied across the studies. For example, where relationships between mental health and other variables were specifically researched in the studies, for example between mental health and street-robbery victimisation, specific tools[4] tend to be used to measure the mental health impact. These

[3] Primary studies or secondary analysis of primary data, excluding research where subjects or respondents are not the adults with mental health problems, such as population surveys of public attitudes.

[4] An example of a measurement tool is the Brief Psychiatric Rating Scale, Impact of Event Scale or the Mental Component Summary (MCS12).

measures therefore cover a range of mental health states including those where there is no mental health 'problem'. Other studies use different criteria or standards for 'measuring' or determining variables relating to the 'mental health' of participants, such as 'being a client of community-based mental health services' or having been specifically diagnosed. The different criteria used for each study are referred to throughout the report.

Despite differences in their design, studies tended to be mainly concerned with participants within the 'severe' mental illness category, usually signified with a psychiatric diagnosis or referral to a service with a high need threshold.

3.3 Associations between offending and mental health problems

In the early 1980s, a number of studies challenged the hitherto accepted view that those with schizophrenia were no more likely than the general population to be violent. These studies were undertaken before the time range of this review and so have not been covered. However, it is worth noting their position in the history of research into this association. The studies of the 1980s and 1990s consistently found evidence of an association between schizophrenia in particular with the likelihood of violence, albeit by virtue of the activity of a small sub-group. However, such findings are not without controversy and authors have since argued that methodological difficulties have skewed the absolute risk posed by people with mental health problems (e.g. Walsh *et al*., 2002). The studies reviewed here present a more recent picture of the academic debate on such links.

A number of studies in this review explored the associations between criminal offending and mental health. These studies were all primary studies. The majority of these are evaluation studies which seek to assess the impact of certain interventions aimed at adults with mental health problems who are also offenders. In these studies the populations were included specifically because they are offenders with mental health problems (Boothroyd *et al.*, 2005; Green & South, 2005; Kingham, 2005; Kisely & Preston, 2005; James *et al.,* 2002; Lamberti *et al*., 2004; Moore & Hiday, 2006; Steadman *et al.,* 2005; Swanson, 2001). Other studies were observational and designed to investigate *prima facie* associations and underlying causes between mental health and offending (Brekke *et al*., 2001; Theriot & Segal, 2005; Sheldon *et al*., 2006; Riches *et al*., 2006).

There is a long tradition of research that notes the high prevalence of offending amongst people with mental health problems[5] and the studies included in this review generally

[5] See for example the discussion in James *et al.,* 2002, pp. 1-3.

corroborate these. In observational studies, rates of offending behaviour amongst study participants with mental health problems ranged from 15 to 45%. The variation in these rates is probably attributable to differences in definitions of offending and mental health. However rates of offending or alleged offending amongst adults with mental health problems are generally higher than for the general population in the studies. Annual rates of police contact were found to be more than twice that of the general population (Brekke *et al*., 2001) and offending behaviour was reported amongst around 20% of mental health service users in Sheldon *et al.* (2006) compared with a rate of 15.4% of the general population. However, in the Sheldon study, comparison between the general population and the study group is difficult as definitions of 'offending' are not consistent.

Conflicting stories were presented in two studies about the severity of offences that adults with mental health problems are engaged with. The Brekke study found adults with mental health problems were less likely to be involved with serious crime, such as violence, assault or 'felony offences'[6] than offenders generally (Brekke *et al*., 2001). Theriot and Segal found high levels of involvement in 'index'[7] offences amongst adults with mental health problems, compared to another 'high risk' group the so called 'urban male' (Theriot & Segal, 2005). However, no comparison with rate of index offences perpetrated by the general offending population is offered.

Some studies presented the evidence on the relationship between offending and mental health problems from the **opposite** direction i.e. by looking at the rates of mental health problems within known offending populations (Weisman *et al*., 2004; Riches *et al*., 2006; James *et al*., 2002). In these studies, reference is made to research which finds evidence of mental health problems in between 6 and 15% of US prison inmates (Weisman *et al*., 2004) and rates of intellectual disability amongst prisoners in New South Wales of 12.9% (Riches *et al*., 2006). These rates are three-four times and three-times higher, respectively, than the rate found in the general population. James *et al*. (2002) cite UK evidence that prevalence rates of serious or psychotic mental illness amongst those in police custody ranges from 1.2 to 1.6% (James *et al*., 2002). No comparison to the general population is made.

[6] A felony is described by the USA court information website as a serious crime, usually punishable by at least one year in prison. This is comparable to a UK indictable offence.

[7] FBI index offences are serious categories of crime. The FBI defines two types of criminal offence: type 1 offences are the most serious (murder, manslaughter, assault); while type 2 are those less serious in nature (forgery, drug offences).

Population sub-groups

Gender differences

Study populations were dominated by males, probably reflecting higher rates of men compared to women in the offending population, generally. One study reported white older women were more represented in a US specialist mental health court compared to a traditional court, a pattern which is repeated in other US 'diversionary' schemes that share a similar philosophy of 'therapeutic jurisprudence' (Steadman *et al*., 2005). Reasons for this higher than expected prevalence of white older women is not explored in the study. Observational studies based in therapeutic settings which are not exclusively attached to the criminal justice system, included higher numbers of female participants than in the criminal justice-based studies, although rates of offending were found to be lower for women than men in these settings (Sheldon *et al*., 2006).

Ethnicity

Most studies collected data on the ethnicity of participants (Theriot & Segal, 2005; Brekke *et al*., 2001; Boothroyd *et al*., 2005; Green & South, 2005; Weisman *et al*., 2004; Lamberti *et al*., 2004; Moore & Hiday, 2006; Kingham, 2005; Steadman *et al*., 2005). The studies of criminal justice interventions for offenders included populations that were more likely to be black peoples than the general population - most likely reflecting the higher prevalence of these groups in the general 'offender' population.[8] However, in studies whose design included a comparison group from a non-specialist criminal justice setting and which did not deliberately 'match' for ethnicity, the study group was more likely than the control group to be white (Moore & Hiday, 2006; Steadman *et al*., 2005). The reasons for this higher than expected rate of white participants were not explored but were noted worthy of further investigation. One explanation might be that some groups are perhaps not accessing specialist services as would be expected. Unfortunately, the two community-based studies of adults with mental health problems, where data on ethnicity was collected did not present any further analysis of the role of ethnicity in prevalence rates (Brekke *et al*., 2001; Theriot & Segal, 2005).

Mental health status

The mental health status of study participants was mainly determined by participants' meeting specific referral criteria for interventions. However, where effects of interventions on clinical outcomes[9] are investigated, more sensitive measurement instruments tend to be

[8] This association is complex and linked to various risk factors. For a discussion, please see Phillips, C. & Bowling, B. (2003), *Racism, Ethnicity and Criminology: developing minority perspectives.* British Journal of Criminology.

[9] Outcomes relating to the mental heath of individuals.

employed, such as the Brief Psychiatric Rating Scale (Boothroyd *et al*., 2005), Multnomah Community Ability Scale (Lamberti *et al*., 2004) or the Brenner Scale of clinical outcomes (James *et al*., 2002). It is not possible to compare mental health status of participants as the tools used to measure this are inconsistent across the interventions and studies. Even within intervention types, such as specialist mental health courts, the referral criteria or 'thresholds' for accessing services and means of assessment differed. However, it is possible to say that the study populations tended to have high level needs in the 'severe mental illness' (SMI) range, such as schizophrenia, bi-polar disorder or schizoaffective disorder. The observational studies based in community settings also focused on populations with SMI (Theriot & Segal, 2005; Brekke *et al*., 2001).

3.4 Possible underlying risk factors associated with offending and mental health problems

Additional associations between characteristics of the study populations and offending behaviour were provided by four studies. These describe *prima facie* associations with offending and are thus presented as possible risk factors for offending (Theriot & Segal, 2005; Sheldon *et al*., 2006; Green & South, 2005; Swanson, 2001).

The potential risk factors linking offending and mental health problems include instability of housing, which was linked to higher arrest rates (Sheldon *et al*., 2006; Brekke *et al*., 2001; Swanson, 2001), as were alcohol and substance misuse (Sheldon *et al*., 2006; Brekke *et al*., 2001). Self-perceived lack of social support amongst the study participants is also found to be positively associated with participants' arrest rates (Sheldon *et al*., 2006). Poor social functioning was found to be a predictor of arrest rates within two studies. Social functioning is characterised as 'willingness to participate' in community-based activities; the ease with which one makes social contacts; contact with family, friends, and acquaintances; and involvement (Theriot & Segal, 2005, p. 181). It is also characterised in terms of 'work, independent living, social skills, family relations, levels of substance misuse and housing stability' (Brekke *et al*., 2001, p. 1360). History of arrest, history of hospital recidivism, housing instability, and drug and alcohol use were found to be positively associated with convictions amongst some study participants (Swanson, 2001).

However, these associations are not compared to the experience of the general population, where the associations between housing instability, drug and alcohol dependence and offending are also well documented.[10] This lack of comparison limits the studies' ability to

[10] For a general discussion of this see the NACRO website http://www.nacro.org.uk/services/housing.htm.

elucidate the particular experiences of adults with mental health problems. Furthermore, the studies do not seek to explore the particular interactions between these risk factors or the mechanisms which link them to offending behaviour amongst adults with mental health problems. Green and South do offer some insight on this, through the inclusion of qualitative data. This reveals positive associations between a lack of housing, material deprivation, mental health problems and offending, which are shown as interdependent: one factor causing another (Green & South, 2005).

Four studies provide an assessment of one set of variables that are not shared with the general population, namely those relating to symptoms of mental ill health or the management of mental ill health, in determining the risk of arrest. Two of these studies in community-based settings found higher levels of 'psychological disability' increased the likelihood of arrest (Brekke *et al*., 2001; Theriot & Segal, 2005). A third study, focusing on court-ordered out-patient treatment, found an association between previous episodes of hospitalisation and arrest rates (James *et al*., 2002). A history of medication non-compliance was also associated with higher risk of arrest (Swanson, 2001). However, the notion that the most 'symptomatically severe' are also most at risk of offending behaviour is challenged by Sheldon *et al*. (2006) who found no significant relationship between severity of psychiatric symptomology and arrest rates. Furthermore, the underlying mechanisms and interaction between symptom variables and other variables, such as homelessness, for example, are not explored in the studies, so we cannot learn **why** being symptomatic may have the reported effect of increasing risk of arrest.

3.5 Associations between victimisation and mental health problems

Eleven studies explored the associations between crime victimisation and mental health problems. These were all primary studies of SMS level three, except the Teplin *et al*. study, which is a secondary analysis of a large national survey in the USA. All but the evaluation studies of special measures for vulnerable and intimidated victims and witnesses (VIWs) were observational studies or surveys. The studies all lend support to the hypothesis that adults with mental health problems are more vulnerable to victimisation.

Three studies examined the prevalence of victimisation amongst populations with known mental health problems, all within the SMI range (Teplin *et al*., 2005; Brekke *et al*., 2001; Fitzgerald *et al*., 2005). The Fitzgerald study is based in an in-patient setting, the two others are in community-based settings. The prevalence of victimisation amongst adults with mental health problems is found to be higher than the general population across these

studies. Victimisation rates ranged from 17.7% (in the past three years) in Brekke *et al*. (2001), to 25% for violent crime (one year period) in Teplin *et al*. (2005). This compared to victimisation rates of the general population of 7.7 and 2.79% respectively. For all recorded crime types, Teplin *et al*. (2005) also find rates of victimisation amongst people with SMI up to 23 times higher than the general population.

Amongst victims and witnesses who appear in court it is estimated up to 45% are vulnerable or intimidated (VIW), (N=225), based on a random sample of 500 prosecution victims and witnesses (Burton & Sanders, 2006). Of these VIWs, around 6% were identified as VIW due to having a mental disorder or learning disability.

Population sub-groups

Little information was presented which explored the effects of demographic variables on rates of victimisation amongst adults with mental health problems. Where such demographic variables were collected, no useful comparison is made to the general population which would allow the **effect** of the variable to be isolated. However, some crimes are more likely to affect certain demographic groups and the mental health impact of these crimes will, therefore, disproportionately affect these groups also.

Gender

Studies failed to establish any effect of gender on rates of victimisation amongst adults with mental health problems.

Teplin and colleagues (2005) report that within their sample of adults with SMI in the USA, more women than men were victims of violence, rape or sexual assault, personal theft, and motor vehicle theft. The authors also found significantly more men than women were victims of robbery. However, these prevalence rates are consistent with the general population.

Gender was not found to be a significant factor in predicting victimisation rates generally amongst adults with schizophrenia in Melbourne, Australia (Fitzgerald *et al*., 2005).

More females than males were identified as VIWs in one evaluation study (57 v 43%). However, these proportions probably reflect the fact victims of sexual offences are often perceived as 'vulnerable' *per se* and the majority of these victims are female (Hamlyn *et al*., 2004).

Ethnicity

Within a study sample of adults with SMI in the USA, higher rates of victimisation across

crime types were found amongst African American people than for other ethnic groups. However, these demographic variables are consistent with the general population also (Teplin *et al*., 2005).

Ethnicity was not found to be a significant factor in rates of victimisation amongst adults with schizophrenia in Melbourne, Australia (Fitzgerald *et al*., 2005).

3.6 Potential risk factors associated with victimisation and mental health problems

Where the impact on the mental health of victims of certain crime types is investigated, demographic variables cannot be synthesised because the studies feature different populations, subject to different crimes. For example, three studies were either entirely or almost entirely based on female participants, as they investigate crimes more often experienced by women: domestic violence and rape (Guggisberg, 2006; Vostanis, 2001; Gale & Coup, 2005). However, studies showed some demographic variables are a factor in the experience of **certain** mental disorders because these are likely to result from certain types of crime. In this way, demographic variables may be a risk factor of mental health, after a fashion, although they are primarily a risk factor of victimisation. For example, women are more likely to experience domestic abuse and rape than men, and African American and Hispanic men are more likely to be victims of violent crime than white men. Furthermore, rape and sexual assault and violent crime are more likely to result in Post Traumatic Stress Disorder (PTSD) than other crime types (Kilpatrick & Acierno, 2003). Based on an international review of evidence, female victims of domestic abuse and rape were found to be almost four times more likely to have suicidal ideation compared to non-abused women and up to 50% to have PTSD although not compared to rates of PTSD in the general population (Guggisberg, 2006). In this sense, gender and ethnicity may be considered a risk factor of certain mental health problems but the hierarchy of cause and effect is not established: it would be difficult to say being female increases ones risk of suffering PSTD, for example. One study found however, that one particular crime type affected male and female victims differently. Compared to all victims of street robbery in the UK, higher levels of psychiatric morbidity were recorded for female victims (Gale & Coup, 2005).

Other factors found to underlie the association between crime victimisation and mental health problems for adults with more severe mental health problems include a lack of 'significant daily activity' for adults with schizophrenia (Fitzgerald *et al*., 2005) and being more 'symptomatic' for those with SMI (Brekke *et al*., 2001). Although causal relationships between mental health symptoms and other social factors or histories i.e. 'which came first',

are very difficult to assess (Fitzgerald *et al*., 2005). The studies do not explore these linkages fully. Brekke and colleagues further suggest adults with mental health problems are unlikely to report their victimisation to the police (as unlikely as the general population), thus leaving a vulnerable group without adequate protection and potentially making them more vulnerable to victimisation. However, this hypothesis is not tested in their research.

3.7 Associations between mental health and non-criminal justiciable problems

Studies were included if they examined access to justice for adults with mental health problems in the fields of 'civil' justice, civil processes, including courts and tribunals and justiciable problems, such as debt, housing, family problems, employment and discrimination. These have been grouped together as 'non-criminal' justiciable problems.

Twelve studies provided information about populations with mental health problems who experienced non-criminal justiciable problems (Pleasence *et al*., 2004; Moorhead *et al*., 2006; Meltzer *et al*., 2002; Vostanis, 2001; Stuart, 2006; Buck *et al*., 2005; Marwaha, 2005; Alexander, 2006; Roeloffs *et al*., 2003; Powell & Clarke, 2006; Schulze & Angermeyer, 2003; Gaebel & Zäske, 2005). Only one study was an evaluation of services targeted specifically at adults with mental health problems who also have non-criminal justiciable problems (LSC, 2005).

It is not possible to draw any conclusions about the role of ethnicity or gender in determining the experiences of non-criminal justice amongst adults with mental health problems, due to a lack of information in the studies.

Much evidence was presented in the studies suggesting adults with mental health problems experience a range of non-criminal justiciable problems and are less able or likely to address their problems effectively compared to the general population.

A significant body of UK-based research, which investigates experiences of non-criminal justiciable problems is based around the annual English and Welsh Civil and Social Justice Survey,[11] conducted by the Legal Services Research Commission (LSRC) (Pleasence *et al*., 2004; Buck *et al*., 2005; Moorhead *et al*., 2006). Evidence from these surveys show mental ill health is associated with having a long-term disability (Pleasence *et al*., 2004); perhaps unsurprisingly as mental ill health is considered to be a disability in itself. It is also reported that a greater number of justiciable problems, reported across a range of issues (for example

[11] Formerly the National Periodic Survey of Justiciable Problems.

housing, children, employment), was positively correlated with experience of long-term disability. A deduction may be made from this that adults with mental health problems are also more likely to experience these non-criminal problems, but this is difficult. A limitation with the LSRC surveys is that mental health problems are not specifically addressed as a variable. Those with a long-term disability do not necessarily have mental health problems or *vice versa*. Data is delineated from the LSCR surveys only on mental health-related justiciable problems, such as issues to do with 'care or discharge from hospital'. For adults reporting such justiciable problems, they are also more likely to experience medical negligence and discrimination (Buck *et al*., 2005). Respondents who report mental health-related justiciable problems, were also the least likely to take any action to resolve their problems (Buck *et al*., 2005), which may mean problems worsen or incubate new ones.

That adults with mental health problems are vulnerable to non-criminal justiciable problems is corroborated by Meltzer and colleagues (2002). In this population survey of adults with psychotic disorder, high levels of debt and relationship breakdown were found compared to a counterfactual group of those with 'no disorder' (44 compared to 23%).

Other studies explored the relationship between mental health problems and discrimination (on mental health grounds). The findings are based on qualitatively reported experiences except Roeloffs and colleagues' study, in which rates of self perceived stigma amongst adults with depression are compared to other health problems: hypertension and diabetes. Three studies were based in the UK (Marwaha, 2005; Powell & Clarke, 2006; Stuart, 2006), one in Germany (Schulze & Angermeyer, 2003), and one in the USA (Roeloffs *et al*., 2003). All studies report high levels of discrimination and stigma in employment and in social attitudes in general.

Only one study investigated the effectiveness of a service specifically targeted at adults with mental health problems who also have non-criminal justiciable problems in the UK (LSC, 2005). This provided qualitative data. The service clients are all referred into the service because they have mental health problems. Study respondents (staff working in or in connection with the service) describe their clients' needs as including unemployment, debt and poor housing problems. However, the client group is not compared to a sample of the general population (LSC, 2005) and so the findings are limited.

3.8 Potential risk factors associated with non-criminal justiciable problems and mental health problems

Few studies presented data that might elucidate the potential underlying causes of the high

incidence of non-criminal justiciable problems amongst adults with mental health problems. People's ability to deal with their non-criminal justiciable problems is an important factor and 'inability' in this arena could constitute a 'risk factor'. Meltzer *et al*. found adults with psychotic disorders also have difficulties with 'activities of daily living', including personal finance and managing money. Twice as many adults with a mental disorder have at least one difficulty of this kind, compared to those with no disorder (Meltzer *et al*., 2002). This would appear to be a significant risk factor for experiencing civil or non-legal justiciable problems as those without these basic abilities to cope with daily living activities, will be less able to take action to mitigate or prevent such problems from arising.

3.9 Discussion

Although the studies were diverse in design and purpose, some key associations are found across studies, which present a picture of the hazards and negative outcomes faced by adults with mental health problems.

Taken together, the studies demonstrate greater misfortune and comparative disadvantage amongst this group. This is experienced in higher levels of crime victimisation, particularly violent crime, as well as offending. The higher prevalence of offending amongst this group is associated in the studies with material factors, such as homelessness or instability of housing, economic disadvantage and unemployment, although this association is also well documented amongst the general offending population. To summarise these associations, the experience of offenders with mental health problems has been called a 'merry-go-round' lifestyle (Green & South, 2005) in which lack of material resources mean this group is repeatedly in contact with the criminal justice system. An illustration of the merry-go-round is the '13-week rule' in the UK, whereby those who receive a custodial sentence of 13 weeks or more lose their local authority tenancy. The impact of these system failures specifically on adults with mental health problems, compared to the general population, is not illustrated in the studies but one may speculate that these difficulties will affect an already vulnerable group in worse ways.

It is also known there is a high number of adults with mental health problems within the prison system and rates of mental health problems amongst this group are three to four times higher than amongst the general population in the US (Weisman *et al*., 2004) and 14 (for men) and 23 (for women) times higher than that of the general population in the UK, for psychotic disorder (Prison Reform Trust & Mind, 2004). Other research has found high proportions of prisoners requiring transfer to a NHS hospital for treatment in the UK, and 7%

of men and 14% of women with a 'functional psychosis' (cited in James *et al.*, 2002). The high number of prisoners with mental health problems in itself suggests a failure of policy in which people with mental health problems should be channelled into the treatment they need. This policy imperative followed the 'Reed Report' which recommended 'mentally disordered offenders should, wherever appropriate receive care and treatment from health and personal social services rather than in custodial care' (Department of Health & Home Office, 1992). The evidence is that such a policy is not being fully applied. However, treatment is costly and no new money has been made available to accompany prisoners being referred through the court or through so called court diversion schemes (James *et al*., 2002). Another explanation for the policy failure has been that as 'care in the community' support has failed in the public eye, both due to high profile violent crimes committed by people with mental health problems (such as the murder of Johnathan Zito) and due to under-resourcing, people with mental health problems are again being channelled into prison. Adequate investment in court diversion is urged and better training for probation staff in order to lift the burden from prisons in order to meet these challenges (Rickford, 2003; Rickford & Edgar, 2005).

The treatment of so called 'mentally disordered offenders' in the UK criminal justice system is a politically and morally loaded issue. The need to treat a person for their problems is balanced against a need to prosecute and punish for offences committed (Home Office & Department of Health, 1995) and a public appetite to ensure 'justice is done' for violent crimes that receive a great amount of media attention. However, the more prison becomes the default repository for those with mental health problems who have committed an offence, the more people will be denied access to treatment they need, as prisons are not equipped to treat mental health problems (James *et al*., 2002). To make policy even more complex, an additional and increasingly important competing political demand is the need to decrease the ever expanding prison population (NAPO, 2006). Given such a complex political environment surrounding the treatment of offenders with mental health problems, it is ever more important to consider the issues in a balanced, pragmatic way. Whatever the risks posed by offenders with mental health problems, the duty to meet mental health needs is not diminished. What is needed, therefore, are practical suggestions for interventions and policies that allow adequate services to be provided. Such interventions are considered in the following chapter.

At the individual level, the risks associating mental health problems with offending include being more 'symptomatic', and failing to take medications. These findings have supported calls for mental health treatment and the risk management of offending to be more closely

linked, so for example, mental health professionals regard reducing arrest and risk of arrest as a clinically relevant outcome indicator (Swanson, 2001). Criminal justice interventions, such as mental health specialist courts and other so called 'diversionary' schemes partly respond to this call. However, the extent to which the material deprivation, often experienced by adults with mental health problems, is tackled by these initiatives, is not demonstrated.

Some studies found black peoples are over-represented in study populations of adults with mental health problems who have also offended. Again, however, this may be explained by the higher prevalence of this group in the general offender population. Interestingly, however, a disproportionate rate of white participants was found in two studies of court-based diversion schemes in the USA (Moore & Hiday, 2006; Steadman *et al*., 2005). This could suggest discrimination is preventing non-white participants from accessing interventions designed to offer a more therapeutic solution to their offending. Speculations as to why this might be the case might include the notion that criminal justice systems tend to 'criminalise' people from black and minority ethnic communities more than white people, or it could be explained by the reluctance of black court clients to engage with diversion initiatives. These are speculations, which would need further investigation. Nevertheless, diversion schemes should be watchful of the potential equalities pitfalls.

A particularly striking message to emerge from the research is adults with severe mental health problems are disproportionately at risk from crime victimisation compared to the general population. This is the case even after controlling for demographic factors, suggesting it is the **symptoms** of having a SMI, which increases risk. This finding has implications for those working with adults with mental health problems. Improved risk assessment and planning to reduce the risk of victimisation is an obvious call from the research.

Some studies suggest it is the reluctance of adults with mental health problems to report victimisation that puts them at increased risk of victimisation in which case, crime prevention and criminal justice agencies need to work to improve confidence in their services (Mind, 2001; Brekke *et al*., 2001). Crime and Disorder Reduction Partnerships (CDRPs) which are based around the UK and involve police, local authorities and primary health care teams would be well placed to address these issues. However, CDRPs do not routinely include representatives of the Crown Prosecution Service (CPS) or other legal professionals, such as local solicitors and these agencies play an important role in public confidence in justice systems. Attempts would have to be made to ensure all such agencies are included, as has been done with another complex issue involving vulnerable people: domestic violence. In terms of civil or 'non-criminal' justice, there is limited evidence that adults with mental health

problems are more likely to experience problems to do with debt, housing, relationship breakdown and unemployment, compared to the population who do not report having a mental health problem. Qualitative evidence further suggests discrimination, stigma and employment problems are also experienced by this group as a result of their illness. These experiences suggest adults with mental health problems may benefit from targeted interventions to provide advice in order to address such problems.

3.10 Summary of key findings

- Adults with mental health problems experience higher rates of offending and are over-represented in the prison population, although not enough is known about the underlying mechanisms that link mental health problems and offending.
- Higher rates of offending amongst this group are associated with material factors, such as homelessness, economic disadvantage and unemployment, although the mechanisms linking these with mental health problems and offending are not adequately explored.
- Being more 'symptomatic', and failing to take medications are associated with an increased risk of arrest and risk of victimisation.
- Adults with severe mental health problems are disproportionately at risk from crime victimisation compared to the general population.
- Adults with mental health problems are also more likely to experience problems to do with debt, housing, relationship breakdown and unemployment, compared to adults with no reported mental health problems.

4. Services and agencies accessed by adults with mental health problems and their effectiveness

4.1 Introduction

Eighteen studies provided evidence on services or agencies accessed by adults with mental health problems who are experiencing justiciable problems. It is interesting to note the large majority of these studies focused on interventions designed to reduce **offending** amongst adults with mental health problems. This chapter describes the interventions and explains their processes and intended outcomes; there is also a discussion of the evidence of effectiveness of each intervention. The interventions are categorised into three types:

1. interventions targeted at offenders with mental health problems;
2. interventions and services for victims and witnesses with mental health problems; and
3. non-criminal justice services and interventions for adults with mental health problems.

Fourteen studies were evaluation studies of interventions designed to improve access to or facilitate justice for adults with mental health problems. The majority of these evaluation studies were for interventions for offenders with mental health problems (Boothroyd *et al*., 2005; Green & South, 2005; Kingham, 2005; Kisely & Preston, 2005; Weisman *et al*., 2004; James *et al*., 2002; Lamberti *et al*., 2004; Moore & Hiday, 2006; Swanson, 2001; Steadman *et al*., 2005). Three further evaluation studies were based on surveys of vulnerable victims and witnesses (Hamlyn *et al*., 2004; Burton & Sanders, 2006; Plotnikoff, 2007) and there is also an evaluation of targeted civil legal advice services for adults with mental health problems, which is based on a qualitative design (LSC, 2005). The remaining four studies were observational: one of the experience of adult victims of domestic violence who subsequently experience mental health problems (Guggisberg, 2006); two studies of clients of universal community civil legal advice (Moorhead *et al*., 2006; Alexander, 2006), and finally a survey of staff in criminal justice settings (Mind, 2001).

4.2 Interventions targeted at offenders with mental health problems

There are a number of interventions which are targeted at getting adults with mental health problems who have offended into treatment. We have only addressed those that have been evaluated in adequate studies for this review. The majority of interventions for offenders with mental health problems included in the studies mentioned are based in the USA. The criminal justice context is different in the USA to the British experience which diminishes

the ease with which lessons may be applied to the UK. However, general lessons from the studies are applicable, particularly where specific mechanisms at work behind the interventions included are evaluated and may be applied to the British context. In particular, moves towards 'therapeutic jurisprudence' in the UK (witnessed in innovations, such as the Dedicated Drug Court pilots for example, and Criminal Justice Mental Health Teams, which are discussed below) suggest lessons from the interventions included in the studies may be relevant. Criminal justice-based interventions for offenders with mental health problems can be divided into three categories within the studies:

1. specialist mental health courts (SMHCs);
2. compulsory out-patient treatment (COT); and
3. 'other' criminal justice-based 'diversion' schemes.

All interventions can be described as 'diversion' schemes and identify with problem-solving justice or so-called 'therapeutic jurisprudence'. That is to say, their purpose is primarily to identify offenders who have mental health problems and divert them away from criminal justice into treatment. The similarities between the different interventions are located in the broad rationale for the programmes. This includes a belief in the need to treat the **causes** of the offending, thought generally to be related to the function of the mental health problem itself as well as underlying causes of socio-economic disadvantage. The rationale is to offer an improved response to offending amongst adults with mental health problems in order to break the 'merry-go-round' (Green & South, 2005) or 'Bermuda Triangle' (Lamberti *et al*., 2004) of punishment, release and further offending, so that the cycle of offending and release may be broken. Despite these commonalities, diversion schemes have different processes and designs.

'Diversion' has been encouraged in the UK since the 1992 Reed Report. Criminal justice-based interventions for offenders with mental health problems, as described in the studies, are mainly accessed by people within the 'severe' illness category including schizophrenia, bi-polar disorder, severe depression and psychotic symptoms. Randomised control trials are not usually possible for evaluations of such diversion schemes because it is not possible to manipulate inclusion and exclusion to the schemes for ethical reasons. The studies on criminal justice interventions targeted at offenders with mental health problems are, therefore, mainly quasi-experimental in design, with the exception of the Swanson study which is a randomised control trial. Diversion interventions have each evolved uniquely according to their location and locally available treatment. They have also evolved different referral and assessment processes (Steadman *et al*., 2005), which makes comparison of the schemes difficult.

Specialist mental health courts (SMHCs)

Three studies, all based in the USA, examined the effectiveness and impacts of specialist mental health courts (SMHCs) (Boothroyd *et al*., 2005; Moore & Hidey, 2006; Steadman *et al*., 2005). All studies are rated at Maryland Scientific Methods Scale level three. SMHCs are dedicated courts, which specifically, and exclusively, process offenders or alleged offenders who have been assessed as having mental health problems. Processes and procedures of SMHCs differ from location to location (Boothroyd *et al*., 2005). Although all the studies included used the term 'mental health court' or 'specialist mental health court', there is no single definition of the model. Moore and Hidey (2006) list seven possible features of the SMHC model. These include:

1. 'a separate docket for defendants with mental health problems;
2. a dedicated judge, who presides at the initial hearing and subsequent monitoring sessions;
3. dedicated prosecution and defence counsel;
4. a non adversarial team approach which involves joint decision-making between criminal justice and mental health professionals;
5. voluntary participation by defendants agreeing to follow a treatment regimen;
6. monitoring by the court; and
7. promise of dismissed charges or avoidance of incarceration'.

(Moore & Hidey, 2006, p. 660)

Two SMHCs included in the studies featured a specified docket for offenders with mental health problems (Moore & Hidey, 2006; Steadman *et al*., 2005). Informal interaction and dialogue between the judge and SMHC participants also feature in the SMHC model evaluated in the Boothroyd study. The third study included a SMHC model that features continuity of the judges or magistrates assigned to deal with court clients, as well as informality in court proceedings. Another feature was offenders' non-compliance with court orders were generally viewed as part of an accepted process of relapse and recovery, which it is seen as the court's job to manage (Steadman *et al*., 2005).

Referral to SMHCs may happen in a number of ways, although the studies did not all report on referral processes. Referral may be undertaken by magistrates, judges, mental health staff of a jail, mental health advocates or family members, from other forensic diversionary programmes, the public defender's office, court officials, other judges or magistrates. One study specified that referral takes place after an initial hearing and mental health screening by referring agencies (Boothroyd *et al*., 2005). Although referral may happen pre-adjudication (conviction), one study reported referral to SMHCs happens

post-adjudication in six out of the seven SMHCs included in their study (Steadman *et al*., 2005). Referral to SMHCs was described as 'voluntary' i.e. with the consent of the offender in two studies (Moore & Hidey, 2006; Steadman *et al*., 2005).

Following adjudication by the SMHC, clients typically access mental health treatment services that are either based in the community or hospital in-patient services. Specific services include behavioural health services, therapy, medication, anger management, housing and employment advice and services, and social services support. However, there was little emphasis in the studies on what treatment and services were accessed by SMHC participants and so little data or analysis was presented on this factor. The compliance and progress of SMHC clients may be monitored by the court around once a month, although the frequency of this monitoring is only specified in one study (Moore & Hidey, 2006).

There is conflicting information about the role of demographic variables in determining the processes and outcomes of SMHCs. One study reports older white women tend to be more represented in US SMHCs compared to the general offender population. Forty per cent of all referrals to SMHCs are women, compared to the population of the general US inmate population in which between only 5 and 10% are female (Steadman *et al*., 2005). Although a more useful comparison would have been with the inmate population of offenders with similar offending and substance misuse histories; the 40% statistic does seem to indicate a higher proportion of women than might be expected in SMHC dockets. Gender variables are not reported to be significant in other studies and one other study specifically reports gender ratios were not significantly different between SMHCs and traditional courts (Moore & Hidey, 2006). Ethnicity played a role in whether people were likely to be accepted to the SMHC caseload in two studies with white people being disproportionately represented in the SMHC caseload, compared to the prison population in general and African American people significantly less likely to be part of the SMHC caseload, compared to a counterfactual in a traditional court. Furthermore, the 'imbalance' of ethnic groups of SMHC caseloads is found to occur at the point of initial referral to the SMHC (Steadman *et al*., 2005).

Effectiveness of SMHCs

In the USA, SMHCs have multiplied at a fast rate (Steadman *et al*., 2005; Moore & Hidey, 2006) and a relative lack of evidence exists on their effectiveness, considering their large number.

Evaluations of SMHCs focused mainly on the workings of the court's processes and are quasi-experimental in design. Measures of the SMHCs' effectiveness, (hereafter referred to

as 'outcome measures') were presented in the studies and mainly derive from the courts' stated aims and objectives, except the Steadman *et al*. study, which is observational in design (Steadman *et al*., 2005). Studies were interested in different aspects of SMHCs and, therefore, have different outcome measures. The measures include rates of acceptance from initial referral to the SMHC (Moore & Hidey, 2006; Steadman *et al*., 2005); clinical outcomes[12] of referral to SMHCs, based on the Brief Psychiatric Rating Scale (BPRS) (Boothroyd *et al*., 2005) and rates of recidivism and severity of recidivism offence[13] of SMHC clients (Moore & Hidey, 2006).

Of the offenders initially referred to SMHCs, rates of acceptance into the court vary. This ranges from 12 to 100%. Reasons for the rejections also vary. An ineligible mental health diagnosis is the reason in 6.9 to 30% of rejections. Ineligibility due to past history of criminal charges was the reason in 20% of rejections and concerns for public safety in 5.2%. However, in one SMHC included in the studies, 100% of rejections were for reasons of ineligible diagnosis. There is clearly great variation in rates and reasons of rejection from one SMHC to another, suggesting local implementation and process variables are crucial in understanding the impact of SMHCs. Disappointingly, no assessment is provided as to why one SMHC model managed to obtain a 100% rate of acceptance from referral in the study.

The impact of the SMHCs on accessing mental health treatment was found to be positive, where reported. In one study, 83% of SMHC participants received treatment compared to 52% of those in the traditional court counterfactual group (Boothroyd *et al*., 2005). Anecdotally, Moore and Hidey found treatment availability appeared to be improved for SMHC participants, compared with traditional court participants, although this was not specifically measured in the research.

Effectiveness of SMHC medical assessments is assessed in the studies by the level of external provider agencies' (such as hospitals) agreement with the diagnosis given by SMHC assessment teams. This was generally high. Where information is given, rejection of the original diagnosis ranged from 6.9 to 20%. Reasons for this variation are not available within the evidence and would need to be researched further. However, the variation does imply the need for vigilance at a local level to ensure court assessment processes are adequate.

Clinical outcomes resulting from referral to the SMHC are explored by one study only and this did not find any significant difference between SMHC clients and traditional court clients,

[12] Those relating to the mental health of the individuals concerned.
[13] Measured on the offence severity scale: a summation scale indicating recidivism severity.

based on the BPRS of court clients (Boothroyd *et al*., 2005). The authors propose this may be due in part to the lack of available local treatment services, over which the courts themselves have no administrative control.

Recidivism rates were found to be significantly affected by participation in the SMHC in the one study, which used this measure. SMHC clients' re-arrest rates were found to be less than half that of the traditional court counterfactual group over a 12-month period.[14] Even after controlling for arrest history before the SMHC, the effect of SMHC participation on re-arrest rates is significant. Furthermore, it is the successful completion of the court-ordered programme[15] which obtains the biggest impact on re-arrest rates in the 12-month follow-up study period (Moore & Hidey, 2006).

Compulsory out-patient treatment (COT)

Two studies feature COT for offenders with mental health problems. One is a randomised control trial (SMS level five) (Swanson, 2001) and the other is a review of experimental research (Kisley & Preston, 2005). COT is community-based treatment for offenders with mental health problems, which is ordered through the criminal justice system. In the studies presented in this review, COT clients are within the SMI range. COT is not exclusively applied to offenders and may be applied to any person with mental health problems as part of their treatment or as an alternative or follow-up to compulsory in-patient admission. However, the element of compulsion in treatment is a key mechanism for many criminal justice-based interventions, so lessons about the impact on offending of COT programmes is germane across interventions for offenders with mental health problems. Moreover, there is significant overlap of populations who have been admitted for treatment through the criminal justice system and those who have been compulsory treated through non-criminal justice means.[16] So what might be said to be effective about such measures can be applied to both non-offenders and offenders with mental health problems.

COT is accessed via the same routes as in-patient civil commitment. It is therefore an intervention for those with SMIs who are unable or unwilling to seek treatment themselves (Swanson, 2001) and who may be treated in the community. COT is applied in a number of ways including: provisions applied at the time of discharge from compulsory in-patient treatment in the UK (Kisley & Preston, 2005); as a result of a court order by a judge in the USA

[14] This period covered the minimum 6 months' of monitoring and treatment through the SMHC.
[15] Defined as consistently and continuously fulfilling the Mental Health Court Team's treatment recommendations for 6 months.
[16] As reported in a study of a different diversion scheme (James *et al*., 2002), discussed below.

(Kisley & Preston, 2005; Swanson, 2001); or an application by mental health professionals for individuals who are not already in in-patient care in Australia (Kisley & Preston, 2005). The COT order may include medication as well as community-based treatments but only in Australia does it include the power to enforce medication use in the community (Kisley & Preston, 2005). However, the effect of this particular mechanism is not assessed in the research. The threat of hospital-based treatment may be used as a sanction for non-compliance to the compulsory community treatment (Kisley & Preston, 2005; Swanson, 2001).

Effectiveness of COT

Both studies explore the impact of COT on offending behaviour. Swanson finds COT clients were significantly less likely to be arrested than the control group of the study but only for those with a history of hospital recidivism combined with criminal behaviour. Furthermore, the more time spent in receipt of COT the less likely arrest becomes. Compliance with medication, reduction in substance misuse and lower levels of violent behaviour amongst COT clients was found to be significantly linked to reductions in recidivism amongst offenders subject to COT (Swanson, 2001). However, Kisley and Preston found arrest rates of those subject to COTs were **not** significantly different to those in standard care. The divergence of these findings may be because variables relating to the study participants were not consistently recorded between the studies, with Swanson being more interested in the interaction of mechanisms and outcomes than Kisely and Preston's paper which, as a review of studies, is limited in its ability to make similar observations across multiple settings.

Kisley and Preston (2005) report no significant difference in hospital re-admission rates between COT clients and standard community treatment clients. As for the potential cost benefits of COT, 85 COT orders were needed to prevent one hospital re-admission (Kisley & Preston, 2005).

Other criminal justice 'diversion' schemes

Other criminal justice interventions or 'diversion' schemes for offenders with mental health problems, which stop short of being 'specialist mental health courts', involve co-ordinating criminal justice and mental health referral and assessment through a range of mechanisms such as courts, prison or police station based mental health referral and assessment teams. There is no single definition of such interventions but they are typically designed to identify offenders or alleged offenders with mental health problems and to facilitate their referral to either community-based or hospital-based treatment. Diversion schemes have also been established further upstream of the criminal justice system by offering mental health

assessment and referral at police stations (James *et al*., 2002) but the studies presented in this review do not address such schemes. Five studies of 'other' criminal justice diversion schemes for offenders with mental health problems were included in the review. Two were based in the USA (Lamberti *et al*., 2004; Weisman *et al*., 2004) and three in the UK (Kingham, 2005; James *et al*., 2002; Green & South, 2005). All studies are assessed at SMS level three.

The USA studies are evaluations of one particular model of intervention, namely Forensic Assertive Community Outreach Services (FACTS). The three UK-based studies focused on court-based diversion schemes, so called Criminal Justice Mental Health Teams (CJMHT) based at magistrates' courts. Only one study is concerned with outcomes for participants who were not diagnosed as having a SMI but who have 'less' severe illnesses (Green & South, 2005). Finally, the James *et al.* study provides a literature review and primary study specifically of court-based diversion for offenders who are subsequently diverted into psychiatric hospital (James *et al*., 2002).

Referral to the diversion schemes described in the studies is primarily through the courts: magistrates' courts in the UK or county courts in the USA. Referral to the USA-based diversion schemes may also be undertaken by county jail, state prisons, attorneys and court justices (Lamberti *et al*., 2004).

FACTS in the USA are a discrete intervention model. One FACTS project is described in detail. 'Project Link' involves an integrated team which co-ordinates services for offenders with mental health problems including referral, assessment and monitoring. The purpose of the FACTS model is to break down professional boundaries between criminal justice and mental health staff so offenders or alleged offenders with mental health problems can be dealt with appropriately.

FACTS provide a range of holistic services including co-ordinated referral and assessment from county jails, state prisons, attorneys and court justices; training and awareness-raising for court staff; liaison with specific court judges; and links between central project staff and other criminal justice system staff. FACTS also involve pro-active liaison between the core project staff and the primary healthcare system. Links are also made between core project staff and in-patient providers to co-ordinate and plan the discharge of patients. FACTS also provide links with social services in order to improve access to welfare benefits and social supports for offenders who belong to the programme.

Referral to CJMHTs in the UK, which may consist of just one community psychiatric nurse or a team of mental health and other professionals permanently based in a court (James *et al*., 2002), is followed by a mental health assessment. Depending on the result of this, CJMHT clients are generally referred onward, either to community mental health services, group therapy or in-patient care. Treatment will be part of a court order.

Effectiveness of other criminal justice 'diversion' schemes

Admission and acceptance rates to diversion schemes from initial referral is an important way of measuring the effectiveness of schemes at identifying and channelling offenders who need treatment (James *et al*., 2002). It is difficult to compare acceptance rates across the schemes as these are measured differently. However, there does seem to be variation across the schemes in how often those referred are accepted. For example, conversion of initial referral from (mainly) the police to a diagnosis[17] was reported in 70% of referrals to a CJMHT which was then agreed 96% of the time by courts (Kingham, 2005). However, as few as 12% of clients who were assessed by CJMHTs were subsequently referred into mental health services (Green & South, 2005). 'Admission rates' to psychiatric hospital from court referral were also found to be low at around 25% (James *et al*., 2002). Even where acceptance rates from initial referral are high (as in the Kingham study) it is still not known how many more offenders or alleged offenders with mental health problems have not been identified. Given the high number of offenders estimated to have mental health problems, as discussed in chapter 3, numbers of referrals generally would need to be higher in order to reach more of those who are in need (Kingham, 2005). Without this consideration, it is impossible to state how effective diversion schemes are at channelling offenders into treatment.

The FACTS model has diverse referral mechanisms across the different US states where it is implemented, which makes comparison of 'acceptance rates' difficult both between the FACTS schemes and with other diversion schemes. This may be why no such analysis was provided in the studies of FACTS. However, Lamberti *et al*. (2004) point out the types of clients accessing the different FACTS schemes across the USA vary in their symptomology and whether they are referred pre- or post-adjudication. This variation suggests clients are accepted inconsistently and therefore, some likely candidates may be falling through the net. This was highlighted as an area for further investigation and research (Lamberti *et al*., 2004).

The impact of the diversion schemes on accessing treatment was not reported consistently between the studies. One of the FACTS studies describes the range of services that

[17] Where some diagnosis of mental health problem is made.

participants were able to access, although these provisions are not compared to a control group or other interventions (Lamberti *et al*., 2004). Anecdotally at least, the FACTS participants seem to receive far more holistic and integrated services than other criminal justice-based interventions described in this review. An assessment of the impact of the specific mechanisms of the FACTS model is not provided in either evaluation study of the programme. It is also disappointing that information on the numbers of FACTS participants who actually access treatment services is not provided.

Some evidence of improved access to treatment services was found for UK CJMHT clients. Following assessment, significantly more clients were found to have had contact with statutory mental health services 12 months after assessment than 12 months before, possibly as a result of referral to services by a CJMHT at assessment. However, clients who were assessed as having SMI by the CJMHT were significantly more likely to have had contact with statutory mental health services than those who were not assessed as SMI (Green & South, 2005). This suggests clients who are falling short of certain threshold criteria may be missing out on services they need or that might help them to reduce their offending behaviour.

Comparing community-based referrals to those being referred through the court for psychiatric admission, no one group was found to be less likely than the other to complete treatment or to stay for less time than required in hospital. So, in terms of services received, court-ordered referrals for those requiring psychiatric services appear to be just as effective as community-based referrals on these measures at least (James *et al*., 2002). However, it is difficult to compare the effectiveness of court referrals in this way due to differences in the characteristics of community-referred and court-referred groups.

Four studies provided evidence on clinical outcomes of diversion schemes (James *et al*., 2002; Green & South, 2005; Weisman *et al*., 2004; Lamberti *et al*., 2004), however these were reported inconsistently. The most frequently used measure of clinical outcome across the studies was numbers of hospital admission. A significant decrease in subsequent hospital admissions was reported as a result of compulsory court-ordered psychiatric admission, comparing two years before the admission to two years after (James *et al*., 2002). This is not the case for clients of CJMHTs where no similar reduction in hospital admissions is reported, comparing 12 months pre- to 12 months post-referral (Green & South, 2005). In the USA, both FACTS studies report significant reductions in hospitalisations amongst the project participants, comparing the group a year before involvement with the project and a year following (Lamberti *et al*., 2004). For FACTS

participants, the total number of hospital days dropped from a total of 2,153 for the group, a year before involvement to 321 a year following involvement (Weisman *et al*., 2004). However, it is difficult to compare effectiveness between the different diversion schemes on this basis as the availability of local treatment is likely to vary across schemes, thus affecting their effectiveness on measures of admission rates.

On a different measure of clinical outcome, based on the Brenner scale of 'good to bad' clinical outcomes, court-ordered psychiatric admission was reported to result in a 'good' clinical outcome in 63% of cases and an 'acceptable outcome' in 86% of cases. This was found to be similar to other community-based referrals for admission (James *et al*., 2002). Significant improvements in community functioning were also detected amongst Project Link clients[18] (Weisman *et al*., 2004).

Reconviction rates were found to be affected differently across diversion schemes, although assessment of the impacts within each intervention is complicated by the ways offending is reported. Reconviction rates of court-ordered psychiatric patients were found to be approximately half that of offenders given prison or community disposals over a similar time frame (James *et al*., 2002). However, the effect of being in hospital, having closer monitoring and therefore having less opportunity to offend may explain this effect.
For clients of CJMHTs, offending rates were actually found to increase by 23% between pre- and post-assessment stages, regardless of the outcome of the CJMHT assessment, which is a significant rise in the **opposite** direction to what is intended (Green & South, 2005). However, this may be explained by secondary offences, such as non-payment of fines or failure to attend, which were related to the original offence. No comparison is offered with a control group in this respect.

FACTS were found to be effective at reducing offending amongst clients. Weisman *et al*. (2004) report the mean number of jail days per patient dropped from 107.7 (standard deviation ±133.5) to 46.4 (±83.7), over a two-year period, for Project Link clients. Lamberti *et al*. (2004) also report that the mean yearly jail days per patient dropped from 107.7 (±133.5) to 46.4 (±83.7) across three FACTS projects. These results seem encouraging although they are not compared to a counterfactual so the decrease cannot be attributed to the intervention with confidence.

Only the Lamberti *et al*. study provided details of cost savings. Total savings in jail costs

[18] As measured by the Multnomah Community Ability Scale.

during the one-year study period were $157,000, and total savings in hospital costs were $917,000. It is not clear if these are savings after counting project costs.

Not enough information is given to analyse rates of acceptance by ethnicity, age or sex across the studies.

4.3 Interventions and services for victims and witnesses with mental health problems

Five studies examined the services received by victims or witnesses of crime who also have mental health problems. These include both services specifically designed for vulnerable groups (including adults with mental health problems and intellectual disabilities) and universal prosecution services and agencies. Specific services include so-called 'special measures' for VIWs (Burton & Sanders, 2006, Hamlyn *et al*., 2004; Plotnikoff, 2007). Universal services include criminal justice staff and services, such as the CPS and criminal courts (Mind, 2001), and mental health professionals who work with victims *(*Guggisberg, 2006*)*. All studies are based in the UK except the latter which is an Australian study.

None of the studies provided information on the effect of demographic variables, such as ethnicity, age or gender.

Special measures for VIWs were introduced following the Youth Justice and Criminal Evidence Act (1999) to improve the access and experience VIWs have in court. Those eligible for special measures include children under the age of 17; those who suffer from a mental or physical disorder; or who have a disability or impairment that is likely to affect their evidence; and those whose evidence is likely to be affected because of their fear or distress at giving evidence in the proceedings. The measures include video-recorded evidence-in-chief; live television links for giving evidence; and removal of wigs and gowns in court (Burton & Sanders, 2006). Two evaluation studies of special measures are rated at SMS level three (Burton & Sanders, 2006; Hamlyn *et al*., 2004). The third study focuses on one special measure only: intermediary schemes. This is a qualitative study of new roles which are designed to improve communication between VIWs and criminal justice staff including police, judges and lawyers (Plotnikoff, 2007).

Studies of universal services accessed by victims and witnesses with mental health problems include the Mind study, which is a survey of legal professionals and witness support staff. Guggisberg's study is a review of evidence on how services respond to domestic violence victims who develop mental health problems, such as suicidal ideation and PTSD.

Effectiveness of interventions and services for victims and witnesses with mental health problems

The evaluation studies of special measures use different notions of effectiveness or 'success' of the schemes including improvements to VIWs' satisfaction and positive impacts on VIWs' experiences at court (Hamlyn *et al*., 2004); the successful identification of potential VIWs (Burton & Sanders, 2006); and positive feedback from court, other criminal justice staff and people acting as intermediaries (Plotnikoff, 2007). Effectiveness of the 'universal' services for victims and witnesses with mental health problems is measured through subjective responses of research respondents.

The impact of special measures on VIWs who accessed them was generally positive. Positive impacts include a reduction in the numbers of VIWs who feel anxious or distressed overall, compared with VIWs who did not access special measures (63% of special measures users v 73% of VIWs not using the measures). VIWs who used special measures were also less likely to be upset by cross-examination and more likely to say they had been able to give their evidence accurately, compared with non-users of special measures. Results from two surveys of VIWs conducted approximately one year before and one year after the introduction of special measures show there was a significant decrease in VIWs saying they are 'very dissatisfied' overall with the experience of being a witness (Hamlyn *et al*., 2004). Satisfaction with the intermediary schemes was also found to be high amongst VIWs (Plotnikoff, 2007). However, a limitation with both the Hamlyn and Plotnikoff studies is that the impact of special measures **specifically** on adults with mental health problems or intellectual disability are not defined and participants in this category are simply counted within VIWs generally.

Despite the positive impacts reported by users of special measures, there is evidence relevant agencies are failing to identify people who would be eligible for the measures. Comparing numbers of VIWs identified by the police and the CPS and numbers identified in the same files by independent researchers, a discrepancy of around 36 percentage points was found, suggesting the police and the CPS are failing to identify some VIWs (Burton & Sanders, 2006). Furthermore, the numbers of potential VIWs identified by researchers far exceeds Home Office estimates which are between 7 and 10%, compared to 45% found by researchers. The authors suggest the police have particular difficulty in identifying VIWs with learning disabilities or mental disorders (Burton & Sanders, 2006).

As a result of an intermediary scheme, more cases are reported to reach trial stage as a result of the measure. This is reported to be due to improved interaction between police and

court staff and VIWs (Plotnikoff, 2007). Unfortunately the specific mechanisms underlying reported positive impacts were not expanded on in the other two studies of special measures.

Evidence on the effectiveness of **universal** services is that for adults with mental health problems who are victims of crime, services are ineffective at securing justice. A survey conducted with 179 staff members of the CPS, police and witness support projects and other legal staff, such as solicitors, revealed access to justice for adults with mental health problems is problematic.[19] Seventy-nine per cent of respondents reported this view (Mind, 2001). Additional anecdotal evidence reported suggests in cases involving a witness with mental health problems, a non-guilty plea is more likely to be given, which results in the CPS reconsidering evidence or accepting a plea to a reduced charge (Mind, 2001). The study concludes that responses given by agencies to victims with mental health problems are based on incorrect assumptions about mental health.

The Mind study took place before many special measures were introduced to try to improve the experience of justice for people with mental health problems (Mind, 2001). However, the issues explored in the study go beyond the scope of what the special measures address and the findings are still, therefore, relevant.

Evidence about health service agencies who respond to victims of domestic violence who later develop PTSD or suicidal ideation shows health professionals' attitudes unfairly focus on the role of the victim in precipitating the violence. This attitude was found to exacerbate the mental ill health of the victims leading to an 'increase in feelings of fear and helplessness' (Guggisberg, 2006, p. 6).

Although the evidence on universal services is from very diverse research designs they do, nevertheless, highlight the important role these services play in ensuring adults with mental health problems access justice. Attitudes within professions can be discriminatory which may serve to preclude justice or worsen the impact of victimisation. The effect of discrimination and stigma is discussed further in the final chapter of this review.

4.4 Non-criminal justice services and interventions for adults with mental health problems

Three studies examine the impact and processes of non-criminal justice services or

[19] The Mind survey respondents included staff from victim support schemes and crown court witness service, local Mind association or Mental Health Action Group, solicitors, advocacy projects, service user groups, family support workers and patients' councils.

interventions for adults with mental health problems (Alexander, 2006; Moorhead *et al*., 2006; LSC, 2005). Only the Alexander study is a primary study based on a survey of service clients, meeting SMS level three. The others are project evaluations with a qualitative design. Only one study examines services specifically targeted at adults with mental health problems (LSC, 2005). The others are focused on universal services: a survey of personal injury compensation claimants who attend a stress clinic (Alexander, 2006); and a qualitative examination of community legal advice services whose clients also experience mental health issues (Moorhead *et al*., 2006).[20] No information was available to compare experiences by gender, ethnicity or age.

The studies include populations with a range of mental health problems, although details of these are not specified in great detail and are not scientifically measured in the studies. No analysis is given on the impact of ethnicity, age or other demographic variables on access to or experiences of these services, or on the effectiveness of these services.

Community civil legal advice services are provided through solicitors, citizens advice bureau and local authority advice providers (Moorhead *et al*., 2006). The categories of advice include housing, debt, welfare benefits, consumer, immigration, children, employment and discrimination. Clients are given appointments with legal advisors in the form of one-to-one sessions. As a result of their sessions with advisors, advice is given and the client continues to deal with the problems themselves in 17% of cases (N=30). In 48% (N=85) of cases the client is given advice with the advisor continuing to provide advice. Referral to another agency for assistance is made in 8% of cases (N=14).

The targeted civil advice services in the study offer advice on welfare benefits, immigration, debt and employment for adults with mental health problems (LSC, 2005). The services are provided by various agencies including Citizens Advice Bureaux, specialist mental health caseworkers, and money and benefits advice teams. Referrals are made mainly through organisations that already engage mental health service users, so the service is very much targeted at adults with mental health problems. The target population includes those with a range of mental health problems from severe to common mental health problems, although specific information on this is not recorded. The advice is provided through both an appointments system and drop in sessions.

[20] It should be noted that in the Moorhead *et al*. study the data given is on **all** clients of community civil legal advice agencies and specific data is not provided on clients with mental health problems. However, observational data and qualitative data from the study suggest that high numbers of these clients also have mental health problems.

Limited information is given about the process of claiming personal injury compensation. As described, the process involves assessment by medical staff for 63% of claimants and 59% of participants had psychiatric assessments. Legal advice is also provided to personal injury claimants.

Effectiveness of non-criminal justice services and interventions for adults with mental health problems

The targeted civil legal advice service for adults with mental health problems resulted in improvements in benefits take up amongst clients, although this is not quantified (LSC, 2005). Seventy-eight per cent of respondents in this study also reported that they always or regularly see an improvement in the mental health of their clients. Other outcomes for clients were reported, such as preventing homelessness and writing off debt. Improvements to the therapeutic relationships between clients and their referring health care services were also reported. Benefits to the agencies acting as hosts for the projects include increased awareness of mental health issues amongst staff (LSC, 2005). Particularly positive elements of the working practices of the project were reported to include offering flexible or extended appointment times. The weakness of this study is that the outcomes reported by respondents were not validated by researchers and so the impacts cannot be robustly attributed to the programme.

Personal injury compensation claimants in a stress clinic report high levels of satisfaction amongst those receiving both medical and psychiatric assessments, although this is not quantified in the study. Satisfaction with legal advisors was also high, with 93% reporting satisfaction with levels of courtesy; 83% reporting satisfaction with sensitivity towards their feelings; and 80% satisfied with the quality of advice given. Satisfaction amongst personal injury claimants was lowest with the speed at which their case progressed (40% were satisfied with this). Despite high levels of satisfaction with legal advisors and medical and psychiatric assessments, 53% of respondents claimed their health had worsened as a result of their claim and 33% reported their relationships had worsened (Alexander, 2006).

Limited information on the impact of general community legal advice services on clients with mental health problems is available in the study addressing this (Moorhead *et al*., 2006). Qualitative feedback included in the study was that clients report a sense of burden being lifted as a result of the advice and support given, which was linked, by the respondents, to a reduction in stress levels. Other observations made during the study were that some advisors felt uncomfortable with clients' emotional or mental health problems.

4.5 Discussion

Studies presented evidence on a range of initiatives concerned with both criminal and non-criminal justice services and agencies for adults with mental health problems. The interventions and the studies are very different in design so it is difficult to compare the effectiveness of these interventions. Criminal justice diversion schemes have evolved quickly and their scope and design is dependent on the local contexts in which they are set. The availability of treatment, the nature of co-operation between local agencies and local attitudes towards offenders with mental health problems will all influence their success (Boothroyd *et al*., 2005; Steadman *et al*., 2005). Therefore, the importance of referral processes to diversion schemes is underlined by the studies, which also demonstrate variations in rates of acceptance following referrals. The differences in rates of acceptance suggest some offenders who have mental health problems and are in need of treatment are not being detected. As Kingham (2005) points out, low rates of detection of offenders with mental health problems are still a problem and many people are, therefore, not being appropriately channelled into treatment. In 1999, the joint working group of the Prison Service and National Health Service Executive recommended 'Prisoners should receive the same level of community care within prison as they would receive in the wider community and policies should be put in place to ensure adequate and effective communication and joint working between NHS mental health services and prisons' (Joint Prison Service & National Health Service Working Group, 1999). However, in May 2008, the Sainsbury Centre for Mental Health and Lincoln University reported prison in-reach teams receive about one-third of what they need to offer the same level of service as community mental health services.

Promising practices are emerging through the studies, particularly with targeted civil legal advice for adults with mental health problems (LSC, 2005) and FACTS (Lamberti *et al*., 2004; Weisman *et al*., 2004). Although there was no evidence on the comparative success of the FACTS model, a process evaluation did describe some interesting ways of working that would seem to address many problems with the criminal justice system that diversion schemes were supposed to address. These problems have been described as the 'revolving doors' (Moore & Hidey, 2006) or the 'merry-go-round' (Green & South, 2005) of relapse and arrest. A FACTS type model, which is an integrated model of psychiatric care linking criminal justice, health and other agencies, may help to halt the 'merry-go-round', by joining up services and their responses.

Evidence on the effectiveness of criminal justice interventions for offenders with mental health problems was mixed, although the studies are too diverse in nature to provide a

complete picture of 'what works'. There is very limited evidence that offenders who are given criminal justice-sanctioned treatment orders, either in the community or in-patient, are more likely to access statutory mental health services, than those who are not. However, more longitudinal studies are necessary to be able to compare the effects of SMHCs and other diversion schemes, on access to services. The evidence is also unconvincing about the impact on clinical outcomes of criminal justice-sanctioned treatment, although, equally there was no evidence to suggest negative outcomes result from this form of accessing treatment.

Other theories behind criminal justice-based schemes for adults with mental health problems include the idea it will reduce arrest rates. The evidence to support this is not conclusive and more will need to be done to establish the optimum conditions for such a theory to be proved true i.e. in what circumstances, with whom, and when can arrest rates be reduced. Another important factor is 'dose' of intervention. The length of time which the intervention is 'received', for example, length of COT orders (Swanson, 2001) or successful completion of court-ordered treatment through SMHCs (Moore & Hidey, 2006) is found to be important in determining the success of the intervention in reducing arrest or re-arrest rates. This effect may be due to increased monitoring and supervision of offenders whilst subject to such interventions, although this hypothesis was not tested in the studies.

There was little analysis of the role of ethnicity, gender or age on so called criminal justice 'diversion' outcomes. However, one study did note a higher than should be expected number of white, older females in a court diversion project (Steadman *et al*., 2005). Another study found African American males were more likely to be excluded from a SMHC than white counterparts (Moore & Hidey, 2006). This imbalance is thought to occur at the point of the initial referral into diversion schemes. The lesson from this may be that criminal justice agencies, particularly the police, need to be more effective at identifying mental health problems in a non-discriminatory manner. One aspect of the FACTS model was designed to address the potential bias against non-white clients by providing awareness-raising training and a culturally diverse team (Weisman *et al*., 2004). The role of demographic variables, particularly ethnicity, is worthy of further investigation especially given that the issue of mental health is frequently politically interpreted (Moore & Hidey, 2006), and therefore sensitive to issues of equality.

Criminal justice diversion schemes have evolved from a strong consensus that adults with mental health problems are over-represented in the criminal justice system. However, the manner in which solutions have developed has been heavily dependent on local context and resources, and is vulnerable to the vicissitudes of local politics and attitudes. In particular,

the availability and quality of treatment will affect the likely outcomes of interventions (Boothroyd *et al*., 2005). This has prompted calls for courts to have more say in how such services are planned. This would be difficult to advocate in the UK, without additional funding. Mental health services are beyond the control or influence of criminal justice agencies both in the UK and elsewhere and so may present significant obstacles to the success of such schemes. However, closer partnership working between mental health agencies, service planners and criminal justice agencies may be an easier call to make. The experience of the FACTS model in the USA presents evidence that more joining up of criminal justice, mental health and support agencies is good practice. The project reported improved access to services as a result of better communication and information sharing between criminal justice case managers and other relevant providers at a local level. It has also been able to demonstrate some cost savings in terms of reduced jail time and reduced hospitalisation, although this is inconclusive (Lamberti *et al*., 2004).

From the perspective of victims and witnesses, adults with mental health problems are shown to be disadvantaged in terms of their access to justice, possibly as a result of discrimination and prejudice. This has led to calls for training and awareness-raising amongst court and other legal professionals so legal decisions are not based on incorrect stereotypical views (Mind, 2001). Training the police is called for in two studies to improve their reaction to adults with mental health problems, so as not to discourage reporting (Swanson, 2001; Brekke *et al*., 2001). Although special measures for VIWs seem to have some promising results, not enough is known about how these effect adults with mental health problems in particular.

There is limited evidence on the effectiveness of non-criminal justice advice provision. Early qualitative evidence from targeted interventions providing civil legal advice to adults with mental health problems is encouraging (LSC, 2005). In mainstream civil advice services there is evidence, albeit limited and qualitative in nature, that advisors would benefit from additional training to identify and work with adults with mental health problems (Moorhead *et al*., 2006). This would seem particularly important in sectors where there are thought to be high levels of mental health problems, exacerbated by stress and poverty, especially in socially excluded areas (SEU, 2004). Particular lessons about advice provision for those with mental health problems include offering extended appointment times or more appointments per case (LSC, 2005).

4.6 Summary of key findings

- Criminal justice-based diversion schemes have evolved quickly and their scope and success is dependent on the local contexts in which they are set.
- The differences in rates of acceptance for inclusion in diversion schemes suggest many offenders who have mental health problems and are in need of treatment are not being detected.
- There is inconclusive evidence that offenders who are given criminal justice-sanctioned treatment orders, either in the community or in-patient, are more likely to access statutory mental health services, than those who are not.
- Victims and witnesses with mental health problems are shown to be disadvantaged in terms of their access to justice, possibly as a result of discrimination and prejudice.
- Promising practices are emerging in terms of targeted civil legal advice for adults with mental health problems and FACTS.

5 Experiences, barriers and potential barriers to accessing justice for adults with mental health problems

5.1 Introduction

This chapter sets out to describe the barriers and potential barriers to accessing justice experienced by adults with mental health problems. The barriers described are those experienced from an individual's perspective, rather than in terms of service effectiveness (which was discussed in the previous chapter). The evidence has been taken from a number of studies, many of which are not specifically about access to justice (criminal or non-criminal) but nevertheless they do provide some useful lessons that can be applied to the present enquiry.

Fifteen studies provided information which illustrates some of the barriers, difficulties and experiences adults with mental health problems face when attempting to access justice or advice. The majority of these presented evidence from the perspective of study participants' experiences of, or actions following, justiciable problems (Buck *et al*., 2005; Campbell *et al*., 2001; Gee *et al*., 2006; Marwaha, 2005; Meltzer *et al.*, 2002; Moorhead *et al*., 2006; Powell & Clarke, 2006; Roeloffs *et al*., 2003; Stuart, 2006; Schulze & Angermeyer, 2003). Two studies directly presented evidence on criminal justice agencies' responses to justiciable problems faced by adults with mental health problems (Mind, 2001; Watson *et al*., 2004). Two studies presented some evidence on social attitudes and prejudice towards mental health problems (Department of Health, 2003; Gaebel & Zäske, 2005).

All but two studies were focused on SMI, such as schizophrenia, bi-polar disorder or psychotic illnesses. The others did not specify the type of illness. Thirteen studies were UK-based, one in the USA, one in Germany and one in Canada.

5.2 Experiences of criminal justice

The two studies which explored barriers to justice through agencies and services focused on the criminal justice system, one based in the UK and one in the USA (Mind, 2001; Watson *et al*., 2004). The studies had very different research designs, although both were interested in barriers for those with SMI. Both studies are based on reported opinions, experiences and views of agency staff rather than victims and witnesses themselves, although they serve to elucidate the kinds of experiences and responses adults with mental health problems receive in criminal justice contexts. The response of criminal justice agencies to adult

victims and witnesses is reported to be poor. This includes reports of the CPS refraining from prosecuting cases on the grounds that victims will provide unreliable evidence and cross-examination in courts unfairly focusing on victims' mental health. Qualitative data from the same study provides further insight into the problems: victims were reported to be reluctant to report their victimisation to criminal justice agencies because they anticipate a negative or inadequate response by them. Qualitative data also suggests police doctors do not deal with victims with mental health problems appropriately, for example asking inane questions as a way of 'testing' their competency. The problems reported in the study are particularly prominent for victims of rape and other sexual offences who have mental health problems (Mind, 2001).

A study of police officers' attitudes towards schizophrenia in the USA was conducted by testing randomly assigned vignettes of situations involving people with schizophrenia on 232 police officers at a police training venue (Watson *et al*., 2004). The study found officers believed a person with schizophrenia would be more dangerous than a person without schizophrenia, whether as a victim, suspect or witness of crime. The heightened sense of risk officers hold when presented with a person with schizophrenia may cause situations to 'escalate', the authors conclude. However, officers were also found to be more sympathetic towards alleged offenders, victims and witnesses with schizophrenia than those who did not have schizophrenia. These findings mirror a number of other studies already discussed, which point out the importance of police officers' attitudes and responses to adults with mental health problems (Swanson, 2001; Brekke *et al*., 2001). Contact between the police and people with mental health problems is frequent, as the latter are associated with higher offending as well as victimisation rates. The need for an appropriate response from the police is, therefore, paramount.

One study reported on victims' responses following rape in Chicago, USA (Campbell *et al*., 2001). Women from ethnic minority communities are less likely to seek mental health support than white women: 69% of white women sought support compared to 31% of women from ethnic minorities. Reasons for this discrepancy were not explored in the research but may present a case for more culturally sensitive mental health services for victims of sexual offences. This would need further research.

5.3 Experiences of advice and support for non-criminal justiciable problems

Only one study provided information on the experiences of adults with mental health problems as they seek to resolve non-criminal justiciable issues (Moorhead *et al*., 2006).

The study was based in the UK and set in community civil legal advice services. The information provided is limited because it does not identify participants with mental health problems specifically but identifies mental health problems amongst the service clients through observation. Observations describe the 'isolating and unnerving impact of the bureaucratic fiat on a client's life' of seeking to deal with a justiciable problem (Moorhead *et al*., 2006, p. 58). The dealings with bureaucracy and frustrations associated with this are cited as being a cause as well as consequence of mental health problems.

5.4 Experiences of stigma and discrimination amongst adults with mental health problems

Evidence was presented of the experiences of stigma,[21] discrimination and prejudice experienced by adults with mental health problems, which has the potential to affect advice or help-seeking behaviour. The evidence was derived from studies of people with SMI (Gee *et al*., 2006; Marwaha, 2005; Powell & Clarke, 2006; Roeloffs *et al*., 2003; Stuart 2006; Schulze & Angermeyer, 2003; Gaebel & Zäske, 2005). Only two of these studies were based in the UK, the others were in the USA, Canada and Germany so the transferability of the information may be limited.

Stigma and discrimination is something that can both be measured by social attitudes as well as something that is perceived by a person who is its target. A recent population survey of attitudes towards mental health in the UK found the population to be broadly sympathetic and tolerant (Department of Health, 2003), although there is a longer-term trend of attitudes hardening. This contrasts with a population study in Germany which identified prejudicial attitudes towards mental health in the context of the workplace, with 16% of respondents reporting they would feel disturbed working with someone with schizophrenia (Gaebel & Zäske, 2005). However, regardless of actual levels of prejudice, study participants across the studies seemed to perceive high levels of stigma and discrimination. The effects and causes of discrimination are far beyond the scope of this study but, of particular interest for the present review, two effects of discrimination are reported: one is that it may increase social exclusion and therefore, the likelihood of experiencing justiciable problems (Meltzer *et al*., 2002). Secondly, the expectation of discrimination may lead someone to conceal their illness thus inhibiting their access to the necessary services (Marwaha, 2005; Powell & Clarke, 2006).

[21] Stigma refers to general negative stereotypes that exist within society associated with a condition, such as mental illness. Discrimination is being treated unfairly or denied opportunities. Prejudice is public fear, misunderstanding and intolerance around mental health issues (SEU, 2004).

For those with SMIs, discrimination is reported in the realms of employment (Gee *et al*., 2006; Marwaha, 2005; Stuart, 2006; Schulze & Angermeyer, 2003; Roeloffs *et al*., 2003), and health services (Roeloffs *et al*., 2003; Powell & Clarke, 2006). Study participants also expressed expectations of negative reactions when seeking health insurance and among friends. Qualitative information found discrimination and stigma result in adults with SMI attempting to conceal their illness from employers (Marwaha, 2005; Stuart, 2006; Schulze & Angermeyer, 2003). This concealment happens to the extent that it even prevents employees from accessing special assistance programmes for fear of revealing their illness. Embarrassment over having a mental health problem was found to inhibit information-seeking behaviour in the context of health services (Powell & Clarke, 2006). Fear of discrimination also leads those with mental health problems to conceal their illness from prospective employers despite feeling that it would generally be better for them if employers knew about their illness (Marwaha, 2005).

An instrument of justice, relevant to any discussion about 'access to justice', is protective legislation. The Disability Discrimination Act (DDA) was introduced in the UK in 1995 and extends to adults with mental health problems. However, qualitative information from the studies suggests discrimination may still happen subtly, despite the Act; for example, in the workplace, by being asked to move to an area which is not so easy to commute to or being asked to take a demotion (Marwaha, 2005). The tendency to try to conceal one's illness would also make it difficult to find protection under the DDA: if the illness was not known, how could it have been discriminated against?

5.5 Discussion

Negative or inaccurate perceptions about mental health may be preventing adults with mental health problems from accessing justice, as victims of crime. This may be due to false perceptions or prejudices about this group's competence or reliability as witnesses. Victims themselves may, in turn, become reluctant to report crime to authorities for fear of not being taken seriously (Mind, 2001).

Discrimination, stigma and prejudice against mental health problems are pervasive and the extent of its implications is beyond the scope of this study. However, the studies included in the review underline some of the potential impacts discrimination may have on adults with mental health problems who also have justiciable problems. Regardless of actual social attitudes, stigma or perceived discrimination may still affect persons' decisions and behaviours. The limited evidence presented here is that such influences discourage adults with mental

health problems from disclosing their illness or seeking advice and support in the context of employment and health care. In this case, it is likely that the same fears are affecting advice-seeking behaviour in the context of non-criminal or criminal legal advice. Not disclosing conditions, which may be relevant to determining the appropriate response and level of support, may mean that people do not receive the help needed to resolve their problems.

This has been the case with other socially sensitive issues, such as sexuality or domestic abuse, and agencies have had to learn to be sensitive, through training packages and pro-active national or regional strategies. Examples of such initiatives include the National Plan for Domestic Violence (2005) and the duty on local authorities to publish race equality schemes. The same case may be made for mental health. The DDA does cover people with mental health problems, however limited evidence was presented in this review that its protection is not extended fully to this group. Employer attitudes play a central role in the success of anti-discrimination legislation (Powell & Clarke, 2006) and some evidence from the studies, particularly outside the UK, indicated employers still have prejudicial attitudes towards mental health problems (Gaebel & Zäske, 2005; Marwaha, 2005).

Discrimination and prejudice may present a double jeopardy for adults with mental health problems: the discrimination in the first place combined with negative mental health impacts that such experience incurs. The content of prejudicial views has been subject to much research including analysis of common media portrayals of mental health problems. People who experience mental health problems are frequently portrayed in the media as dangerous or likely to commit crime, they are considered less in control and less likely to be able to recover from their illness (Rose *et al*., 2007). Work to challenge and improve media reporting on mental health is supported by this research and some useful work is already underway.[22] Prejudice and discrimination has been found to have a negative impact on mental health in other fields of study, particularly race, gender and sexuality discrimination.[23] Mental health impacts include internalised prejudice, low self-esteem and depression. When prejudicial attitudes result in inappropriate service responses following victimisation or a negative event this can exacerbate the problem further - an effect which is known as 'secondary victimisation'. This effect has been widely studied in other fields where discrimination and prejudice are known to exist and lessons from these can be usefully applied to adults with mental health problems.

[22] For example, the Department of Health SHIFT campaign to tackle stigma against mental health problems.
[23] See, for example, Araujo & Borrell, 2006; King *et al*., 2003; Moradi & Funderburk, 2006.

5.6 Summary of key findings

- Negative or inaccurate perceptions about mental health may be preventing adults with mental health problems from accessing justice as victims of crime or witnesses.
- Discrimination and prejudice may present a double jeopardy for adults with mental health problems: the discrimination in the first place combined with negative mental health impacts that such experiences incur.
- Discrimination and stigma discourages people with mental health problems from disclosing their illness or seeking advice and support for fear of disclosure.
- More research is needed to understand the different experiences of accessing justice for adults with mental health problems, for different demographic groups particularly by ethnicity.

6. Conclusions

The studies reviewed presented evidence from a variety of fields, research designs and settings. Because of this diversity, a meta-analysis of the information has not been possible. However, a first overall note to observe from the studies is that mental health is under-researched within the context of access to justice. It is under-researched in the sense that there are not enough studies specifically to understand the impact of mental health problems on civil justice outcomes. It is also under-researched in the sense that the research that has been done is based on very different interventions and so comparison or synthesis is difficult.

The advantage of a review such as this, which covers a broad scope, is that it provides an overview of the problems adults with mental health problems face in accessing justice and pulls in evidence from a diverse range of academic and policy disciplines. The review presents evidence of the prevalence and scope of justiciable problems amongst adults with mental health problems. As the population characteristics from the studies show:

- adults with mental health problems are over-represented in populations of offenders;
- adults with mental health problems are more at risk of crime victimisation than the general population, even after controlling for demographic variables;
- adults with mental health problems are likely to experience higher rates of some civil justiciable problems, such as debt, financial arrears and relationship breakdown, compared to adults with no mental health problem.

The risk factors for victimisation include being more 'symptomatic' and a lack of meaningful daily activity. Risk factors for offending include homelessness, substance misuse and history of offending. However these risk factors are present for the general population also so it is difficult to state how such risks function for the specific population of adults with mental health problems. Some studies suggested particular symptoms of mental health problems and failure to take medication were also risk factors behind offending (Swanson, 2001; Brekke *et al*., 2001).

Studies were heavily weighted towards adults with SMI rather than more common mental health problems, such as depression or anxiety. This is probably because a large number of the included studies focused on criminal justice interventions for which the thresholds for participation are within the SMI category. Proponents of the social model of disability would say this focus is predictable given that mental health is usually understood in terms of

diagnosis or symptomology, rather than the social causes of mental ill health, which would identify mental ill health and good health on a spectrum, thus including more commonly experienced conditions.

The fact that thresholds for many of the criminal justice interventions featured in the review are so high indicates many more people within the criminal justice system have needs that are not being met and also, more controversially perhaps, precedence is given for punishment rather than treatment within the criminal justice context so only those with high level needs are given access to support. The ever-increasing prison population, which includes high rates of those with mental health problems, suggests early intervention, community-based treatments or services are not adequately provided resulting in increasing populations further downstream. This trend has to be seen in the context of recent care in the community policies that have fallen out of favour amongst the public and in social policy. Whatever the interpretation of the causes, prevalence rates of mental ill health within the prison population, across a range of disorders, suggest there is a large unmet need. Moreover, this need cannot be met by prison staff and so external treatment for prisoners or diversion before prison is needed.

The historic tension between the need to treat people with health problems and the need to punish has perhaps been at the root of this policy failure. Interestingly, in the field of drug abuse and drug using offenders, more has been done to break the cycle of offending and the cause of offending. It is not clear why the field of mental health has not followed this path as systematically and this would be an interesting line of enquiry for future research. One early hypothesis might be that stigma and prejudice still criminalises mental ill health, in particular by associating mental ill health with risk of violence, and this has prevented a balanced social policy on the issue.

Importantly, previous research finds that treatment for so called ‘mentally disordered offenders’ is possible and does work (at reducing offending) (McGuire, 1995, 2002). The evidence presented here also broadly supports that view, although more research is needed to identify the main mechanisms that bring about these positive changes across schemes.

Some clear gaps in the research emerged from the review. There appears to be a lack of high quality experimental research for so called criminal justice ‘diversion’ schemes. In particular, there is little evidence to examine the underlying mechanisms and the interaction of these behind such schemes. Given that criminal justice and mental health services are planned locally and shaped by the availability of local resources and services, an

understanding of the processes and mechanisms affecting local outcomes would be useful. A theory-based approach to evaluations might be more appropriate for such research, which might benefit from an initial critical realist synthesis of evaluation reports.

Promising practice from elsewhere seems to support the development of far more integrated criminal justice teams than are currently in place in the UK. The services necessary to assist someone out of the 'merry-go-round' of offending, prison and release are diverse, often operating across authority boundaries. The integrating effect of the FACTS model in the USA appears promising in this regard (Weisman *et al*., 2004).

On the subject of non-criminal or civil justice, the limited evidence from one study (Moorhead *et al*., 2006) presented in this review suggests justice processes and bureaucracy can have a negative impact on mental health. It is also suggested good procedural justice can have a positive effect (Boothroyd *et al*., 2005). The effects of agency responses to victimisation, on the mental health of victims and those with justiciable problems need further research, particularly large-scale surveys of victims using validated tools to measure mental health impact.

For non-criminal or 'civil' legal advice and services, there is very limited evidence from one study (LSC, 2005), but encouraging evidence from projects which target support at known mental health clients but again, this does not address those whose mental health issues may a) be less obvious and difficult to detect, and b) emerge as a **result** of non-criminal justiciable problems and the stress which is associated with them. Furthermore, given the high prevalence of mental health problems in society and the links between poverty, mental health and social exclusion (a predictor of civil justiciable problems), it would take a great deal of planning and resources to establish enough specialist advice services to meet demand. There is a case for 'mainstreaming' the benefits of civil legal advice for people with mental health problems by learning from specialist, targeted projects. This might mean further training for advice staff, including solicitors and local authority advice providers to be able to identify stress and mental health problems and learn some basics skills in how to work with people suffering mental distress. Currently the Citizens Advice Bureaux offer training and awareness-raising to staff on the issue of mental health, however learning from this experience may be valuable for other agencies.

Further specific calls for criminal justice agencies to respond more appropriately to victims and witnesses with mental health problems resound from the studies. Special measures for VIWs appear to be promising in terms of improving the experience in court of people with mental health problems. However, these measures are applied after a crime has been investigated

and prosecution begins. As there is evidence that victims with mental health problems are less likely to report crimes or for their victimisation to reach the stage of prosecution, the positive impacts of special measures are limited. Furthermore, the research on special measures does not address sub-groups of VIWs, such as those with mental health or learning difficulties and so the impact specifically on this group cannot be clearly determined.

Many of the problems associated with criminal justice for victims with mental health problems are connected with under-reporting and under-confidence with the system. It may be confidence will improve over time following the introduction of special measures but attitudes are not changed by legislation alone. Cultures and knowledge need to evolve. In particular, prejudicial attitudes amongst criminal justice system staff including the police and the CPS may benefit from awareness-raising training and information to prevent legal decisions being made on the basis of prejudicial and incorrect information about mental health.

An obvious sign that criminal justice agencies have, arguably, an outdated understanding of mental health are the terms used within these settings to discuss it. 'Mentally disordered offender' is a good example of a term that would not be acceptable amongst mental health campaigners or advocates. A useful piece of research to explore this issue further would be a critical discourse analysis of terms used within different legal contexts to help understand the concepts that underpin the legal system's understanding of mental health. Work to improve awareness amongst criminal justice and associated staff has been undertaken around the issue of domestic violence. Valuable lessons may be learnt from this.

The fact that legal language is out of step with health or social services language concerning mental health is testament to the fact that legal contexts are very specific with strongly formed cultures and practices that remain relatively stable compared to the wider political and social climate (Tait, no date). Applying a new understanding and awareness of mental health may be a difficult challenge, particularly as the legal context is very diverse and operates on a variety of principles and in different physical settings. Court buildings may be more or less formal, larger or smaller, based on older or modern architecture for example, all leading to different experiences by those accessing them (Tait, no date). Initiatives that seek to improve the experience of adults with vulnerability should take account of the very different court contexts in which justice may be sought.

Underpinning systems of either adversarial or inquisitorial justice also delineate court procedures, the former being more associated with criminal systems and the latter with civil systems. Adversarial systems are more concerned with protecting individual rights by the

rigorous and dispassionate implementation of the rules (laws) (Feeley, 1973). They are perhaps more keenly associated with Weber's definition of a rational organisation which relies heavily on rational modes of thinking, organisation and authority in which roles are allocated according to a strict hierarchy (Weber, 1954). In such systems, changes to overall attitude and understanding of issues, such as mental health, will depend more on the will of a few individuals. In these environments, district judges or bench chairs in magistrates' courts will be instrumental in any programme to improve services for adults with mental health problems.

Inquisitorial systems on the other hand, which are more often associated with civil procedures, involve the court being actively involved in determining the facts of the case. A useful theory for understanding the organisational dynamics of inquisitorial systems is the functional approach in which horizontal relationships, interactions and co-operation between actors is seen as more important to explain the court's functioning (Feeley, 1973). In this framework professionals are not dispassionate and rules are more elastic in their application so one can see that introducing new understandings of mental health will involve educating multiple and diverse actors. These theoretical frameworks need much fuller expansion but may provide a useful starting point in seeking to understand how organisational change may be brought about in relation to mental health, particularly in improvising understanding and awareness.

6.1 Costing policy responses

Policy decisions about how to improve the experiences of adults with mental health problems in accessing justice will necessarily involve an allocation or re-allocation of resources. The legal or justiciable issues considered in this review are very wide ranging affecting both a relatively small section of the population (those involved in offending) and those affecting a large section of the population (as in the case of many of the civil justiciable problems). It is well known that crime and victimisation is costly both financially and emotionally (even leading to worsened mental health) and any intervention that reduces crime will always yield an attractive cost saving.

There is a sound business case for investing in criminal justice-based interventions for offenders with mental health problems and given the pressure that is mounting on prison populations it would be wise to consider how best to channel offenders out of prison into treatment that will reduce their offending. Effective projects in this regard include those, which improve the co-ordination between offender and patient management so the two are seen as integrally important objectives. FACTS and, to a lesser extent, CJMHTs in the UK

are useful models. However, more co-ordination is needed so services may be planned and **crucially** resourced at a local level.

Not enough is known about effective mental health services for general victims of crime, however, there is evidence victims experience high levels of trauma and stress. More research is needed to assess the outcomes of such services, particularly a representative sample survey. For those with existing mental health problems, who are also victims of crime, a key factor would seem to be ensuring appropriate agencies are made aware of the victimisation so that already vulnerable people can be assisted at times when they are harmed. This, of course, relies on victimisation being reported in the first place. However, if more services are available for victims with mental health problems then, the more likely offences are to be reported. This notion has been tested, with some success, in the development of third party reporting systems for victims of race or homophobic crime in which reporting a crime does not lead to a police enquiry and victims are able to access services regardless of whether a prosecution is commenced. To some extent, these services exist already in the form of Victim Support however, their effectiveness for adults with mental health problems is not known. A useful policy initiative around this issue might be better targeting existing victim support services to adults with mental health services, if this is found to be needed. In which case, the costs of such a project may be limited.

Other areas of non-criminal justice are very broad and crossover at multiple points with wider agendas to tackle social exclusion. These crossovers are mainly at the philosophical level in which policy support is given to the idea of empowering people to 'tackle adversity' (SEU, 2004) and civil legal advice and support may be one mechanism for this to take place. However, limited research shows mainstream civil or pseudo-legal advice agencies may not be adequately trained to understand the impacts on mental health of legal issues or *vice versa*. An initial policy aimed at improving this understanding through an awareness-raising exercise might be a useful, cost effective and evaluate-able policy through which more can be learnt about the potential impacts of adequate civil legal advice on adults with mental health problems.

6.2 Summary of key findings

- Adults with mental health problems are over-represented in populations of offenders.
- Adults with mental health problems are more at risk of crime victimisation than the general population, even after controlling for demographic variables.
- Adults with mental health problems are likely to experience higher rates of some civil justiciable problems, such as debt, financial arrears and relationship breakdown.
- Promising practice, in terms of criminal justice systems for offenders with mental health problems, appears to be a more integrated model of criminal justice, housing, mental health services and social services.
- Some promising practice is emerging from civil justice advice projects which specifically target adults with mental health problems where mental health has been seen to improve, as have social welfare outcomes.
- There is evidence prejudicial attitudes within the criminal justice system may result in negative justice outcomes for adults with mental health problems.
- Discrimination and prejudice against mental health problems may deter people from disclosing their illness, seeking advice or support, for fear of disclosure.
- Mainstream advice agencies work with clients who also have mental health problems and would benefit from further training to be able to work effectively with this group.

The review suggested some potential areas of future research and policy development including:

Research

- Evaluations that seek to understand the underlying mechanisms may cause positive outcomes in terms of criminal justice. For example, the effects of referral and assessment processes, multi-agency working, availability of local mental health services and attitudes of staff of criminal justice agencies. This could be approached with a critical realist synthesis of existing research however, only where enough information exists on the processes involved in each intervention.
- Critical discourse analysis of legal language used to describe and discuss mental health.
- Generally, there needs to be more research into the experiences and outcomes for adults with mental health problems in the domains of civil or non-criminal justice.
- More research is needed on the interaction of the effects on certain mental health problems, symptoms and coping strategies, with risks of offending and victimisation.

- More research, possibly action research, to understand the effects of improved understanding of mental health amongst mainstream civil legal advice and pseudo-legal advice services for adults with mental health problems.
- More research to identify and apply theories of organisation to civil and criminal justice processes, to identify how understanding and awareness of mental health and inter-agency working can be improved.

Policy

- Working towards more integrated criminal justice mental health teams, which facilitate communication and information sharing between agencies and which can be pro-active if a client experiences problems, is encouraged.
- More strategic guidelines for integrating the conflicting goals of ensuring justice is done and providing effective treatment should be available for local agencies particularly to facilitate and stimulate local multi-agency co-operation around mental health and offending. This has been done through a strategic response to drug using offenders, for example, through which national treatment and criminal justice interventions have been jointly developed.
- Further training and awareness-raising to challenge prejudicial attitudes amongst civil and criminal legal service providers, should be instigated for which valuable lessons can be learnt from the experience of anti-race discrimination practices and initiatives to tackle domestic violence. This policy should draw upon what is learnt through the above-recommended research.

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Appendix 1: Key terms referred to in the review

Terms relating to concepts of mental health or mental ill health	Generic terms relating to mental health were used when searching for articles included in the review. The studies that are included, therefore, use a range of terms to either describe or measure mental health. These include both clinical terms based on specific diagnoses as well as subjective states based on various measuring instruments. A list of these terms and concepts is provided at appendix 6. Most studies use the term 'mental illness'. We have used the term 'mental health problem' when our discussion is more general or in summarising. This term is used in an inclusive sense to cover a range of diagnosis and disorders both common and severe. We clarify the definitions used in the studies as we discuss the studies in turn.
Mentally disordered offender	The term **mentally disordered offender** is a Home Office term referring to persons who have been compulsorily admitted to hospital under Part V of the Mental Health Act 1959, Part III of the Mental Health Act 1983 or the Criminal Procedure (Insanity) Act 1964 as amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 or the Domestic Violence, Crime and Victims Act 2004 (whose provisions came into force on 31 March 2005). The term is not a clinical definition but a legal one.
Risk and 'risk factors'	There is a wealth of academic literature and debate about the nature and function of risk. However, the concept of risk was not the subject of this review and the term is used mainly in the lay sense of the word and relates to the circumstances or experiences, which increase the likelihood of a negative outcome. For example, in chapter 3, the term 'risk factor' is used to discuss the circumstances and experiences of a person with mental health problems, which may increase the likelihood of their being involved with offending.
Vulnerability	Government policy has increasingly been interested in the notion of 'vulnerability' to describe people with circumstances or conditions which make them less able to access the benefits or protections afforded to most other people within society. Examples of vulnerability include adults with mental health problems, adults with learning disability or difficulty, or elderly adults. The term may also refer to adults in particular circumstances, such as adults who have been victims of specific crimes or adults who are cared for by another person.
Treatment	Treatment is referred to throughout the report in the context of the research articles being discussed. 'Treatment' includes a variety of examples but always refers to an intervention designed to address mental health problems or disorder (however described) and not other social issues (such as housing or employment). The term 'treatment' is therefore used in the clinical sense and may include, for example, drug therapy as well as counselling, group work, Cognitive Behavioural Therapy, motivational interviewing.
Justiciable problem	This term is used throughout the report and is defined in a very wide sense by Buck *et al.* (2005) as 'Problems for which there may be a legal remedy'. The term, therefore, covers problems which are currently receiving a legal remedy, such as through a civil court or tribunal or criminal justice prosecution as well as those which could potentially be addressed through such means but are not currently.

Offender/ offending	Definitions of offending or offenders are down to the individual researchers and may include convicted offences/offenders, self-reported engagement in criminal activity and people who have been arrested but not necessarily convicted.
Re-offending/ recidivism	Definitions of re-offending or recidivism are down to the individual researchers but may include multiple convictions, self-reported criminal activity or arrests within given time frames, for example within 6 months or 12 months of a given baseline measure.
Offending behaviour	This term refers to a general measure of involvement in criminal activity and is defined by the individual researcher(s), for example (Sheldon *et al*., 2006) use a combination of self-reported nights spent in a police cell, incidence of arrest and time spent on probation, in a given time frame, to measure offending behaviour.
Victim	The use of the term 'victim' depends on the individual researcher(s). However, the term may include victims of reported or non-reported activity, victims of harassment, anti-social behaviour or criminal activity.
Witness	Witnesses may also be the same person as the victim, particularly in the context of discussions of criminal prosecutions and vulnerable victims or witnesses.
Vulnerable or intimidated witnesses (VIW)	The term refers to a definition in the Youth Justice and Criminal Evidence Act (1999) which identifies vulnerable or intimidated victims or witnesses as: 'all witnesses aged under 17; witnesses with a physical disability; witnesses with a mental disorder or otherwise with a significant impairment of intelligence or social functioning (learning disability); and witnesses likely to suffer fear or distress about testifying, including victims of sexual offences and witnesses who fear or suffer intimidation'.
Outcome (outcome measure)	Outcomes are states resulting from a particular intervention and may include clinical outcomes (those relating to the treatment of a person with mental health problems), social outcomes (for example, improved housing or employment prospects) or criminal/offending outcomes (such as decreased rates of offending). Outcome measures are descriptions of the desired outcomes of a particular intervention and are used in the research included in this review to measure the 'effectiveness' of a particular intervention. It is down to the individual researcher(s) and research design as to which outcome measures are used.

Appendix 2: Search strategies used

AASIA

justice or legal adj system or legal adj problems or court or family adj proceedings or family adj cases or family adj law or civil adj proceedings or legal adj process or criminal adj justice adj system or criminal adj justice or victims or witnesses or victimology or defendant or plaintiff or psychological adj jurisprudence or psycholololegal or justiciable adj problem

AND

mental adj health or mental adj illness or psychological adj distress or emotional adj distress or psychological adj well adj being or anxiety or depression or severe adj mental adj illness or common adj mental adj disorder or minor adj psychiatric adj disorder or emotional adj disorder or psychological adj outcomes or generalised adj anxiety adj disorder or post adj traumatic adj stress adj disorder or depressive adj disorder or dysthymic adj disorder or major adj depressive adj disorder or person adj with adj serious adj mental adj illness or psychiatric adj morbidity or behaviour adj problem

NOT

child* or adolescent

C2 Prot

{justice} or {legal system} or {legal problems} or {court} or {family proceedings} or {family cases} or {family law} or {civil proceedings} or {legal process} or {criminal justice system} or {criminal justice} or {victims } or {witnesses} or {victimology} or {defendant} or {plaintiff} or {psychological jurisprudence} or {psycholololegal} or {justiciable problem}

AND

{mental health} or {mental illness} or {psychological distress} or {emotional distress} or {psychological well being} or {anxiety} or {depression} or {severe mental illness} or {common mental disorder} or {minor psychiatric disorder} or {emotional disorder} or {psychological outcomes} or {generalised anxiety disorder} or {post traumatic stress disorder} or {depressive disorder} or {dysthymic disorder} or {major depressive disorder} or {person with serious mental illness} or {psychiatric morbidity} or {behaviour problem}

C2-spectre

Access to justice AND mental health OR mental illness NOT children

Community Wise

Mental health or mental illness AND civil justice or legal system or legal problem or family law or family cases or criminal proceeding or victim

IBSS search strategy

justice or legal system or legal problems or court or family proceedings or family cases or family law or civil proceedings or legal process or criminal justice system or criminal justice or victims or witnesses or victimology or defendant or plaintiff or psychological jurisprudence or psycholololegal or justiciable problem

AND

mental health or mental illness or psychological distress or emotional distress or psychological well being or anxiety or depression or severe mental illness or common mental disorder or minor psychiatric disorder or emotional disorder or psychological outcomes or generalised anxiety disorder or post traumatic stress disorder or depressive disorder or dysthymic disorder or major depressive disorder or person with serious mental illness or psychiatric morbidity or behaviour problem

Intute Social Sciences "civil justice" or "access to justice" or "family law" or "private law" or "legal process" or "legal" or "justice" AND "mental illness" or "mental health" or "depression" or "anxiety"	
JStor ti: ("mental health" OR "mental illness") AND "justice" OR "civil justice"	
Social science citation index TS=(civil AND justice) OR TS=(justice) OR TS=(legal AND system) OR TS=(family AND proceeding*) OR TS=(civil AND proceeding*) OR TS=(legal AND process) OR TS=(family AND law) OR TS=(family AND case*) Or TS=(criminal proceeding*) Or TS=(criminal AND justice) OR TS=(witnesses*) OR TS=(victimology) OR TS=(defendant*) OR TS=(plaintiff*) OR TS=(claimant*) OR TS=(psycholegal) OR TS=(hearing) OR TS=(discrimination) AND TS=(mental illness) OR TS=(mental health) OR TS=(psychological distress) OR TS=(emotional distress) OR TS=(psychological well being) OR TS=(anxiety) OR TS=(depression) OR TS=(severe mental illness) OR TS=(common mental disorder*) OR TS=(minor psychiatric disorder*) OR TS=(emotional disorder*) OR TS=(psychological outcome*) OR TS=(generalised anxiety disorder*) OR TS=(post traumatic distress disorder*) OR TS=(depressive disorder*) OR TS=(dysthymic disorder) OR TS=(major depressive disorder) OR TS=(serious mental illness) OR TS=(psychiatric morbidity) OR TS=(behaviour problem)	
Other databases[24] were searched using the following general search terms:	
Mental Health	mental illness, mental health, psychological distress, emotional distress, psychological well-being, anxiety, depression, severe mental illness, common mental disorder, minor psychiatric disorders, emotional disorders, psychological outcomes, generalised anxiety disorder, post traumatic stress disorder, depressive disorders, dysthymic disorder, major depressive disorder, persons with serious mental illness, psychiatric morbidity, behaviour problem, assessment, referral, support
Access to Justice	civil justice, justice, legal system, legal problem, court, tribunal, family proceedings, civil proceedings, legal process, family law, family cases, criminal proceedings, criminal justice system, criminal justice, victims, witness, victimology, defendant, plaintiff, claimant, psychological jurisprudence, psycholegal, social adversity, justiciable problem, social exclusion, discrimination, assessment, referral, support, benefits, welfare
Intervention	advocacy, advice, legal advice, community legal advice, support, witness support, victim support, defence

[24] See appendix 3 for the full list of databases searched.

Appendix 3: Databases searched

- Psychinfo
- Psychlit
- Embase
- C2-Spectr
- Jstor
- Social Science Citation Index
- Arts and Humanities Citation index
- Campbell collaboration (DARE, C2-ripe)
- Community Wise
- International Bibliography of Social Science
- Rand publications online
- Mental Health Specialist Library
- Scottish centre for social justice publications
- Criminal Justice Abstracts
- NACRO abstracts database
- Liberty policy papers (criminal justice)
- British Medical Journal on line
- UCL Library catalogue
- UCL eprints
- Intute Social Science
- Policy Action Network
- ASSIA
- Current Contents Connect
- Inside Web
- ISI Proceedings
- Journal Citation Reports
- PolicyFile
- REGARD
- Economic and Social Research Council database
- Sabinet

Appendix 4: Maryland Scientific Methods Scale (SMS)

Rating	Description of the rating
1	Reporting of a correlation coefficient denoting the strength of the relationship between, for example, a particular intervention and its effectiveness in preventing re-offending at a given point in time.
2	Reporting of a comparison group present but this might lack comparability to the target group. Alternatively, where no comparison group is present, before and after measures (of offending behavior, for example) have been obtained for the target group.
3	Reporting of a controlled experimental design with comparable target and control groups present, with pre-post comparisons being made and experimental-control comparisons on (a) specific variable/s.
4	Reporting of a controlled experimental design, as in 3 above, but with additional controlling for other variables that might pose a threat to the interpretation of the results. Examples of controlling extraneous variables include, but are not limited to, the use of statistical procedures or matching.
5	Reporting of a fully randomised experimental design in which groups consist of randomly assigned individuals and appropriate measures are taken to test the intervention effects.

Appendix 5: Qualitative research quality criteria

Source: Popay *et al*. (CRD, 2001)

1. **A primary marker**: is the research aiming to explore the subjective meanings that people give to particular experiences of interventions?
2. **Context sensitive**: has the research been designed in such a way as to enable it to be sensitive/flexible to changes occurring during the study?
3. **Sampling strategy**: has the study sample been selected in a purposeful way shaped by theory and/or attention to the diverse contexts and meanings that the study is aiming to explore?
4. **Data quality**: are different sources of knowledge/understanding about the issues being explored compared?
5. **Theoretical adequacy**: do the researchers make explicit the process by which they move from data to interpretation?
6. **Generalisability**: if claims are made to generalisability do these follow logically and/or theoretically from the data?

Appendix 6: Terms used to describe mental health

Severe mental illness (SMI): The NHS National Service Framework for Mental Health includes the following definition of SMI:

> - 'there must be a mental disorder as designated by a mental health professional (psychiatrist, mental health nurse, clinical psychologist, occupational therapist or mental health social worker) and either
> - there must have been a score of 4 (very severe problem) on at least one, or a score of 3 (moderately severe problem) on at least two, of the HoNOS items 1-10 (excluding item 5 'physical illness or disability problems') during the previous six months or
> - there must have been a significant level of service usage over the past five years as shown by:
> - total of six months in a psychiatric ward or day hospital, or
> - three admissions to hospital or day hospital, or
> - six months of psychiatric community care involving more than one worker or the perceived need for such care if unavailable or refused'.
>
> **(NHS, 1999)**

SMI generally refers to mental illness which is diagnosed and for which the symptoms are severe.

Schizophrenia: The following definition and explanation is provided by the National Institute of Clinical Excellence (NICE):

> 'Schizophrenia is a term used to describe a major psychiatric disorder (or cluster of disorders) that alters an individual's perception, thoughts and affects behaviour. Although the terminology for addressing schizophrenia has varied, the International Statistical Classification of Diseases and Related Health Problems (ICD–10; World Health Organization, 1992) uses the terms schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder. Symptoms include hallucinations and delusions, and negative symptoms, such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect'. **(NICE, 2003)**

Psychiatric morbidity: This is a generic term indicating a value of psychiatric health and can be measured in a number of ways using scales and measuring instruments, an example of this is the General Health Questionnaire.

Common mental disorder: These are mental disorders, such as anxiety, depression or phobias which are more commonly experienced in the population and which have less severe symptoms than SMI. There are no commonly held definitions of common mental disorder (Seymour *et al*., 2005). However, the NHS National Service Framework for

Mental Health includes depression, eating disorders and anxiety disorders amongst the most common mental disorders (NHS, 1999).

Post Traumatic Stress Disorder (PTSD): The following definition is provided by NICE:

> 'PTSD disorder is one that people may develop in response to one or more traumatic events, such as deliberate acts of interpersonal violence, severe accidents, disasters or military action. The most characteristic symptoms of PTSD are re-experiencing symptoms. Sufferers involuntarily re-experience aspects of the traumatic event in a vivid and distressing way. This includes flashbacks in which the person acts or feels as if the event is recurring; nightmares; and repetitive and distressing intrusive images or other sensory impressions from the event'. **(NICE, 2005)**

Psychosis: This term is used to describe a symptom. Stedman's Medical Dictionary defines psychosis as 'a severe mental disorder, with or without organic damage, characterized by derangement of personality and loss of contact with reality and causing deterioration of normal social functioning'. Psychotic disorders are those characterised with experiences of psychosis, examples of psychotic disorders include schizophrenia and delusional disorder.

Specific instruments that measures mental health and ill health include:

The General Health Questionnaire (GHQ): The GHQ is a self-administered questionnaire that screens for non-psychotic psychiatric disorders. The GHQ is a 28-point questionnaire, which includes questions on psychiatric symptoms and is used to measure psychiatric morbidity or mental health.

Brief Psychiatric Rating Scale (BPRS): The BPRS is a well-established tool for measuring psychiatric symptoms. The scale relates to a questionnaire, which contains 24 symptom constructs, each to be rated on a 7-point scale of severity, ranging from 'not present' to 'extremely severe'. Symptoms measured include anxiety, depression, guilt and hostility. The BPRS is another instrument to measure psychiatric morbidity or mental health.

Appendix 7: Inclusion and exclusion criteria

General

Inclusion criteria:
Studies that were published from 2001 onwards
Studies that include populations of 18 years and older
Research focuses on participants with justiciable problems
Study measures at least one outcome for mental health

Aspects of civil or 'non-criminal' justice

Inclusion criteria:
Studies that measure at least one outcome for instigators of 'civil' (non-criminal) processes including family cases and family issues **or**
Studies that measure at least one outcome for defendants of 'civil' (non-criminal) processes including family cases and family issues

Aspects of crime and criminal justice

Inclusion criteria:
Studies that measure at least one outcome for victims or witnesses of crime **or**
Studies that measure at least one outcome for defendants or offenders in criminal processes

Other

Inclusion criteria:
Studies that investigate the effectiveness of an intervention(s) to improve mental health outcomes for people with justiciable issues
Studies that investigate the effectiveness of an intervention(s) to improve access to justice for those with mental health problems

Exclusion criteria

Studies published before 2001
Studies referring to under 18 year olds only
Studies that focus exclusively on issues connected to the mental health bill
Studies that are not published in English language

Appendix 8: Data extraction sheet

Access to Justice for People with Mental Health Problems
Data extraction sheet

Reviewer name:

STUDY DETAILS
AUTHORS (first author and et al.):
SOURCE AND YEAR OF PUBLICATION:
□□□□□
Language and country of study
VERIFICATION OF STUDY ELIGIBILITY
Please indicate presence of the following inclusion criteria by circling one of the options

1. The study sample is exclusively victims of crime, OR witnesses of crime OR people with experience of any justiciable (including civil, family issues) problems AND reports a mental health OR psychological outcome **YES/NO/NOT CLEAR**
2. The focus of the study/intervention is to support people with mental health problems to access justice (either criminal or civil) **YES/NO/NOT CLEAR**
3. The study/intervention observes effect on mental health for people experiencing justiciable problems **YES/NO/NOT CLEAR**
4. The study design includes a control group **YES/NO/NOT CLEAR**
5. The study measures at least one outcome pertinent to mental health **YES/NO/NOT CLEAR**
6. The intervention/study measures at least one outcome pertinent to access to justice **YES/NO/NOT CLEAR**
7. The intervention/study does not exclusively work with issues connected to the Mental Health Bill **YES/NO/NOT CLEAR**

INTERVENTION (S)
Type of intervention(s):

STUDY CHARACTERISTICS
STUDY DESIGN – please circle one of the following options
a) RCT
b) Quasi-experimental study with matched controls
c) Quasi-experimental study with unmatched controls
d) Observational
e) Qualitative
f) Other (please state)

At which points were participants assessed interview covered a three year period (retrospective ints)
Drop out rates:

Follow up attrition rates for each condition

Justiciable problem involved & % of each type observed:

Study setting (e.g. court, mental health service, academic institution):

Brief description of conditions:
Where was the study carried out? (county, region)

Theoretical framework model:

Unit of intervention measured (e.g. number of advice sessions):

Total units given (e.g. 6 sessions): KM: this is about length of intervention

Intensity of units given (e.g. no of sessions per week, duration of single session):

What type of agency delivered the intervention (e.g. specialist agency, criminal justice)?

SAMPLE CHARACTERISTICS (total and by condition)
Number: Intervention group Control/counterfactual Group

Give data for sample and control group, where applicable:
Gender (% female/male):
Age (mean, SD, range):
Ethnicity (%):
Socio-economic status (any details):
Inclusion criteria used (e.g. diagnosis of PTSD):

Exclusion criteria used (e.g. child only study):

ARE THE INTERVENTION AND CONTROL GROUPS COMPARABLE ON
a) Demographic variables: YES/NO/PARTLY/INFORMATION NOT GIVEN
b) Pre-treatment symptoms: YES/NO/PARTLY/INFORMATION NOT GIVEN

For quasi experimental studies Counterfactual used:
Nature of counterfactual:

Reason for use of this counterfactual**:**

QUALITATIVE STUDY DESIGN

Study objectives:

Study design (e.g. matched pair interview, focus group):

How were participants selected?

Theoretical basis for the method chosen (e.g. participatory, emancipatory)

Main findings:

Ministry of Justice Research Series 6/09

Access to Justice: a review of the existing evidence of the experiences of adults with mental health problems

This report on how adults with mental health problems experience civil, family and criminal justice systems was commissioned as part of the 2006 Research Programme of the Department for Constitutional Affairs (now Ministry of Justice – MOJ).

This review was conducted using systematic review methodology and only includes evidence based on studies that meet acceptable standards of method and reporting. It includes UK and international evidence published between 2001 and 2007.

The evidence highlights the prevalence of justiciable problems amongst adults with mental health problems and possible risks factors. Some limited evidence was found of effectiveness of interventions and services that adults with mental health problems may access when experiencing a justice problem.

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