

REPORT

Centre for
Mental Health



Keys to diversion

Best practice for offenders with multiple needs

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Executive Summary

A large proportion of people in the criminal justice system have multiple or complex needs including a range of mental health problems. Many have repeated contact with the police and courts yet rarely get the support they need from public services.

Liaison and diversion services aim to identify and support people with mental health problems, learning difficulties and other vulnerabilities in police stations and courts. Some do this more successfully than others. This report looks at some of the key ingredients of services that engage people with complex needs based on visits to sites and interviews with staff, service users and partners of four liaison and diversion schemes in different areas of England. The schemes are based in Lewisham, Manchester, Portsmouth and in Plymouth, Bodmin and Truro.

Needs and missed opportunities

Most of the users of these four services had at least moderate mental health problems and most had come into contact with them after committing offences. Among the needs and backgrounds of these people we found:

- At least half had a family history of mental ill health;
- Many had experienced bereavement early in life, including the loss of a parent or sibling;
- Half had been the victims of crime themselves, often violent crimes, targeted because of their vulnerabilities;
- About a third had experienced disrupted childhoods, including periods in local authority care.

The life stories of the people we interviewed were catalogues of missed opportunities. About two-thirds had sought help for their mental health as adults. Most received help intermittently and were found to fall below thresholds for access to secondary mental health services.

As well as mental health problems the people using these services also needed help with:

- housing, including urgent help with rent arrears or homelessness
- finance, including debt, benefits and food
- employment

Offering support

The services we visited offered support for a broad range of people's needs. Staff possessed an encyclopaedic knowledge of local support for housing and welfare issues and linked service users with employment support. The services took a 'client's eye view' when assessing needs, often focusing first on basic needs.

These services offered crisis care to people other services were unable to help. They linked across boundaries to build support packages for people from different organisations. They offered case management for people while they put support in place rather than simply identifying need and signposting people to other services from a distance. And they stayed in touch with people after they had 'moved on' to other services and offered a 'drop in' service for those who needed extra help.

Recommendations

For NHS commissioners

- Clinical commissioning groups should identify a lead commissioner with a specific remit to coordinate care across agencies for those identified with multiple and complex needs. Such commissioners would have charge of a specific set of pathways for individuals meeting appropriate criteria. Within this remit would be the identification and long-term monitoring of those at higher risk or most persistent vulnerability.
- Commissioning of liaison and diversion services should provide for some ability to track individuals who receive services. This ought to be part of the performance monitoring and will give some indication of outcome.

- User experiences and perception should influence commissioning decisions.
- Liaison and diversion services should be commissioned to provide an element of indefinite support, in the form of drop-in support focused on averting crises and reconnecting service users with mainstream services where required.
- Strengthening positive social networks in the service user's community is a vital part of the diversion infrastructure. This should include a capacity to intervene with and support families and the provision of alternatives such as volunteer mentoring to fill gaps in the support available.
- Local NHS commissioners need to ensure that offenders have timely access to psychological therapy services with clear referral routes from liaison and diversion services and from probation.
- Liaison and diversion services, where staffed by appropriately qualified mental health practitioners, should act as a gateway for secondary care. Onward referral and assessment should only be required in exceptional circumstances (for example to specialist services such as forensic services).

For liaison and diversion services

- Effective liaison and diversion requires robust systems to identify people coming through criminal justice services with poor mental health and learning disabilities. Liaison and diversion teams need to be able to assess for a broad range of psycho-social needs.
- Effective liaison and diversion requires an emphasis on engagement as many of those it will want to target will have had previous poor experience of engagement with mental health and other professionals and services.
- Effective liaison and diversion needs to be personalised to the individual, with an infrastructure in place to respond to their needs from a range of different agencies. In addition to screening and identifying people with a specific range of problems, liaison and diversion teams should act as connecting services, offering gateways to a range of services. To do this they require staff who can span agency boundaries to negotiate personalised packages of care.
- Liaison and diversion services need to offer access to housing and benefits advice as part of the initial intervention.

The keys to diversion

These are the key components of these successful liaison and diversion services.

- A comprehensive knowledge of local social and health economies and relationships with agencies across it.
- Engagement as a key activity.
- A psycho-social orientation.
- Immediate access (within team) to housing and benefits advice.
- Service user's view of their needs being at the core of their assessment.
- A focus on meeting basic needs first.
- Being sufficiently resourced to connect people to a range of services (this might include accompanying people to appointments).
- Pro-activity and assertiveness (services that are active and not just reactive to a clients needs and where possible offer not just a formal appointment based service).
- Providing some indefinite support with a focus on crises and educating service users on averting these.
- Providing a drop-in service after the initial intervention.
- An interest in outcomes and following up on referrals and sign-posting.
- Understanding the needs of police, probation and sentencers.
- Improving mental health awareness among criminal justice agencies and staff.

1. Introduction

Centre for Mental Health has embarked on a project that explored the services provided by a number of small specialist teams working with people with complex and multiple problems who have offended or are suspected of having offended. This report describes the need for these services, the interventions they offer and most importantly shares the service users' experience of these, and how they compare to previous experiences of seeking help.

We have worked with many mental health services and it has always been apparent that some services have greater success than others in engaging people. Such services were typically small but well organised and more often than not provided by the voluntary sector (though not always). A characteristic of these services was their ability to form relationships, not just with their service users, but with a whole range of local health and social care providers in their community.

This report is an attempt to capture the essence of these services for people with multiple and complex need who come into contact with the criminal justice system. Such people often have repeated contact with the police and courts, but seldom have contact with services that might help them.

Centre for Mental Health visited four services, in Manchester, Lewisham, Portsmouth and one service that worked in courts in Plymouth, Bodmin and Truro. Each of these works with people with mental health problems or learning disabilities as part of multiple and complex needs and each provides a period of case management (formal or informal) after the screening and assessment. The provision of case management post screening and assessment is unique as most diversion and liaison teams provide some management during the criminal justice process, but then refer on or signpost for all further support. All four used the period of case management to link people in to a range support and care.

2. Liaison and diversion

Why divert?

Research in the UK and internationally has demonstrated that prison populations have significantly higher psychiatric morbidity than the general population. The last comprehensive research in England and Wales (Singleton et al, 1998) found that 90% of prisoners suffer either from substance misuse, personality disorder or a mental health problem (for incarcerated women and all juveniles the proportion is 95%), and that 70% have two or more of these problems. Learning disability is less well understood but estimates have suggested that perhaps 7% of prisoners have marked learning disability (i.e. IQs scoring below 70) and a further 25% have borderline learning disability (i.e. IQs scoring 70 – 79) (Prison Reform Trust, 2013).

Other parts of the criminal justice system are less well surveyed. Recent research with the Metropolitan Police suggested that daily contact with people with vulnerabilities is as much as 40% and “...that mental health issues account for at least 20% of police time...” (Independent Commission on Mental Health and Police, 2013). Research in a single probation trust, meanwhile, found the proportion of those supervised by probation with current mental health problems was 39%, and this went significantly higher if one included those with histories of poor mental health (Centre for Mental Health, 2012).

There is therefore a strong argument for filtering out those people coming into contact with the criminal justice system where there is no public protection interest and where treatment and care are more appropriate options. For the small group of offenders with poor mental health and learning disability that pose risk to the public due to their disorder or disability, diversion to a secure mental health care facility might better serve public protection (and the individual’s treatment needs) than prison. However, achieving all this is dependent on those working in criminal justice services having support available from professionals with mental health and learning disability expertise, and also

increasing the awareness of such vulnerabilities amongst police officers, probation officers, court staff and sentencers.

Evidence for liaison and diversion

In 2009, we presented its review of liaison and diversion and concluded that the evidence for its efficacy was limited, largely due to the diversity of scheme types both nationally and internationally and the absence of sufficient well-conducted multi-site studies (Sainsbury Centre for Mental Health, 2009). Since then two major systematic reviews have been conducted. The Offender Health Research Network (OHRN, 2011) review stated “...They are universally regarded to be a ‘good thing’, but there is no robust body of research evidence to support the belief that they improve the health, social and criminal outcomes of people who are in contact with them...”. The systematic narrative review conducted by the Institute of Mental Health on behalf of the Offender Health Collaborative, as part of the National Liaison and Diversion Development Programme (Kane et al, 2012), concluded much the same. However it found evidence to support the following:

- Diversion should happen at the earliest possible point on the pathway.
- Defendants in the police station/court should be screened face-to-face for mental illness.
- Individuals and their behaviours should not be inappropriately pathologised, creating stigma, unjustified coercion and unnecessary cost through service duplication and over intervention.
- A clear and bounded definition of the service should be provided with multi-agency commitment to that definition.
- Availability of a service infrastructure into which individuals can be diverted.
- Diversion and liaison services are most effective when commissioned on the basis of joint funding from mental health and criminal justice agencies.

- Liaison and diversion teams should work more closely with substance misuse teams in co-ordinating care.
- Diversion and liaison teams should develop and agree plans for the provision of training in mental health issues and learning disabilities for criminal justice staff and vice versa.
- Diversion and liaison teams should undertake follow-up work as a core part of their business to ensure that their clients engage satisfactorily with the services into which they have been diverted.
- Commissioners and managers of community-based mental health services should ensure that a potential client's offending history does not act as a barrier, formally or informally, to receipt of these services.

Adult liaison and diversion services, regardless of size and structure, have largely confined themselves to the screening and identification of mental health problems in criminal justice settings and have not case managed those whom they identify. Instead they have referred and signposted on. As services have not had the ability to track those they signpost or refer on, this has contributed to the very limited evidence base for diversion.

The development of liaison and diversion

We have known for well over two hundred years that significant numbers of our prison population have mental illness and learning disability. However, systematic means of addressing this are only very recent. Mental health inreach teams were only introduced to English and Welsh prisons in 2001.

Liaison and diversion schemes were launched in the late 1980s in small number of areas in England and Wales with funding from the Home Office and Department of Health. The liaison and diversion teams that developed after that followed no set blueprint and have come in all shapes and sizes and covered different parts of the pathway an offender can follow. But

commonly such services have attempted to identify suspects and offenders with mental health problems, assess these, provide advice to practitioners, and provide a route into a treatment alternative, where appropriate and possible. Many such schemes have also increased the awareness of their criminal justice colleagues about mental health.

This type of service reached a peak in 1997, with 194 teams for adults (Spurgeon, 2005). Since then some have disappeared and others have shrunk. In 2005, there were an estimated 150 teams (for adults) in England with another 14 in Wales (Spurgeon, 2005). Many of the early services have fallen by the wayside, not being a policy 'must do' and not having featured at all in the decade of mental health reform based on the National Service Framework for Mental Health, ending in 2009 in England.

Diversion services in England have varied from those which are multi-disciplinary and proactively visit both police custody suites and courts to others which consist of single individuals responding to referrals perhaps just from courts. The vast majority of schemes in England and Wales have worked only with courts (both magistrate and crown) while a smaller number have worked exclusively or additionally with police custody suites. But probably less than half of all courts and very few police custody suites had any coverage (Centre for Mental Health, 2009).

Scotland has operated a different model with diversion to social work for vulnerable people. The Scottish Office provided full funding for 18 pilot schemes in 1997 (Barry & McIvor, 2000) and a recent survey identified some 26 schemes (but acknowledged there may be more) that address the needs of people with mental health problems (Gormley, 2013). The Scottish Government have increased investment in this area (2011). The Scottish Association for Mental Health and Centre for Mental Health are currently reviewing diversion for poor mental health in Scotland.

Provision in Northern Ireland is currently limited and there has been some psychiatric nurse liaison with police custody in Belfast. NIACRO, Northern Ireland's largest charity

supporting the rehabilitation of offenders, has recently published a business case for diversion (NIACRO, 2013).

The Bradley Report

Lord Bradley was commissioned in 2007 by the then secretary of State for Justice, Jack Straw, to review the provision of mental health liaison and diversion across England. The Bradley Report was published in April 2009 (Department for Health, 2009). It took an ‘all stages’ approach and made some 82 recommendations covering early intervention, all ages, neighbourhood policing, police custody, courts, prison mental health care, personality disorder, resettlement/ re-entry, alternatives to custody and use of the mental health treatment requirement. Diversion for learning disability was also seen as a priority.

The next Government continued to see mental health and learning disability diversion as a priority and despite making drastic cuts in public spending, it committed £50 million to a development programme. The ambition of this programme was to develop the right model and also a business case to justify the roll-out to all courts and all police custody suites. Crucially this was an all age approach.

Mental health diversion for children and young people is very recent, with the first 6 pilot schemes being established in 2008. These sites were developed as part of a joint programme between the Department of Health, Youth Justice Board and Centre for Mental Health, and were evaluated independently by the University Of Liverpool (2012). These have now expanded and the National Liaison and Diversion Development Programme included 37 such sites across England. The primary focus of these services has been on early intervention which is part of a programme designed to prevent first time entrants from further offending. Each scheme collects a particularly rich dataset which is published on the Children’s Public Health

Observatory Website (<http://www.chimat.org.uk>), collecting prevalence data for each individual on some 26 vulnerabilities.

The National Liaison and Diversion Development Programme

The Coalition Government announced in 2010 that £50 million was being made available to support a development programme for liaison and diversion across England. The Offender Health Collaborative (OHC) was formed in response to the announcement in 2011 and is a partnership between Nacro, Centre for Mental Health, Centre for Health and Justice at the Institute for Mental Health – University of Nottingham, Revolving Doors Agency and until Autumn 2013 the Mental Health Network of the NHS Confederation. The OHC successfully tendered to support the development element of this national programme and commenced work with 101 diversion and related services just before the summer of 2012. At the same time the Offender Health Research Network (University of Manchester) commenced work with a smaller number of these schemes to collect data to support the business case.

A significant part of the recent work of the OHC has been the production and consultation on an Operating Model for Liaison and Diversion. The OHC will support a selection of schemes and their commissioners in embedding the Operating Model by April 2014. These schemes will then be subject to a robust independent evaluation that will focus on outcomes for the users of these services, and form the final part of the business case, to be presented in Autumn 2015. The Government announced a further £25 million investment and that if a successful business case is made liaison and diversion by services will roll out to all areas of England by 2017.

Changes to commissioning

A great many public services, and especially health services, have been affected by the reforms the Coalition Government has brought to the organisation of the National Health

Service. Health services provided to and within criminal justice were formally commissioned locally by the 150 Primary Care Trusts (PCTs; though there were and remain considerable gaps in provision and not all PCTs were commissioning such services). From April 2013 a new national commissioning body, NHS England, took over responsibility for prison health care, liaison and diversion and will be responsible for commissioning health care in police stations once current contracts have come to an end. The 150 PCTs were also replaced by 211 Clinical Commissioning Groups. The crucial challenge for successful liaison and diversion is that much of the post diversion infrastructure (i.e. what someone is diverted to) falls within the realm of these local commissioning bodies. In addition to this there are other commissioning bodies with whom it is crucial to have influence and shared vision for successful liaison and diversion; including 150 upper tier local authorities, 40 or so English police forces (including the British Transport Police) and 35 Probation Trusts (currently).

Complex and multiple need

One of the key findings of *From the Inside* (Durcan, 2008) was that prisoners typically had multiple and complicated needs of which their mental health problem was just a part. Other Centre for Mental Health evaluations within prisons have allowed for the profiling of mental health inreach caseloads and primary mental health care caseloads, and to compare these. The key differences were that mental health inreach teams' caseloads predominantly consisted of people suffering severe mental illness, such as psychosis while primary mental health caseloads tended to be people with mild to moderate mental health problems. However, when Centre for Mental Health used the Threshold of Assessment Grid (which measures severity of problems across seven domains) (Slade *et al.*, 2000) to rate both groups, the scores for overall severity were very similar. Both were similar to inner city community mental health team and assertive outreach team caseloads that Centre for Mental Health had previously profiled. So multiple, complex

problems, which are quite severe when taken together, are very much part of the profile for prisoners (often regardless of diagnosis).

Interviews with liaison and diversion service users drawn from services from across South East England strongly suggested that the people who use these services have a very similar profile to those prisoners Centre for Mental Health had interviewed and profiled.

People with multiple and complex needs account for much of the 'repeat business' in police stations and courts, but often fall in the gaps between services. While they have multiple problems, their individual problems may fall below individual service thresholds, particularly those of secondary mental health care. Left unsupported, their difficulties can often escalate leading them to a succession of episodes in and out of the criminal justice system building up significant additional costs for the public purse.

3. The services

Centre for Mental Health visited several services that worked with people with mental health problems in contact with the police and or courts, and selected four very different services, each of which attempted to support their service users not just while they were in contact with the criminal justice system but also beyond.

Each of the services was visited on several occasions and there were opportunities to observe them in action, to interview local stakeholders and most importantly to speak in depth with people using the service. In total around 45 service users were interviewed and several of these on two sites were able to take part in follow-up interviews.

The interviews with service users covered their histories including: family, education, employment, health and mental health, offending and contact with criminal justice system, their experience of seeking help and service history. We also explored their experience of the 'diversion' service.

Mo:Del – City of Manchester:

A multi-disciplinary NHS provided service which includes probation staff within the team and provides liaison and diversion in the City of Manchester's courts and police custody suites. What separates it from the majority of other liaison and diversion teams is that it is able to carry a caseload of up to 150 service users for up to six months. Over that 6 months, Mo:Del aims to connect people into mainstream services, including mental health. Mo:Del will place some of those they assess on the Care Programme Approach as this greatly aids the process of successful access to community mental health teams. However, whilst a sizeable proportion of people seen by Mo:Del have multiple complex needs and would benefit from CPA, local services that are geared towards severity and not complexity effective use of CPA for those with complex needs remains a significant challenge.

Few liaison and diversion services have the capacity to work with families, but where appropriate Mo:Del aims to engage with a service user's family and support network.

Another important aspect of the Mo:Del approach is its close relationship with the Hope Project, which provides a range of activities to support Mo:Del service users between Mondays and Fridays. These activities can involve daily contact for some people and include advice on housing and benefits, support towards employment, cooking and so on, and engagement in leisure activities. Staff at the Hope Project are able to undertake some 'one to one' work with their clients. For some people the Hope Project provides on-going support and this might be particularly important to those whose needs fall short of other service thresholds.

Mo:Del, during the course of this project, became one of the sites selected to be part of the National Liaison and Diversion Development Programme, and was one of the sites asked to collect additional data for the business case.

Portsmouth Criminal Justice Team:

This team dates back to the 1990s and is well established with both the local courts and police custody, having built and maintained those relationships over years. The team works with all of its service users while they have any involvement with criminal justice agencies. Like other teams it provides much informal support for former clients and for some is the first port of call when seeking help or guidance, for example for concerns over their housing or their medication. However, it is also able to run a small caseload usually for those with the most marked or chronic need, who do not engage well with other services (or with whom other services have not engaged). The caseload size is in the region of 30 at any one time. The team was originally provided by the local authority but now provided by the NHS. Like the Mo:Del service, this was also co-opted into the National Liaison and Diversion Development Programme and was one of the small number of schemes contributing data for the business case.

CASS (Community Advice & Support Services) - Plymouth, Bodmin & Truro:

This is a voluntary sector service now run by Rethink Mental Illness, working across three courts in Devon and Cornwall. CASS was not established to provide liaison and diversion for people with mental health problems or learning disabilities, but rather has its origins in a Ministry of Justice programme which established several court-based problem solving pilot services. CASS, the only surviving one of these pilots, works with three magistrate benches to provide support to vulnerable people, who have acknowledged their offence and are willing to be helped. It is in effect providing liaison and diversion across the three courts. The team may provide problem solving interventions pre- and post-sentence, depending on when they are able or are asked to work with defendants. However, at the specialist weekly Community Court in Plymouth it often conducts its initial assessment during an adjournment, and makes recommendations via probation or sometimes directly to magistrates. The vast majority of its clients have some level of mental health problem, but most would fall below the threshold for acceptance to secondary mental health care.

Another feature of this service that separates it from others is that it is largely provided by volunteers. CASS has only two employed full-time team members and has additional seconded hours of a police officer one day a week at the Community Court. Even though this service requires only very limited funding it has at times struggled to survive due to very time limited contracts, and in spite of demand it is unable to expand its service to other Devon courts at the present.

CASS has an office in each of the three courts, which itself is an acknowledgement of how well regarded it is by the courts, and runs in both Plymouth and Cornwall on three days a week. CASS workers do not have a formal caseload, but do work over quite extended periods of time with many clients. The demands on their services and limitations in their funding mean that they cannot provide an assertive service and that most of their face to face work with

clients is conducted within the courts. However, this does appear to be acceptable to their clients and like the Portsmouth team they are the first port of call for many of their former service users.

The CASS team members are extremely knowledgeable about their local health and social care economies and form strong relationships with many key services and they support people into these.

Penrose – Lewisham:

Penrose is a charity that provides a range of practical care and social rehabilitation services for offenders, adults with forensic mental illness and people with personality disorders and other vulnerable people in contact with the criminal justice system who have drug, alcohol and other complex needs. Penrose Fusion offender service in Lewisham is one of three Penrose projects in the borough, the other two projects are both residential and floating support services for offenders with forensic mental health issues. Penrose Fusion was funded by Lewisham Borough Council as one of the Ministry of Justice incentive payment pilots, the aim of which was to reduce reoffending for short sentenced offenders. Penrose Fusion's mental health alternative to prison service (MHAP) came about as a response to a recognition that a significant proportion of the offenders Penrose Fusion are working with in Lewisham have some level of mental health problem.

The Penrose MHAP project provided a wide range of group work, one to one counselling and other meaningful activities for offenders who have been identified with a mental illness whilst in custody, court or by probation. Its mental health worker was based both in probation offices and the Penrose Fusion Resource centre. The activities provided were spread across the working week for clients. The funding for Penrose MHAP service came via the National Liaison and Diversion Development Programme, and in particular the tranche of this aimed at providing alternatives to custody. Penrose MHAP has a full time mental health practitioner (a psychiatric nurse) supporting over 30 individuals and other support staff (funded

by Lewisham Council) who have supported the desistance of over 700 offenders. It has formed links with probation, courts and police custody. Originally it was designed to work with 20 offenders at any one time, but it currently supports more than this number. Many of its clients have not engaged with or been engaged by other support services, particularly statutory sector services.

Methodology

This report presents findings from observations and conversations with professional, experts and most importantly and significantly those people who have used these four services. Centre for Mental Health has also had the opportunity to visit other projects and the findings from these are also presented here.

The professionals interviewed included probation officers, police, magistrates and other court officials, community mental health practitioners, voluntary sector mental health services and staff and managers from various voluntary sector agencies.

The service users interviewed were by and large those who were using the service on the days Centre for Mental Health visited, though some service users were specifically invited to attend services for interview on such a day. All were current service users. All service users attending on the day we visited who were asked to be interviewed agreed, and only six service users specifically asked to attend an interview did not attend. In some cases we were able to meet these on a different occasion.

All of the services were engaged in other activities during the lifetime of the project, for example three of the sites were engaged in the National Liaison and Diversion Development Programme, and one was involved in two other evaluations (both launched after this project). Another did not receive funding for several months, resulting in it suspending activity for a period. The result of all this meant that the project had the greatest access to two of the four services, Portsmouth and CASS (in Plymouth, Bodmin and Truro). For each of these there was the opportunity to conduct follow up interviews with a small number of service users.

4. Who uses these services?

All the people we met during this study had at least moderate mental health problems; a small number had a severe mental illness, such as bipolar disorder or schizophrenia. A few had been diagnosed with personality disorder (e.g. Borderline Personality Disorder, Anti-social Personality Disorder and Paranoid Personality Disorder), while others were reported to have significant traits of personality disorder. About two thirds of those spoken to reported problematic use of substances, and the substances used included both prescription and non-prescription drugs, and alcohol. A small group of service users acknowledged being poly-substance misusers.

The profile of service users' mental health was very similar across all four services.

Almost two thirds of those interviewed were male and most aged between 30 and 45; the range was 18 to 60 years old.

Most had been convicted or cautioned for an offence during this current episode of care. There were service users who were still attending magistrate's proceedings, mainly drawn from one service (CASS); all of these had acknowledged their offence.

The offences they had committed included various crimes of acquisition, fraud (including benefit fraud), public disorder offences and assaults and the practitioners in the services believed that some of the service users might have incurred a prison sentence or a period of remand had it not been for the availability and intervention of their service.

"...Without XXXX being available and in the court sometimes I would have made the decision to remand and in others the decision to give a sentence...I feel reassured by them... it's a matter of being able to trust them..."

- Magistrate

Most of those interviewed had previously been arrested and been to court; and close to half had been to prison either on remand and or as part of a sentence at least once. Around half stated that they had their first contact with the

criminal justice system as a teenager. Only four stated that the offence that had led to this 'episode of care' was their first.

Histories of poor mental health

All the service users we spoke to had long histories of poor mental health, usually dating back to their childhood. Approximately half said there were histories of poor mental health in their families with parents and sometimes siblings suffering from poor mental health.

Early experience of bereavement and particularly the loss of a significant other such as a parent or other significant carer or siblings were common. For a very small number, the bereavement had occurred in particularly difficult circumstances such as suicide or homicide. But in all cases those describing such experiences felt the death of that significant person (or persons) had had a lasting impact on their life and wellbeing and had contributed to their poor mental health early in their lives.

Trauma

When we conducted interviews with a sample of prisoners in the West Midlands in 2006 (Durcan, 2008) we found that a substantial proportion had experienced psychological trauma, often first as children. This also appeared to be a significant factor for the people interviewed for this project, with over a third of the sample revealing childhood experiences of physical or sexual abuse.

Another factor was that although all had been involved in offending, around half reported that they had also been the victims of crime, most often one or more violent assault. This was commonly attributed to being targeted because of vulnerability due to mental health problems.

"...I've experienced quite a bit of bullying... youngsters have robbed me in the street and I have had break-ins....they all know who (and what) I am..."

- Service user - Portsmouth

Experience of help seeking

The service users we met had a range of mental health problems and they were aware that they had these problems prior to their contact with the services. Several described using substances, including alcohol, as a form of self-medication to alleviate the distress that their poor mental health brought them.

“I know it doesn’t make it anything better but I stop thinking for a bit... it’s a bit of relief...”

- Service User – Plymouth

About two thirds of these service users had sought help as adults for their poor mental health. Often this meant visiting their family doctor and a referral to a community mental health team. Fifteen service users had experienced one or more episodes of care by a secondary care mental health service and seven of these had experienced at least one episode of psychiatric inpatient care. The pattern was mostly one of intermittent care often initiated during a crisis leading to discharge after the crisis. Several of the service users acknowledged living quite chaotic lives and not attending appointments, often leading to discharge from community teams. Typically these service users described marked substance misuse as being part of their problem.

The most common experience, even for those who had experienced intermittent periods of secondary mental health care, was of not meeting the criteria for acceptance by the mental health service, i.e. falling below a threshold:

“It’s a f#####g waste of time... you wait ages, get asked the same old questions... then get sent back to (a family doctor)...”

- Portsmouth – Service User

For those who had experienced some help from secondary care, around half found it helpful, but most of the service users felt that the mental health teams had not addressed some of the issues they felt were important to them.

“I’m looking for help... I’ve got no food in the fridge... I tell them ‘do something’ but nothing happens... at least here I can get a voucher.”

- Service user - Truro

What these service users were describing were services that focused on their mental health problem, but not sufficiently on problems the service users felt contributed to their poor mental health. Such problems included their drug and alcohol problems, trauma, housing and debt.

A small number of service users had experienced care under substance misuse services and were generally positive, feeling the practitioners they had met had provided support with everyday issues, such as housing and debt, but experienced less help for mental health and psychological problems.

Missed opportunities

Almost without exception the life stories of the service users were catalogues of missed opportunities. The vast majority traced their poor mental health back into their earliest years.

“I wouldn’t have known at the time... but I don’t think I have ever been happy... I mean I think I’ve always been depressed.”

Many stated that as children they would not have recognised the problems they experienced at the time as ‘poor mental health’ but on reflection recognise that as being the problem.

Many reported problems at school and disrupted school experiences, some leaving school before statutory school leaving age.

“I suppose if anyone had taken the time I think they could have guessed I was f####ed up... no one behaves like that as a kid if they are sorted.”

For five service users there appeared to have been episodes of care by a Child and Adolescent Mental Health team, however in all cases the recollections were vague as were the reasons for referral and the outcomes of care.

Experience of being 'in care'

"...I don't think the state could find a better way of messing you up..."

Approximately a third of those interviewed had experienced disrupted childhoods that included periods in local authority care, some housed during these periods with relatives or other foster parents and some had extended periods in children's homes. In a small number of cases, the period in local authority care had followed the death of a parent or other carer. Those who had lived in children's homes up to the point of being able to live independently all remembered the transition as being particularly difficult. All those who had experienced local authority care stated a belief this had negatively impacted on their later mental health.

"Things were wrong before, but they certainly didn't get any better. You don't know how f##ked up you are until you meet a 'normal' family..."

Some service users had other experiences that they saw as disruptive, such as divorce and family break-up leading to several moves and changes of home, and having a father in the armed services leading to many changes in location and school.

5. Service user needs

Very few of the service users did not have a history of problems with accommodation or were currently experiencing difficulties. When we observed practitioners interviewing people for the first time, this was often the first problem to be raised by the service user.

Practitioners in all four services reported that there were shortages in housing (particularly social housing) and supported housing in the areas where their users came from.

Most were housed with private landlords, often with rent arrears, but a significant minority of those interviewed were homeless at the time of interview, a small number actually street homeless, but most in very unstable housing, typically couch surfing, or in temporary bed and breakfast type accommodation.

The quality of accommodation was also an issue for some clients, and the services in these cases were very active in liaising with housing providers to support a move to safer or healthier accommodation.

“There is very little accommodation on the market - it’s virtually all private landlords. It’s the hardest part of our job and virtually everyone who comes through the door has a problem with it.”

- Practitioner

Debt

Most of the service users had debts that they were struggling to manage when they came into contact with one of these services and understandably this was the cause of considerable distress. Observations of initial interviews and practitioners’ descriptions of their practice revealed this issue was virtually always a problem for service users (and indeed practitioners proactively sought information on this) and followed closely on the heels of accommodation problems.

Benefits and welfare

In the experience of the practitioners, many people they met did not understand what benefits they were entitled to and commonly were not receiving all that they could. This was seen as an important area in which to intervene and appeared to add to the credibility of the service in the eyes of the service user.

All of the services had access to some form of local food voucher or related scheme, and this was very frequently one of the interventions required on initial contact with a service user or perhaps for the first few contacts.

Support in times of transition and crisis

The people we met gave accounts of lives with many crises and also key points of transition that lead to crisis (e.g. leaving care, leaving prison, leaving hospital, losing a job). For those service users who had experienced periods of incarceration, the experience of leaving prison and re-entering society was universally poor and often led to crisis. Centre for Mental Health reported similar findings in 2008 (Durcan, 2008). At least two of the services provided some sort of care for former service users leaving prison during the project and the Portsmouth service often arranged to meet prisoners at the gate on discharge from prison, to avert a crisis.

“We’ve had phone calls from guys and they’ve been discharged that day from HMP xxx and they have blown all their release grant on booze... Often it’s us picking them up or the police and then they are back in trouble...”

- Service manager

Those service users who had been in contact with a service for some period were very likely to call the service first when they experienced a crisis, regardless of whether they were still on

caseload. The services were all always willing to provide help, and acted in effect as an on-going crisis service for these people. This was exactly what several service users felt should be in place for them.

“...we are a sort of casualty department...but actually I think most people call in to see us before things have got too bad...when we can still help them...”

Employment

Most service users were not employed at the time of our interviews, though some were and some of these had been supported into employment by one of the four services, often by being linked into a local employment support service. Other service users were engaged in activities that might give skills that employers would seek or skills in accessing jobs (such as interview training and help with CVs). Most service users told us that they wanted to work and that they felt ready to work. Understandably most were extremely pessimistic about their chances of finding work, and this was based on repeated rejection experiences in the job market.

Support and treatment for mental health problems

Most services users' attempts to seek help for mental health and psychological problems had largely been frustrated up until they reached one of these services. Each of the four services provided some form of counselling (formal or informal), though this was not their main purpose, which instead was to connect people with other services.

Some service users were no longer registered with a family doctor (not all realised this at the time) and this was often a first and necessary step, as most secondary care mental health services require a referral from a family doctor. Those with more severe mental health problems were referred to local community mental health teams, however there was a concern about

how assertive these services were, and a clear view expressed by practitioners from the four services was that for many of those they referred an assertive service was required, and that clinic and outpatient based models of care were likely to fail with these service users.

Most of the service users had had experience of falling below local community mental health team thresholds. This was a frustration for both the services and the service users, especially as there was very limited provision below the level of secondary care.

Where an IAPT (Improving Access to Psychological Therapies) service was in place, it was typically hard to access (due to demand and scale of provision) and the complex nature of these service users' needs meant that they were very often excluded from these (e.g. if they had concurrent substance misuse problems).

In Plymouth, CASS was able to access some local services run by Rethink, its parent organisation. Accounts of practitioners and service users alike, from all four services, revealed access to support for mental health and psychological problems was very limited.

6. Service characteristics

The limited evidence for liaison and diversion highlights the need for somewhere to divert a person to, and more importantly, in recognition of the complex and multiple nature of the needs, having an infrastructure in place that addresses these different needs. Ideally such an infrastructure would have been designed and underpinned by joined-up thinking at the commissioning level, with protocols and service level agreements to support it. But by and large none of this existed in the areas where these four services operated.

What existed in its stead was an encyclopaedic knowledge of the current local social and health economies within these four services, and relationships forged across those economies. In effect the practitioners in these services had created an infrastructure for each of the clients they worked with. This was underpinned by knowledge and relationships, but not any formal ‘architecture’ that coordinated commissioning and service level agreements would provide.

Both Fusion and the Hope Project linked with Mo:Del were created to meet a gap in service, i.e. to provide a programme of support, treatment and activity for a client group that tended to be excluded from existing services. At the time of the project, both of these were dependent either on a temporary programme grant or charitable grant funding.

These four services seemed to operate under a principle of proactively seeking and building relationships with other support services in their environment. Their limited resources made this a challenge but it was prioritised and seen as important to maintain their efforts in this direction, as without it there “was no offer to make to service users”.

Links to housing

Given the high level of housing-related need, some of the most important relationships these services and their practitioners had were with the housing sector. This meant having a knowledge of housing providers

and what housing support was available, and good relationships with these providers; this included private landlords. Some of the services had extensive knowledge of the local housing economy and would champion the needs of clients with particular providers. In some cases the services had provided a line of communication with a landlord and in doing so probably avoided conflict that might ultimately lead to eviction. We have found both in this project and in others that securing a safe place to live is a major issue for many people coming into contact with criminal justice and particularly so for those with mental health problems (Centre for Mental Health, 2011).

Debts and welfare

Each of these services put considerable energy into understanding the benefit system and routinely made assessments of their services users’ needs and entitlements. Budget planning and support over debt management was also commonly provided. An important intervention was liaison between the court and the service on meeting fines and this often required considerable post sentence intervention to ensure the service user managed their budget and met the commitment they had made to the court. This was particularly challenging with a client group that had a tendency to chaotic living, but each of the services appeared particularly skilled at this and in intervening rapidly when there was a breach.

Employment

Both Mo:Del and Fusion offered employment related activities. In the case of Mo:Del this was provided through the Hope Project. In both cases this included some individual work, CV preparation and interview training as well as help in seeking jobs.

Centre for Mental Health observed several first meetings between CASS and its service users, and quite often these led to an appointment (and not just a referral) between the client and a career advisor or a vocational training or further

education provider. Some service users were directly linked to employment support services, where these existed. Following-up by phone to discover the outcome was also commonly done. The other three services had more capacity to accompany service users to such appointments (this was not limited to employment-related referrals). It was key that all four services saw employment and access to services that support people into employment as a vital part of the infrastructure their service users required.

“If we had the time we would do more... but a job and all that goes with it would help some of our folk, it’s cash in the pocket, it’s socialising and it’s activity.”

“It would be great to spend some time talking to employers and getting placements and if these work out, jobs for some of our folk.”

- Service manager

Linking into education was quite important for many clients with low levels of literacy and numeracy; this was the case for around half the service users that we met.

Access to mental health support

Service users had, by and large, experienced great difficulty at some time in receiving help with mental health and related problems. This was still the case for many of the service users.

Two of the services we observed were provided by a local NHS mental health trust, and yet even if a person was assessed and deemed to be suitable for secondary mental health care (by suitably qualified mental health practitioners from the liaison and diversion service), there was no guarantee of entry to other services within the same trust. That would require formal referrals, followed by further assessment by the receiving service. So even where they were provided by the same trust, such liaison and diversion services were not in fact a gateway to other services.

However, each of these two teams was extremely adept in advocating on behalf of their clients; once again this was greatly aided by relationships they formed with peers in other services. This was also true for CASS, who, though not provided for by qualified mental

health practitioners, formed links with them, and understood their criteria.

“It’s about being trusted... our folk are not attractive they come with loads of problems and the mental health can be masked but if we say it’s there we tend to be listened to.”

- Liaison & Diversion practitioner

To some degree Fusion and the Hope Project filled the treatment gap for a client group that would typically fall below the traditional threshold for mental health services in their area. CASS was not funded to provide counselling, though frequently provided informal counselling and importantly a space for a service user to be heard. Likewise an important part of the Portsmouth service role was to temporarily fill any treatment gap, while trying to link the clients to some form of longer term support that might sustain them.

The largest gap for this client group was for counselling to support the impact of past trauma.

Taking a client’s eye view

A characteristic shared by each of these four services was the “client’s eye view” approach they took to assessing need. This was very attractive to the service users we spoke to and unique in their experience.

“I know I got some serious problems, but I get so worried about the rent and also the fine, these are the things on my mind.”

- Service user

While all of those we spoke to were actively suffering from mental health problems of at least moderate severity, their immediate and pressing concerns were for their basic needs, i.e. having some sense of security over their accommodation and enough food and money to get by on, and concern over possible sanctions a court may hand down. For some, support with a substance misuse problem was also important and this needed addressing early in their contact with the service. Service users clearly liked being able to have some say in what they needed and the sense of being listened to was quite important.

“I am not a doctor but I think I know what’s wrong so I need people to listen.”

- Service user

Practitioner experience was that meeting someone’s very basic needs was key, for a number of reasons:

- Offers of mental health treatment were unlikely to be of use if basic needs, such as housing, were not dealt with first or at least at the same time.
- Courts tended to be more doubtful about diverting or choosing non-custodial options if the multiple needs of clients were not met. (Magistrates emphasised their concern over individuals in unstable housing and with debt management problems – both potentially influenced decisions they might make.)
- Clients felt the whole service package was more credible if their perspective was reflected in it.

A crisis service

Most of those we spoke to experienced frequent crises and we observed this to be a particularly important aspect of each of these services’ provision. The crisis that brought them into contact with the services was their contact with criminal justice, i.e. being arrested by the police or an appearance in court. Often another crisis had led to this contact in the first place.

However, the services were all focused on future crises and what needed to be in place to reduce the likelihood of this occurrence, including helping service users identify triggers for their crises and actions to take. In practice, one of the most important crisis-averting actions for many service users was visiting the service (sometimes long after they had been discharged from it) as soon as they recognised the trigger signs. All four services were willing to provide this, though none had been resourced to do so.

Being valued within the criminal justice system

Not all liaison and diversion services we have visited are necessarily valued or understood by the criminal justice agencies they work alongside.

All four services in this project had a thorough understanding of the criminal justice agencies they worked with and emphasised the need to adapt their practice to fit in with the court, police station or probation service. This was recognised by the agencies they worked with, who valued them all the more for it.

We had the opportunity to explore this with the Portsmouth and CASS services, and were able to speak to several people from the criminal justice agencies, including police custody officers, solicitors, probation officers, court security staff and magistrates. Having the team on site or visiting their service regularly was seen as extremely helpful. Both CASS and Portsmouth were well-established and well-known.

“Generally I think mental health services are very poor, but I have loads of time for these guys. They are very responsive and you know they will do their best.”

Being valued by the criminal justice colleagues was something that had to be continually worked on. The ‘proactive relationship building’ principle was applied not just to diversion infrastructure services but also to those colleagues in the criminal justice system.

Changes to police custody personnel and especially at the sergeant and inspector levels were particularly crucial and occurred regularly. Recent and proposed changes to probation were also requiring effort on behalf of the services.

Recent ‘cutbacks’ and changes in the organisation of police, probation and courts had all required shifts from the four services.

Mental health awareness

All four of the services were concerned to ensure the criminal justice practitioners they worked with understood as much as possible about mental health and learning disability. Two of the teams had provided some formal training, focused on the signs that might indicate poor mental health and what to do when identifying them. Referrals and indeed the impact of these teams depended on this. However, conversations with sentencers and police revealed that they most valued the informal contact they had with practitioners from the teams and that most of their awareness came through informal conversations and exposure to the opinions and insights of the practitioners.

“Over time I think we have become synchronised. I now know what to look for but also I learned to look for alternative explanations for an offender’s behaviour...”

Tracking and being a trusted first port of call

These services all expressed an interest in what happened to people after they had moved on to other services. None of the four had any formal means of tracking, but all made an effort to ensure there was at least some follow up contact with the key services to which they had referred a person. This meant that each of these services had at least some notion of the outcomes for their clients.

We observed on several visits that former service users would pop in to seek advice, and practitioners described this as being a regular event. One practitioner described this as a form of attachment, and argued that many clients of such services had histories of attachment problems, hence their poor engagement, but once they found somewhere that they felt listened to they attached to that, and were likely to return when in need. It was seen as a means of averting crisis and all four services were willing to support former clients in this way. Often all this involved was a brief chat and some phone calls.

Centre for Mental Health has observed this with other liaison and diversion services it

has visited, such as Divert in Reading, Elmore Community Services in Oxford and Together ‘s support for probation clients across London. All of these had frequent contact with former service users and saw this as important in averting a potential crisis. All such services did this in the absence of there being another system, service or person to provide this.

Service users stated that they would regularly call back into the see the team even if they were in regular touch with another service such as a community mental health team. In the case of CASS, Centre for Mental Health witnessed this across the three courts in which it works, even though this meant visiting a court building and passing through stringent security procedures.

Continuity and spanning boundaries

There is a small but growing literature on how the needs of those with multiple and complex problems can be supported both by practitioners and at a strategic level. This stresses the need for individuals at these different levels to be able to span different agency boundaries. Terms such as ‘Boundary Spanners’, ‘reticulists’ and ‘boundroids’ are used to describe these. A boundroid is someone who is particularly adept at spanning different agency boundaries, to form the connections and integrated care that some individuals require.

Across all four services the managers and practitioners put considerable effort into relating with other agencies for this very purpose. For at least the period that the service user was engaged with them considerable effort was put into supporting the person into additional services. This might involve extensive advocacy on a service user’s behalf at the referral stage or attending an appointment with the client to ensure the most was gained from it.

“Without having xxxx there I either go off on one or close down... I get too anxious and I don’t get helped on my own.”

- Service user

Although none of these services had been designed to provide long-term care, each service maintained a continuous relationship with

some people. For the two services that had been established the longest, this was most easily demonstrated. However, for some of the service users, continued need for support would be necessary and commissioners need to consider adding boundroids or boundary spanners to their thinking about provision for people with complex need.

Families and support networks

A common narrative for many of service users was that of having little or no supportive social network. Often connections with family had been broken. Some service users admitted being linked in with social networks they acknowledged as unhelpful as these maintained contact with others who actively misused substances and offended.

“It’s the trouble with being housed where I am... everyone knows me and where to find me... it’s so easy to slip back.”

“Until I came to this group I was very isolated. I didn’t know it you know. But it’s good. I don’t say much but if I got a problem they can all help me (referring to fellow members of a group)...”

- Fusion service user

Linking with families and supportive social networks was seen as vital by all services and we observed some engagement with families. However, the capacity for this was very limited and often depended on family members remaining willing to be proactive in supporting the service user.

Where there was no meaningful support network practitioners were more pessimistic.

“It would be great to be able to create that support. I think it would be good to develop a volunteer mentor scheme as part of what we offer.”

- Practitioner

Assertive and proactive support

The degree to which any of these services could be assertive was limited. Mo:Del had some limited capacity for those on its caseload, as had the Portsmouth team with its smaller caseload. Yet all four services recognised that for the sustained recovery of many of the people they saw there needed to be services designed and equipped to address the impact of multiple and complicated problems. They often required the services bringing to them or at the very least additional support to get maximum benefit from the services they did use.

“Some folk just need their hands holding and another set of ears to get the most out of a meeting.”

- Practitioner

Access to employment, accommodation, benefits and many services involves considerable wading through bureaucracy. This was a huge challenge for many of the service users and especially for those with poor literacy. However, what each of these teams was able to demonstrate was the ability to be proactive in every aspect of their work. This included seeking to understand the local social and health economy and then forming meaningful connections with as much of it as possible. But it also included understanding the service user’s needs, anticipating problems and being proactive in connecting the people they worked with into the support they needed. Much of this work was done on the phone, but it was nevertheless a vital part of what they offered.

A broad range of support

What is apparent is the emphasis that all these services had on understanding and addressing the full range of needs. Most of those service users who had been in touch with mental health or other services previously had found them to be primarily interested in one problem. In the case of mental health teams it was their presenting mental health problem. These services, when used in the past, might refer on to other services but those service users who experienced such ‘care’ found it disjointed.

What separated out these four services in their users' eyes was that they were perceived as being interested in what the service user felt was their priority, that they were pragmatic and dealt with issues concerned with daily living and gave these a high priority.

Service users also appreciated the considerable efforts the services put into attempting to provide integrated care packages and in connecting the person to them.

Support through the legal process

All of those we spoke to found their contact with the criminal justice system stressful and this stress sometimes meant it was difficult to follow what was going on, particularly in court. This sometimes manifested in ways that were unhelpful, such as anger or silence.

Several clients described their experience of what they felt was a punitive response by magistrates and judges to an outburst in court, which the service user stated was a result of stress.

"I don't mean it but when you're been talked down to, you're bound to lose it... then you're back in the cells."

- Service user

'Having ones hand held' was how several service users described the support these service provided, and this was seen as particularly important in court.

"It's quite funny really. She is really good at reading me and nudges me when she thinks I'm about to blow. The bizarre thing is I think they're (magistrate/judge) having a go but she translates once we get outside and it's not like that at all."

We witnessed service users being prepared for court, supported in there and having the procedures explained to them.

A small number of people interviewed had some degree of learning disability and understanding what was happening in court or in police stations was a major issue for them. Few had any experience of being supported or of advocacy prior to contact with one of these

services. The services were active in ensuring that those going through a legal process had an appropriate adult present, or made representations on the service user's behalf themselves.

Entry threshold

Each of the services had referral or entry criteria and for Mo:Del and Portsmouth Criminal Justice Team these were fairly typical of a mental health team. However, both of these services saw people who fell below traditional mental health thresholds and in the case of the former worked with the Hope project to provide some on-going support for a proportion of these.

CASS was established to work with people attending three magistrates courts, usually for lower level offences who had acknowledged their offence and agreed to see the service. Although its parent organisation is a leading mental health charity, the people CASS saw did not have to have a mental health problem, but most did.

Fusion also took referrals from probation (and more recently police) and while all would have a mental health problem, not all would have met traditional service entry thresholds, and many had histories of limited engagement with mental health services.

Supporting staff

Working with clients engaged in police cells or courts is stressful for staff and good supervision is crucial for their wellbeing. We observed all four services looking after their staff.

One of the best examples of a model of supervision for mental health practitioners working in criminal justice has been designed by Together for its forensic mental health practitioners (as described when visiting the liaison and diversion service at Thames Magistrates Court, East London):

- monthly reflective sessions among peers,
- monthly group supervision with forensic psychiatrist,
- monthly one to one supervision with a British Psychological Society accredited supervisor.

7. Conclusion

Complex and multiple needs are the rule and not the exception for those with mental health problems who come into contact with the criminal justice system. Yet few services have been established to address this need. It was clear from speaking to service users that they required a service that could not only assess their mental health or learning needs but could also address their accommodation and other basic needs.

Mental health interventions should go beyond medication and talking therapies, and arguably should include interventions that address environmental factors that have an impact on mental health which will at times be of a higher priority. Services need to be equipped, and truly psycho-social in nature to achieve this.

The people Centre for Mental Health met for this study were all substantially disabled by their multiple and complicated needs and yet the care systems they encountered did not recognise this. On the whole they encountered services that were ‘mono-problem’ oriented. Taken individually, their problems fell below thresholds for acceptance by a service, or even where they met a threshold this problem may be masked by others. This appeared to be a common occurrence when a severe mental health problem co-existed with substance misuse.

Recognising needs

The four services taking part recognised multiple need and put together packages of care to meet it. These packages were possible because each service had an encyclopaedic and up to date knowledge of their local health and social economies, and because each had formed relationships across those economies. This allowed them to create individualised pathways for the people they worked with. Doing this meant swimming against the tide as current commissioning arrangements did not address complex and multiple needs and were disjointed. Practitioners in these services felt there needed to be a commissioning architecture to support their work.

Another characteristic of these services was that through their ability to provide some case management, even over a limited time, they were able to link their clients into elements of their packages of care, rather than just refer and signpost on. Practitioners, people working in criminal justice services and service users all felt this linking or ‘hand holding’ aspect was a crucial factor in successful care.

For many service users we spoke to, their meeting with one of these four services was their first positive experience of a caring service. It was apparent from those we were able to follow-up that having this positive experience had made a difference to how they viewed other services. They appeared to be more willing to engage with other services as a result.

Reforms to NHS services

Recent reforms to the health commissioning landscape bring both opportunities and challenges. The formation of NHS England and its responsibility for health and justice services, means for the first time there is an opportunity to learn from the limited evidence and from good practice and incorporate this into more standardised approaches. For liaison and diversion this means that identification and assessment of poor mental health and learning disability can at last be standardised, and good practice can be shared through commissioning. Having a single specialist commissioner also makes it more likely that the outcomes of liaison and diversion will be measured.

The challenge for liaison and diversion in the current context is in the diversion. Diversion requires having somewhere to divert to, and as the experience of the service users in this study shows this means having a range of provision available. The diversion infrastructure is commissioned locally by over 200 NHS and 150 local government bodies. Each of these will have competing priorities and as the practitioners and managers we spoke to stated, providing services to people with an offender label may not be given priority. It needs to be recognised that people with mental health problems and

learning disabilities who come into contact with the criminal justice system do so often only briefly. The label of offender is neither helpful, nor accurate. These people consistently carry the burden of their complex and multiple need wherever they go, often using services but because of their need and the design of these services, to little benefit.

Crises were a part and parcel of the lives of many of the service users we spoke to and beyond these four services, there was seldom anywhere for them to seek help in a crisis or, when they had recognised the triggers, to seek help in averting a crisis. This is why many service users, even after discharge, would contact the services again when they had problems or felt a crisis coming on. A key element of the services' interventions was helping the service user understand their own patterns of behaviour and recognising as early as possible any crisis triggers. We observed several current and ex-service users dropping in to seek help. Often the intervention was brief, involving a conversation and some phone calls to reconnect the person with other services.

Enormous emphasis is rightly placed on liaison and diversion schemes screening and identifying mental illness and related conditions. Clearly much poor mental health goes unidentified and for many people valuable opportunities for intervention are lost. Most police stations and courts still have no access to the type of support described in this report. The National Liaison and Diversion Development Programme should, over the next three years, help to fill this gap.

The services described in this report go beyond identification and assessment and from their first contact they are intervening to ensure a sustainable future for their clients. Diversion and connecting their clients into other services that can meet their needs are part of the mission of these teams.

The keys to diversion

These are the key components of these successful liaison and diversion services.

- A comprehensive knowledge of local social and health economies and relationships with agencies across it.
- Engagement as a key activity.
- A psycho-social orientation.
- Immediate access (within team) to housing and benefits advice.
- Service user's view of their needs being at the core of their assessment.
- A focus on meeting basic needs first.
- Being sufficiently resourced to connect people to a range of services (this might include accompanying people to appointments).
- Pro-activity and assertiveness (services that are active and not just reactive to a clients needs and where possible offer not just a formal appointment based service).
- Providing some indefinite support with a focus on crises and educating service users on averting these.
- Providing a drop-in service after the initial intervention.
- An interest in outcomes and following up on referrals and sign-posting.
- Understanding the needs of police, probation and sentencers.
- Improving mental health awareness among criminal justice agencies and staff.

8. Recommendations

For NHS commissioners

- Clinical commissioning groups should identify a lead commissioner with a specific remit to coordinate care across agencies for those identified with multiple and complex needs. Such commissioners would have charge of a specific set of pathways for individuals meeting appropriate criteria. Within this remit would be the identification and long-term monitoring of those at higher risk or most persistent vulnerability.
- Commissioning of liaison and diversion services should provide for some ability to track individuals who receive services. This ought to be part of the performance monitoring and will give some indication of outcome.
- User experiences and perception should influence commissioning decisions.
- Liaison and diversion services should be commissioned to provide an element of indefinite support, in the form of drop-in support focused on averting crises and reconnecting service users with mainstream services where required.
- Strengthening positive social networks in the service user's community is a vital part of the diversion infrastructure. This should include a capacity to intervene with and support families and the provision of alternatives such as volunteer mentoring to fill gaps in the support available.
- Local NHS commissioners need to ensure that offenders have timely access to psychological therapy services with clear referral routes from liaison and diversion services and from probation.

For liaison and diversion services

- Effective liaison and diversion requires robust systems to identify people coming through criminal justice services with poor mental health and learning disabilities. Liaison and diversion teams need to be able to assess for a broad range of psycho-social needs.
- Effective liaison and diversion requires an emphasis on engagement as many of those it will want to target will have had previous poor experience of engagement with mental health and other professionals and services.
- Effective liaison and diversion needs to be personalised to the individual, with an infrastructure in place to respond to their needs from a range of different agencies. In addition to screening and identifying people with a specific range of problems, liaison and diversion teams should act as connecting services, offering gateways to a range of services. To do this they require staff who can span agency boundaries to negotiate personalised packages of care.
- Liaison and diversion services need to offer access to housing and benefits advice as part of the initial intervention.
- Liaison and diversion services, where staffed by appropriately qualified mental health practitioners, should act as a gateway for secondary care. Onward referral and assessment should only be required in exceptional circumstances (for example to specialist services such as forensic services).

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Keys to diversion

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