



Liaison and Diversion Services: Current practices and future directions

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The **Offender Health Research Network** is funded by Offender Health at the Department of Health, and is a collaboration between several universities, based at the University of Manchester. It was established in 2004 to develop a multi-disciplinary, multi-agency network focused on offender health care innovation, evaluation and knowledge dissemination.

Authors

Report prepared by

Jane Senior, University of Manchester.
Charlotte Lennox, University of Manchester.
Heather Noga, University of Manchester.
Jenny Shaw, University of Manchester.

Address for correspondence

Dr Jane Senior
Offender Health Research Network
Centre for Mental Health and Risk
Room 2.317
Jean McFarlane Building
University of Manchester
Oxford Road
Manchester
M13 9PL

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Executive summary

Liaison and diversion services designed to divert people with mental illness away from the criminal justice system have proliferated in England and Wales over the last twenty years. 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.

Current government policy supports the continued development of liaison and diversion services if they can prove a significant contribution to reducing criminal recidivism and improvements to both individual and public health.

Offender Health at the Department of Health commissioned the Offender health Research Network to review current practices around liaison and diversion and make a number of recommendations for future service development.

We concluded that liaison and diversion schemes provide a service for clients who are currently not always well served by mainstream health and social services, but there appear to be opportunities for service improvement through a standardisation of approach; a national model of practice; improved data collection; and more consideration to the conduct of ongoing evaluations into service impact and outcomes.

Glossary

AMHP	Approved Mental Health Professional
ASHNO	Assessment Health Needs of Offenders
ASW	Approved Social Worker
ACPO	Association of Chief Police Officers
CAN	Camberwell Assessment of Need
CPA	Care Programme Approach
CfH	Connecting for Health
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CJS	Criminal Justice System
DH	Department of Health
ESP	Emergency Screener for Psychiatry
FME	Forensic Medical Examiner
GHQ	General Health Questionnaire
GAF	Global Assessment of Functioning
GP	General Practitioner
HO	Home Office
HoNOS	Health of the Nation Outcome Scales
IT	Information Technology
IDTS	Integrated Drug Treatment System
MHA	Mental Health Act
MHTR	Mental Health Treatment Requirement
MoJ	Ministry of Justice
NPIA	National Police Improvement Agency
OASys	Offender Assessment System
OHRN	Offender Health Research Network
PNC	Police National Computer
PCT	Primary Care Trust
PSQ	Psychosis Screening Questionnaire
RAI-MH	interRAI Mental Health System
ROC	Receiver Operating Characteristic

RDS	Referral Decision Scale
SCAN	Schedule for Clinical Assessment in Neuropsychiatry
SCID	Structured Clinical Interview for DSM-IV
SMI	Severe and Enduring Mental Illness
TAG	Threshold Assessment Grid

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1 Aims and Objectives

The presence of people with mental illness in the England and Wales prison system has been of concern for several centuries (Howard, 1777). In 1990, the Home Office (HO) issued guidance to courts, reminding them of existing powers to divert people with mental illness away from criminal justice system (CJS) processes, into health and social care, where no public interest was to be served by continuing prosecution (HO, 1990). More recently, an independent review into diversion from custody for offenders with mental health problems or learning disabilities was published, making recommendations to government about the organisation of effective court liaison and diversion arrangements and the services needed to support them (Bradley, 2009).

Subsequent to the Bradley Report, the Department of Health (DH) published a national strategy for offender healthcare, *Improving Health, Supporting Justice* (DH, 2009). The strategy focussed on key stages in the offender pathway with specific development priorities, including liaison and diversion services. Similarly, the current Ministry of Justice (MoJ) Green Paper, *Breaking the Cycle* (MoJ, 2010), set out plans for fundamental changes to the CJS, with specific reference to liaison and diversion services, stating that the MoJ would work with the DH to improve the efficacy of diversion for minor offenders with mental illness and drug dependency, into treatment and away from prison, as long as public safety was not compromised. The paper stated the intention to pilot and roll out liaison and diversion services nationally by 2014 for mentally ill offenders and to independently evaluate those services in terms of their effect upon re-offending.

Earlier this year, the DH established a national development network of liaison and diversion services which, following some recent service reconfigurations, currently comprises 21 "Pathfinder" sites and 27 "Development" sites. Services were ascribed to one of the two categories based on their responses to a questionnaire from the DH which identified services' current practices and approaches to a number of key activities, including screening, assessment, referral, multi-agency working, information sharing, commissioning and governance arrangements and financial sustainability.

"Pathfinder" sites were those judged to have well developed practices in all, or the majority of, the key areas. Those allocated to "development" status were acknowledged to have gaps in current practices. The DH intends the liaison and diversion service national development network to become the conduit through which best practice initiatives can be identified and evaluated; appropriate quality and outcome standards can be developed; and services can be prepared to take part effectively in the planned independent evaluation of their impact on both individual and public health outcomes.

To support the DH's work in this area, the Offender Health Research Network (OHRN) was commissioned to identify current liaison and diversion schemes' practices in a number of key areas and to make recommendations to inform on-going developments. This report represents part of this work and focuses particularly on screening practices, triage and assessment processes, onward referral and data collection. Information gathered directly from the sites has been augmented by existing research evidence with the aim of producing a balanced picture of current knowledge.

2 What is Liaison and Diversion?

A fundamental problem for those providing liaison and diversion services is that of a lack of universally agreed core definitions, especially in terms of which key patient groups and/or conditions are included or excluded from services, and what services could and should provide at different points along the offender pathway. Clarity of such issues contributes to the management of realistic and unrealistic service expectations, including helping to determine what success should “look like” and, therefore, how it could be measured.

Bradley (2009) argued that, in terms of diversion, the target population of mentally disordered offenders had yet to be clearly defined, an issue further compounded by differences in the terminology used across different agencies. To clarify the issue, Bradley offered the following definition of diversion, whereby

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

(Bradley, 2009)

Recent reviews of diversion services also include reference to the activity of “liaison”, described by Winstone and Pakes (2010) as a set of processes including information exchange with other health professionals, criminal justice agencies, community providers and the third sector; activities which support access to services to meet social and health needs as well as address dynamic risk factors, for example making telephone calls, arranging appointments, transport, mentoring, support with paperwork, etc.; and advice and reporting to court or police and other relevant agencies.

The Sainsbury Centre for Mental Health (2009) noted that a distinction may be drawn between diversion as an *outcome* and diversion as a *process*. Diversion in the former sense relates to an intended set of aims or objectives, for example reducing re-offending and improving mental health, while diversion in the latter sense refers to the activities and interventions which are used to achieve the desired outcomes.

A further distinction is to be made between diversion *away* from something and diversion *towards* something else. Diversion as an outcome is generally taken to mean diverting someone *away* from criminal activity and *toward* improved mental health and a better quality of life overall. Diversion as a process means diverting someone *away* from the CJS or from prison and *toward* community-based mental health treatment and other support services.

Finally, there is a distinction between diversion *from* the CJS and diversion *within* the CJS. The initial focus of diversion schemes in this country was largely on taking people with severe mental illness out of the CJS altogether and into hospital. However, only a minority of people in contact with the CJS with mental health problems are sufficiently ill to require hospital treatment and thus increasing attention is now given to diversion within the CJS, particularly away from options which involve the use of custody toward sentences which allow supportive mental healthcare to be provided to offenders in the community.

As noted by Winstone and Pakes (2010), most diversion schemes now also play a wider role in offering support and liaison, both to offenders with mental health needs and to the agencies involved with them. Schemes are therefore often described as liaison and diversion schemes. The Sainsbury Centre for Mental Health (2009) regard liaison as a form of diversion, particularly in the outcome sense, i.e. steering people *away* from crime and *towards* better mental health.

In terms of this report, we have primarily adopted the Bradley (2009) definition of diversion, as we feel it usefully reflects the widest definition, acknowledging the varied core tasks of successful diversionary activity, namely the assessment and identification of health and social care needs at the earliest possible point, followed by decisions about suitable treatment, appropriately balanced by considerations of risk.

3 Method

At the same time as this work was undertaken by the OHRN around clinical practices relating to diversion from the CJS for people with mental illness, the NHS Connecting for Health (CfH) work programme had been tasked by Offender Health at the DH to examine whether the work of diversion schemes could be usefully improved through increased access to information technology (IT). Thus, to minimise disruption for the schemes during the process of information gathering, most site visits were conducted jointly with CfH colleagues. Prior to the first visit, a semi-structured interview schedule was agreed between the two organisations (Appendix 9.1). All sites were asked these questions, with further clarification of local practices obtained through supplementary questioning.

The main focus of the OHRN's work was to identify referral processes, methods of screening for mental illness and subsequent assessment and onward referral processes. We asked all sites to provide copies of any service-relevant documents including operational policies, screening and assessment tools/templates, risk assessment tools, demographic data sheets and any standardised/minimum datasets completed. Details of the sites and the service documents received are included as Appendix 9.2.

Information gathered during the site visits was compared, contrasted and augmented by data obtained from other sources, including international research literature, good practice guides and central policy documents to suggest best practice at each point of the diversion pathway. Site visits and subsequent data analysis were undertaken by an experienced clinical researcher, with professional experience of delivering and managing diversion services, a research associate with experience in clinical risk management, assisted by a research assistant undertaking work on a related OHRN project examining best practice around screening for mental illness in police custody with specific reference to "out of hours" provision.

The OHRN successfully contacted all the Pathfinder sites. In the majority of cases, we conducted a joint site visit with CfH colleagues. Toward the end of the data collection cycle, a number of sites were contacted by telephone rather than face to face. This was a largely pragmatic solution to enable us achieve project deadlines. However, after the majority of visits had been completed face-to-face, it was clear that little new information regarding ways of working were likely to emerge, thus the final telephone interviews were used to further augment information in areas where most diversity of approach existed.

4 Recommendations from previous reports

Both historically and currently, it has been described that people with mental illness have been detained inappropriately in prison in our society (Gunn, Maden & Swinton, 1991; Howard, 1777; Reed, 1992; Sainsbury Centre for Mental Health, 2008; Singleton, Meltzer & Gatward, 1998). In 1990, the HO reminded courts of the powers already at their disposal to divert mentally disordered offenders away from the CJS (HO, 1990). Home Office Circular 66/90 stated that, where no public interest were to be served by pursuing a conviction for a minor offence, people with mental illness should instead be channelled into treatment services with the primary aim of improving their health. The document also stated that a mentally disordered person should never be remanded to prison simply to receive medical treatment or assessment, thus indicating a clear need for systems facilitating early assessment of mental health treatment needs.

As noted above, the document did not describe the requirement for any new or extended powers; rather it sought to remind the judiciary and magistracy of their existing responsibilities to ensure people with mental disorder were diverted appropriately. In accord with current offender health policy, Home Office Circular 66/90 clearly highlighted that success in this area was likely to be predicated upon co-ordination and a shared sense of purpose between health and criminal justice agencies working together to achieve best outcomes for clients.

In 1992, the Reed Report (Reed, 1992) explored further the practicalities of mentally disordered offenders being cared for in health and social care services, rather than being processed through the CJS. Reed argued that closer working relationships between the police, prison, probation, health and social services would help avoid unnecessary prosecution of mentally disordered individuals. Based on this assumption, Reed emphasised the importance of developing a flexible multi-agency and multi-professional approach to most effectively identify and meet the needs of mentally disordered offenders. The review also stressed the importance of providing an improved range of community care services as alternatives to prosecution. The most significant legislative proposal within the Reed Report was intended to remove or restrict courts' powers to remand to prison for the primary purpose of medical assessment

"In principle it is wrong that courts should be able to remand to prison for the primary purpose of medical assessment. It is also an unjustifiable use of the prison system. ... Achieving a policy aim of diverting the mentally disordered from prison requires not only alternative provision but also a restriction in the powers and incentives which encourage existing bad practice to continue. Most of the mentally disordered entering the remand prison population have been remanded by magistrates courts for medical reports."

(Reed Report, 1992)

Similar to the multi-agency working model promoted by Reed (*op.cit*), Home Office Circular 12/95 (HO, 1995) sought to embed inter-agency working for mentally disordered offenders and placed specific responsibilities upon each agency within the CJS to help ensure effective partnerships would take place. These included:

- Asking police services to develop arrangements for mental health assessments to be conducted by a mental health professional for those detained in police custody and those detained under Section 136 of the Mental Health Act (MHA, 1983);
- Asking probation services, in co-operation with other agencies, to ensure that, where possible, there were viable alternatives to prison custody and that information about such alternatives was made available to courts before and after the conviction of a mentally disordered offender;
- Asking magistrates and judges, when making decisions, 'to bear in mind that custody is an inefficient means solely to obtain medical records or to meet treatment needs'; and
- Asking justice clerks to consider developing mental health assessment schemes based at magistrates' courts.

Attention was also paid to the vital need to share information, subject to legal requirements surrounding confidentiality, between criminal justice, health and social services and the independent sector to better manage offenders' needs and associated risks.

The circular also gave generic guidance around joint working arrangements that needed to be incorporated into future partnerships. These included:

- The need for all agencies to understand one another's ethos, framework and constraints within which they operated;
- The need to identify training needs and, whenever possible, promote and encourage cross-agency training;
- The need to monitor the effectiveness of arrangements both within and between agencies; and
- The need to nominate a lead agency to provide a co-ordinating role.

The publication of Home Office Circular 66/90 (*op. cit*) can be considered as marking the beginning of the modern era of active work around diversion away from the CJS for mentally disordered individuals. Since 1990, services aiming to divert people away from the CJS and into health and social care have developed widely across England and Wales. These services have proliferated in the absence of a national model of expected, or best, practice, thus what they "look like" has been locally determined, often based upon the views of early clinical managers who established services where none previously existed. Services are currently funded from a range of sources and have a mixture of clinical and organisational allegiances; for example, some are off-shoots of in-patient or community forensic mental health services, some are based in adult general mental health services and some are provided by third sector organisations.

What is perhaps particularly noteworthy is that, over 20 years on from Home Office Circular 66/90, there is no particularly strong national, or indeed international, research evidence base to inform the continued proliferation and expansion of diversion services. The development of a robust evidence base to allow a move from the current, rather intuitive, belief in diversionary activity as a "good thing" is acknowledged by the Bradley Report (*op. cit.*) as a pressing need. Of the research that has been published, most studies do not evaluate anything other than immediate outcomes through, for example, the reporting of short-term routine data, for example numbers of clients seen and types of immediate disposal. Other types of evidence consist of

papers commonly written by practising diversion clinicians, frequently offering qualitative, process-driven descriptions of the services they offer, often without any meaningful or objective critique of their work.

James (1999) conducted a review of all published and unpublished literature on court diversion schemes, including editorials, surveys and audits, since 1990. He concluded that court diversion could be highly effective in the identification and admission to hospital of mentally disordered offenders but that most court diversion services were inadequately planned, organised, or resourced. The author concluded that there was a need for a central strategy, with properly designed and adequately supported court services incorporated into mainstream local psychiatric provision.

Chung et al. (1999) aimed to investigate offenders' living patterns, quality of life, types of aftercare received and psychological well-being following their diversion from one court-based scheme in the UK. Offenders completed the Diversion Interview Schedule, a questionnaire developed by the research team. The aim was to gather information about offenders' present living situation, employment, education and involvement with health and social services. Participants also completed the Life Experiences Checklist, incorporating sections on home, leisure, relationships, freedom and opportunities as indicators of quality of life. Finally they completed the General Health Questionnaire (GHQ; Goldberg, 1992), a screening instrument to estimate the likelihood of respondents being judged as a psychiatric "case" at interview. During the six-month study period, 961 offenders were arrested and held overnight to appear in court the next day. Of these, 189 (20%) were screened and interviewed by a community psychiatric nurse (CPN). They were then followed up at six and twelve months. After six months only 65 (34%) could be traced and at one year only 22 (35%) could be followed up. At six-month interview, four (18%) were employed on a part-time basis; at one year follow-up, two of this four had lost their jobs, and one offender who was not working at six-months was employed. Results of the Life Experiences Checklist and the GHQ showed that life had improved between the six and twelve month follow-ups, but the improvement was not statistically significant. Only half of offenders had regular contact with a general practitioner (GP) at both six and twelve-month follow-up. At six months 38% were living in their own home but at the twelve month follow up only around half of these were still living at home. The research team concluded that an out-reach programme which aimed to improve offenders' quality of life, whilst important, was extremely difficult to execute and that programmes needed to be flexible to take account of offenders' lifestyles and multiple needs.

James & Harlow (2000) evaluated a new, concentrated, psychiatric diversion scheme at a magistrates' court in Inner London which served a population of 500,000. The model involved a fully staffed team of two consultant psychiatrists, an Approved Social Worker (ASW), a full-time administrator and a research worker. The scheme had direct access to both open and secure mental health in-patient beds. A one-year prospective study of 264 consecutive referrals to the scheme was undertaken, with access to police custody records, magistrates' court returns, hospital admission data and remand prison transfer records. Of the 264 cases, 60% were admitted to hospital. Over the period of study, this single scheme instigated 12.8% of all the unrestricted hospital orders in England under section 37 of the MHA 1983, 4.2% of section 35 orders, and 6.4% of section 48 and 48/49 remand prisoner transfers. Of all arrests in the central London area, 0.46% were referred to the scheme, with 0.28% being admitted to in-patient care. Gravity of criminal charge had no significant effect on whether or not hospital admission was achieved. The study concluded that the new model was a powerful intervention in the assessment and diversion of mentally disordered offenders and that similar, supra-district, diversion centres

may have a role to play in other parts of the country, complementing local diversion activity, some of which might better be relocated to the police station.

In 2005, Nacro published findings of a survey of court diversion and criminal justice mental health liaison schemes in England and Wales. The survey did not seek to critically evaluate the effectiveness of the schemes; rather it aimed to gain a clearer picture of the geographical distribution of such services. A questionnaire was sent out in November 2004 to the 143 contacts associated with court diversion schemes listed following a similar survey the previous year; 64 questionnaires were returned. All schemes reported feeling confident that courts followed their recommendations to divert people to hospital but were less likely to accept recommendations for community treatment. A quarter of the schemes said that they had seen a decrease in staffing levels in the previous year. Half reported having no sessional input from a psychiatrist or psychologist and 41% said they had trouble obtaining psychiatric reports. Seventy-two percent cited a lack of available in-patient beds as a barrier to successful operation. Over three-quarters of schemes (78%) collected some routine data, however this was variable; for example, half of schemes that were collecting data did not routinely record client ethnicity and 42% did not collect data on gender (Nacro, 2005).

The Centre for Public Innovation (2005) published a brief review of ten court liaison and diversion schemes, sampling from the Nacro database. The sample was selected in conjunction with Nacro to reflect a range of characteristics, for example "virtual" vs. "actual" teams; urban vs. rural; medical model vs. non-medical model; peripatetic vs. court based; multi-disciplinary vs. single staffed teams; reactive vs. proactive approaches; Monday – Friday services vs. once/twice weekly services; and/or successful vs. less successful (based on Nacro's experience).

The team completed on-site visits to each scheme, conducting semi-structured interviews with staff. In addition, other relevant information e.g. service protocols, statistics and annual reports was gathered. They concluded that the schemes were providing a supportive service to a group of individuals who might otherwise not be accessing appropriate mental and social care. However, wide variety was noted in the quality of services, practices employed and sources of funding. Success was noted to be heavily dependent upon the energy and commitment of the individuals involved and the majority of schemes lacked clear aims, objectives or targets with no performance management in place. Schemes had clearly identified pathways for referral but the success of these was hampered by poor or weak integration with local mental health services and they were disconnected from court psychiatric report arrangements.

The review noted that, whilst it was possible to identify what the schemes "did" on a day to day basis, it was much less easy to identify outcomes and success. The authors suggested that the review supported the need for improved local needs assessments to ensure service provision matched need with better performance management and monitoring. They also recommended better matching of resources to high volume courts and improvements to management and integration within NHS primary and mental health services.

Kingham and Corfe (2005) examined the activity of the East Sussex Court Assessment and Diversion Scheme over a three year period from 1st January 2000 to 31st December 2002. During this period there were 1,830 referrals to the scheme, predominantly made by the police (71%). Twenty percent of referrals were individuals remanded by the court on bail and 8% were individuals remanded in custody by the court. The majority were men (n=1,607; 88%). Six percent of referrals were people from an ethnic minority. The most common primary diagnoses were drug misuse (19%); alcohol misuse (12%); schizophrenia (11%); and personality disorder (9%). A fifth of individuals were assessed as having a secondary diagnosis, most frequently

substance misuse problems (12%). Two percent of all referrals had a co-morbid personality disorder. Following assessment, for 52% of individuals there was no recommendation regarding diversion or liaison. Where a recommendation for treatment was made, this was most commonly a referral for a community intervention (43%). Seven percent were admitted to hospital. The researchers concluded that similar to findings in other liaison schemes, there were high rates of alcohol and drug misuse but that the proportion of people diagnosed with a major mental illness varied greatly between studies. They stated that, in their study, referring agencies generally recognised the presence of mental disorder reasonably accurately; 70% of those referred warranted a diagnosis. However, it is not known how many people with mental disorder were not referred, thus remaining unrecognised.

In 2009, the Sainsbury Centre for Mental Health published *'Diversion: A better way for criminal justice and mental health'*. In this report they visited a number of diversion schemes and made a series of recommendations, including that:

- Each Primary Care Trust (PCT) area should establish a liaison and diversion teams for people with mental health problems who come into contact with the CJS, jointly funded from health and criminal justice budgets and overseen by a cross agency management group;
- Teams should be supported by a national statement of policy and associated implementation guidance;
- Teams should be organised to support offenders with mental health problems at all stages of the criminal justice pathway;
- Teams should extend the use of pro-active methods of identifying potential clients, including 100% screening of selected groups of offenders;
- Liaison and diversion teams should work more closely with drug intervention programme teams in identifying potential clients;
- Government should consider the scope for improving the identification of mental illness by police officers, court officials and other criminal justice staff, including the provision of improved mental health training;
- All liaison and diversion teams should undertake out-reach work as a core part of their business to ensure that their clients engage satisfactorily with local services;
- Commissioners and managers of all community-based mental health services should ensure that a potential client's offending history does not act as a barrier to receiving services;
- PCTs and other commissioners should actively explore the scope for using voluntary sector agencies to provide support for offenders with multiple 'sub-threshold' needs;
- The DH and PCTs should develop new methods of primary care support for offenders with complex needs and other similar groups;
- In appropriate circumstances, criminal justice agencies should make greater use of conditionality in decisions relating to charging, remand and sentencing as a means of promoting engagement with mental health services by offenders;
- More use should be made of the Mental Health Treatment Requirement (MHTR) as a sentencing option; and
- The Government should collect and publish much more information on unit costs in the CJS.

In 2010, Winstone and Pakes completed a best practice guide for liaison and diversion. They highlighted a number of issues faced by currently operating schemes including a lack of comprehensive screening; insecure funding arrangements; unclear and/or inadequate reporting structures; lack of opportunities for staff training or personal development; poor managerial support; poor or absent governance structures; and a lack of data collection and analysis. They also identified a lack of staff confidence around clients with learning disabilities; continued issues around those with substance misuse and/or dual diagnosis falling between gaps in services; and a lack of specialist services for onward referral or strict admission criteria which serve to exclude, rather than include, complex clients.

The authors concluded that current provision

"raises two main policy issues. The first concerns the establishment of services where currently there are none. The second challenge is to transform a pattern of uneven provision into coherent national delivery."

(Winstone & Pakes, *op. cit.*)

Most recently, Dyer (2011) produced a report to inform the North East Offender Health Commissioning Unit's plans to procure an integrated range of liaison and diversion services as part of the regional BIG Diversion Project. She reiterated many of the challenges with service delivery identified by previous reviewers, including unclear service objectives; a lack of national policy guidelines; patchy coverage of services; different models of service not necessarily driven by identified need; and, crucially, a lack of attention or guidance regarding how to measure the impact of diversion services. A number of explanations are offered as to why the original diversion ideal has failed to clearly fulfil its early promise, including the lack of targets which would have accompanied a centralised strategy; the sheer number of possible sites for interventions, including police stations, courts, and prisons; a lack of enthusiasm among some clinicians; a paucity of resources, including a lack of dedicated funding; a lack of robust management structures and limited integration into mainstream services; insufficient viable "alternatives to custody", especially appropriate community provision; and an over-arching lack of consistency or clear understanding about what makes a "good" scheme.

5 Findings

5.1 Overview of the Evaluation Pathfinder schemes

Our information gathering across the 21 Pathfinder schemes confirmed all the service design and provision problems outlined in the recent reviews of diversion (e.g. Dyer, 2011; Winstone & Pakes, 2010; Sainsbury Centre for Mental Health, 2009). Each problem was routinely identifiable at multiple sites.

Service provision

Overall, there were clear examples of practices common to all, or the majority, of diversion schemes. Of the 21 Pathfinder schemes, five provided interventions based in police custody suites only and four in magistrates' courts only. A further 12 covered both police custody and magistrates' courts. Generally schemes covered the 'normal' working week i.e. Monday to Friday, 8/9am to 4/5pm. Two schemes offered extended weekday hours, two provided some weekend/Bank Holiday cover and one offered 24 hour on-call cover. The Mersey Care NHS Trust Criminal Justice Mental Health Liaison Service offered the most extensive coverage, with a seven day service, 9am to 5pm, and an on-call service at all other times. Schemes based only in magistrates' court appeared to offer the most limited service times; most operated on fewer days than their respective courts.

Funding

Funding arrangements were often apparently complex with service managers frequently expressing concern around long-term funding sustainability. Some schemes were funded from other, larger, budgets, for example their host trust's forensic services, but with no sense of their funding being a "ring-fenced" portion of the whole. Some schemes reported having been subject to funding cuts within the previous 12 months. Staff who worked across services, for example operating the liaison and diversion scheme alongside a community or forensic caseload, reported inequalities in time allocation to each function.

Core tasks

The visits highlighted a set of core tasks which the majority of schemes undertook. In broad terms these included accepting referrals from other health and criminal justice staff; undertaking an information finding exercise through local NHS mental health trust electronic records systems; undertaking an initial assessment; onward referral to community mental health, social care and/or substance abuse agencies; information sharing with a person's GP; and providing information to court staff in terms of any treatment recommendations formulated following assessment.

In addition to these core tasks, a minority of schemes conducted initial face to face screening of all detainees (recommended by Sainsbury Centre for Mental Health, 2009; Winstone & Pakes, 2010; Dyer, 2011); short or medium term follow up of clients following initial assessment; specific treatment interventions with clients; maintenance of an ongoing caseload; assessments for detention under the Mental Health Act (MHA); acting as Appropriate Adults for vulnerable detainees; assessments of clients already detained in prison custody; and/or clinical involvement in the cases of people detained for the safety of themselves/others under Section 136 of the MHA, 1983.

Inclusion and exclusion criteria

Each scheme had a slightly different definition of what types of people/issues were appropriate for their services, impacting directly on their inclusion and exclusion criteria. All schemes sought to identify mental health problems; however, for some schemes this was narrowly defined as severe mental illness, while others adopted a broader focus. Commonly, schemes felt it inappropriate for them to intervene where the issue was substance misuse without an accompanying mental health problem. Similarly, needs arising from an identified or suspected learning disability were generally felt to require input from specialist services.

Most commonly, the target population appeared to be generally agreed as those with severe and enduring mental illness (SMI), requiring, or in receipt of, secondary mental health care services. However this did vary across schemes; for example, Derby Criminal Justice Mental Health Team (see Figure 1) and West London Magistrates' Court Criminal Justice Mental Health Team (see Figure 2) have very broad definition for inclusion, which can be contrasted with the Reading DIVERT team's more narrow definition (see Figure 3).

Figure 1. Examples of client group definitions - Derby Criminal Justice Mental Health Team

Derby Criminal Justice Mental Health Team

Those who come into contact with the criminal justice system because they have committed, or are suspected of committing a criminal offence and:

- who may be acutely or chronically mentally ill;
- who have neuroses, behavioural and/or personality disorders;
- who have a mental health problem as a function of alcohol and/or substance misuse;
- who are recognised as having a degree of mental disturbance, even if this is not sufficiently severe to come within the Mental Health Act criteria;
- has a history of self-harm/risk of self-harm;
- has a history of contact with mental health services;
- it is considered the circumstances of their offence is unusual;
- it is considered their behaviour in custody has been unusual;
- criminal justice staff have concerns about their mental health; or
- the person is known to the team

Figure 2. Examples of client group definitions - West London Magistrates' Court Criminal Justice Mental Health Team

West London Magistrates' Court Criminal Justice Mental Health Team

It is anticipated that when the team are asked to assess someone in the Criminal Justice System one of the following clinical presentations will usually be present;

- Psychosis, Schizophrenia or Schizoaffective Disorder or Persistent Delusional Disorder;
- Mood Disorders, Bipolar Affective Disorder, Major Depression and chronic depression where primary care interventions have not met an individual's needs;
- Learning Disability

These clinical conditions may also meet the criteria for inclusion within secondary mental health services and where assessment suggests that the individual needs and is likely to benefit from specialist mental health intervention and is able to engage in the service a referral may be made.

- Personality Disorder
- Severe Neurotic Disorders
- Post Natal problems
- Dependence on drugs or alcohol, alongside significant mental health problems.

With an open referral gateway the team may also be asked to see those people who have:

- Significant risk of self harm, harm to others, risk of harm from others, or serious self-neglect;
- Inability to self care, or sustain relationships.
- Recurrent crisis leading to frequent admissions / interventions
- Significant risk of imprisonment, loss of supportive relationships
- Have difficulty accessing or using mental health services.
- Inability to self care, or sustain relationships.

Figure 3. Examples of client group definitions - Reading DIVERT Team

Reading DIVERT Team

Individuals who meet the following criteria will be seen as soon as possible

- having a mental illness or behavioural disorder of nature and degree requiring treatment;
- the individual is being processed through the criminal justice system;
- they are over the age of 18 years;
- unable to assess individuals with learning difficulties defined as an IQ of 70 or less.

5.2 Referral and Screening Processes

Referral

There are two main referral routes to the Pathfinder diversion schemes and teams used either one, or a combination of both, methods.

- a) Each (usually) week-day morning a staff member from the scheme receives a list of all people held in police custody overnight and/or, if court based, a list of all those expected to appear that day. Lists are either routinely supplied to teams (e.g. by fax) or are collected from police or court staff in person.
- b) A referral regarding a particular individual is received, based on the referrer's concern about that person. Concerns may arise from current or past interactions with the person, or from health or risk information received or recorded, for example on the Police National Computer (PNC). Each detainee in police custody is asked routinely a number of health and risk questions at the start of their detention; responses are recorded on the PNC and thus may prompt a referral to a diversion service:
 - Do you have any illness or injury?
 - Have you seen a doctor or been to hospital for this illness or injury?
 - Are you supposed to be taking any tablets or medication?
 - What are they? What are they for?
 - Are you suffering from any mental health problems or depression?
 - Have you ever tried to harm yourself?

(Association of Chief Police Officers [ACPO], 2006)

Teams reported that, most commonly, such referrals came from police and court custody staff, but may also be received from other agencies, for example Probation or Social Services, Community Mental Health Teams (CMHTs), solicitors, magistrates or, uncommonly, and where permitted, by a detainee themselves.

Clearly, the identification of people of potential concern by non-clinicians is affected by a number of factors including the appropriateness of their training in mental health issues; their personal and professional confidence in adopting a welfare or health oriented approach within their CJS role; and whether or not they receive support to do this from their organisation and management cultures. Recently, McKinnon and Grubin (2010) assessed the efficacy of health screening procedures by police officers. They found that current police screening procedures detected only a limited proportion of active health problems; for example the custody risk assessment questions identified 21 people with depression whereas Forensic Medical Examiner (FME) records identified 40 out of 307 detainees. Similarly, 113 individual drug and alcohol problems were recorded by the custody risk assessment, compared to 202 identified by the FME.

Screening

Following referral, the next stage in the care pathway is to complete a screening exercise to inform the decision-making process around who warrants a full assessment. Winstone and Pakes (2010) note that screening is “regularly confused with a ‘quick scan diagnosis’ of mental illness”, but that screening should instead

“aim to identify either common or severe and treatable mental illness within a population...not to decide whether an individual is actually diagnosable but to support timely decision making regarding those individuals who test ‘positive’ i.e. with whom at first sight something is wrong. In addition, protocols should be in place, to decide what should happen in relation to individuals who test positive.”

Winstone and Pakes (*op. cit.*) differentiate between indirect and direct screening. Current screening practices consist predominantly of indirect screening whereby, following notification of all people in custody/court and/or individuals thought to be of concern, teams routinely then check one or more (usually electronic) records systems, commonly those of the secondary mental health trust to gather evidence of any past/current service contact. Additionally, contact may be made with a range of other sources, for example GPs, Social Services, substance misuse services, CMHTs, all with the purpose of gathering as much detail of service contact and likely clinical and/or social needs as possible.

Teams expressed the value of this information gathering exercise in guiding their decision about whether or not to see someone face-to-face, but also noted that the process was time consuming. For example, receiving responses to enquiries frequently took several hours per individual, during which time a person could be released without charge, bailed or otherwise dealt with, thus leaving court or custody without being seen in person. Additionally, all schemes who undertook this activity based their indirect screening on lists provided first thing in the morning, therefore people detained later in the day, but not then held in overnight custody, were missed completely.

We did not identify any Pathfinder scheme which routinely undertook direct screening all individuals. Similarly, none of the schemes screened those referred by another professional as a first action, i.e. before any indirect screening by information gathering. No scheme used a stand-alone standardised, validated screening tool as a direct screening tool; the nearest to this was the Nottinghamshire scheme’s inclusion of the Threshold Assessment Grid (TAG; Slade et al. 2008) as part of their Custody Assessment Form.

Current practices around screening appear to be sub-optimal for a number of reasons. Effective screening should aim to identify individuals who have a suspected mental health problem, signposting someone into a clearly identified pathway to ensure fuller assessment and identification of needs. A successful early screening process therefore offers potential benefits for both health and criminal justice services as, accurately done, it should provide a way of appropriately filtering individuals into and, of equal importance, away from, more time consuming clinical assessments and/or interventions.

In addition, the use of structured, validated screening tools for direct screening could provide a suitable opportunity for screening to be undertaken by people other than mental health clinicians, for example appropriately trained police officers or nursing staff providing physical healthcare to detainees. This could further streamline the process of referral to mental health services and offer improved inclusion for people detained beyond the limited operational hours of liaison diversion schemes discussed above. Training to undertake this task could be developed as an

extension to the current guidance contained in The National Police Improvement Agency (NPIA) briefing note on *Responding to People with Mental Ill Health or Learning Disabilities* for the police which provides 'best practice' advice on warning signs police officers should look out for, and what information should be recorded (NPIA, 2010).

Using past contact with mental health services as a method for screening people is fundamentally flawed, especially with this client group. Firstly, clinical IT systems which Pathfinder schemes access routinely are local or regional in their coverage, but people in contact with the CJS often live very itinerant lives. Consequently, as an example, checking a London-based clinical system for someone with an extensive history of service contact in Merseyside will return a false negative.

Secondly, people in contact with the criminal justice do not easily or consistently establish or remain in contact with mental health services, even when acutely unwell. The national study of prison in-reach services (Shaw et al. 2009) reported that only 18% of those in a current episode of SMI upon reception into prison had current, active contact with community based mental health services immediately before their imprisonment. The study also reported that in-reach services were much less successful in assessing or treating people who were acutely unwell but who had no past contact with services, illustrating that reliance on historical contact with services as an indicator of current mental health need was fundamentally unsound.

Thirdly, more than one team reported that, if a person was 'positive' for past, or even current, contact with secondary mental health services this did not necessarily guarantee that they would be then be prioritised to be seen in person. We found this hard to logically reconcile with the apparent importance placed upon the identification of service contact.

Winstone and Pakes (*op.cit.*) note that

"at present there is no evidence to determine which screening method is most effective,

but that

"it is suggested that best practice would be to use a breadth of strategies to identify individuals whose needs frequently go unrecognised. 'Casting the net wide' by relying on several screening methods would be most likely to identify the largest proportion of potential clients"

Clearly, if both direct and indirect screening is completed on every person in police custody and/or attending a magistrates' court, this would have an obvious impact, within current staffing levels, on all other activities undertaken by the clinicians within the diversion teams.

Schemes were asked to identify what information from the referral/screening process would trigger the team to conduct an assessment. On the whole, whether to assess a person further or not was described as a clinical decision, based on a culmination of data collected during the information gathering process, augmented by any current observations reported by a referrer. For the majority of schemes, decisions were not directly quantifiable in terms of the absence/presence of a certain number of set criteria which then triggered an automatic assessment; however Sussex Criminal Justice Liaison Team had developed a points-based scoring system which they used to prioritise direct contact with detainees (see Figure 4).

Where individual referrals were taken, all schemes had a process of feeding back the outcome of the referral/screening process to the referrer. Feedback was provided verbally, in writing or electronically. However, in most instances, a person referred and indirectly or directly screened, but then not further assessed, would neither be logged onto an NHS secondary mental health system, nor a scheme's discrete database, if they had one (see section 5.6 below). For those

schemes that screen daily lists of people for previous service contact, the number of people screened with no contact with services is not routinely recorded; therefore this type and level of activity, reported as valuable but time consuming, remains un-quantified.

Figure 4. Example of a points-based decision making process

Sussex Criminal Justice Liaison Team

This team use both types of referral process, checking all names on court and police detention lists and accepting individual referrals of persons of concern. The scheme prioritises cases using a locally developed scoring system looking at index offence, other criminal justice markers and secondary mental health information. Each person will score a maximum of 3 points for each area e.g. 3 points each will be given for a serious offence, major mental health criminal justice marker and if the person has had recent secondary mental health contact.

- 6 or more points all seen
- 5-6 points generally seen
- 4 points may be seen.

They also use a Learning Disability Screening Questionnaire to screen people with learning difficulties; if the person falls within the medium threshold they will be referred to Learning Disability teams.

The whole screening process takes 5 minutes on average.

5.2.1 Research evidence for screening tools

We conducted a brief literature search to identify any existing mental health screening tools which could have potential for further testing in police or court settings by liaison and diversion schemes for the initial identification of people of possible concern. The list offered below is not wholly exhaustive; rather it provides examples of validated tools in use in wider mental health practice which could possibly add extra value to CJS based screening.

The Threshold Assessment Grid (TAG)

The TAG is a one-page referrer-rated assessment of mental health problem severity (Slade, Powell, Rosen & Strathdee, 2000). It assesses severity of need across seven domains: (i) intentional self-harm; (ii) unintentional self-harm; (iii) risk from others; (iv) risk to others; (v) survival needs/disabilities; (vi) psychological needs/disabilities; and (vii) social needs/disabilities. Items are rated across a 4-point scale, scored 0 to 3, reflecting none; mild, moderate; or severe for domains (ii), (iii), (vi) and (vii), with an extra 'very severe' domain (score 4) possible for the remaining three domains (indicating a need for possible immediate action). The TAG total score is the sum of the seven items and ranges from 0 (least severe problems) to 24 (most severe).

The TAG's psychometric properties have been investigated in referral cohorts to 10 adult and older adult mental health teams (n=605), showing good construct and concurrent validity, internal consistency and test-retest reliability and adequate inter-rater reliability (Slade, Cahill, Kelsey, Powell & Strathdee, 2002). It was also shown to be feasible for routine clinical use by primary care referrers to adult secondary mental health services, with a cut-off TAG total score of five maximising sensitivity (76%) and specificity (50%) in matching mental health team view of suitability (Slade, Cahill, Kelsey, Leese & Powell, 2002).

More recently, Slade et al. (2008), aimed to investigate whether introducing the TAG as a standardised measure of mental health problem severity into the referral process improved agreement between primary care referrer and referred-to CMHT practitioners on the suitability of the referral for specialist mental health services. The study utilised a multi-site mixed-method cluster randomised controlled trial of GP referrals from 73 practices (408,839 patients) to 11 CMHTs. Intervention group GPs were asked to complete a TAG rating of mental health problem severity and, subsequently, CMHTs rated referral appropriateness. Two hundred and eighty-one GPs made 1,061 mental health referrals. The intervention was only partly implemented with 25% of intervention group GPs completing TAGs. No difference was found in appropriateness of referral (OR: 1.18; 95% CI: 0.91–1.53) or secondary outcomes. Post-referral primary care contact rates were higher for the intervention group (IRR: 1.36; 95% CI: 1.07–1.73).

Qualitative data identified professional and organisational barriers to implementation; often GPs would forget to use the TAG when making a referral and it was also suggested that the TAG was simplistic and so not reflective of the complexity of patients with mental health problems. Some GPs expressed concern that the TAG score could be manipulated by other GPs to coerce the CMHT to accept referrals, and some feared that TAG would be used by CMHTs to further restrict referrals. For CMHT respondents, the view was expressed that GPs were neither willing to complete schedules nor reliable in their completion of TAGs. However, they also reported that TAGs accompanying referrals had not been considered in their referral meetings, so TAG scores had not, in fact, affected their decision making.

The PriSnQuest

PriSnQuest (Shaw, Tomenson & Creed, 2003) is an eight-item questionnaire designed to screen for mental illness in CJS populations. It was initially designed to provide staff working within the CJS, who were not mental health professionals, with a quick and effective method of identifying prisoners or court defendants who may have a serious mental illness and who would therefore likely benefit from further assessment from specialist mental health services. It was developed in response to research based at a magistrates' court which indicated that the majority of defendants identified by researchers as having serious psychiatric disorder remained undetected by court staff and therefore were not referred to the available mental health diversion services (Shaw, Creed, Price, Huxley & Tomenson, 1999).

The PriSnQuest schedule is a subset of questions from two other mental health screening questionnaires, the GHQ (Goldberg, 1992) and the Psychosis Screening Questionnaire (PSQ; Bebbington & Nayani, 1995). In subsequent validation research, a score of three or above was found to be a reliable cut-off to indicate the need to investigate further for the possible presence of mental illness. A total of 2,920 attendees at two magistrates' courts were screened for serious mental illness and 1,306 were interviewed using the Schedule for Clinical Assessment in Neuropsychiatry (SCAN). One hundred and thirteen had an ICD 10 diagnosis; of these, 38 had a diagnosis of schizophrenia or other psychoses and 68 of depression or bipolar affective disorder. PriSnQuest detected 101 out of 113 cases (weighted sensitivity 89.4%) with 469 false positives (weighted specificity 60.7%). The questionnaire detected all 17 cases of severe depression and 33 out of 38 with schizophrenia. The authors acknowledged the clinical imperative to achieve a balance between missing few true cases whilst inevitably falsely identifying some respondents as positive. Further research suggested that around a third of an England and Wales prison sample would be positive on PriSnQuest, of which a third will have a mental health diagnosis; thus the instrument is over-sensitive but, importantly for groups where under-identification has been routine, highly specific with very few false positives (Shaw et al. 2009).

The K10/K6

Kessler et al. (2002) developed a 10-question (K10) screening scale of psychological distress and a six-question (K6) short-form scale embedded within the 10-question scale. Initial pilot questions were administered in a US national mail survey (N=1,401). A reduced set of questions was subsequently administered in a US national telephone survey (N=1,574). The scales were subsequently validated in a two-stage clinical reappraisal survey (N=1,000) telephone screening interviews in the first stage followed by 153 second stage face-to-face clinical interviews, over-sampling first-stage respondents who screened positive for emotional problems. The screening scales were administered to the second-stage sample along with the Structured Clinical Interview for DSM-IV (SCID). The K6 was subsequently included in the 1997 (N=36,116) and 1998 (N=32,440) US National Health Interview Survey, while the K10 was included in the 1997 (N=10,641) Australian National Survey of Mental Health and Well-Being. Both the K10 and K6 strongly discriminated between community cases and non-cases of DSM-IV/SCID disorders, with areas under the Receiver Operating Characteristic (ROC) curve of 0.87-0.88 for disorders having Global Assessment of Functioning (GAF) scores of 0-70 and 0.95-0.96 for disorders having GAF scores of 0-50.

Swartz & Lurigio (2005) subsequently examined the use of the K6 scale in a sample of past-year arrestees. Participants responded to the K6 items by indicating the extent to which they experienced each of six symptoms of general psychological distress in the last month. Item scores were based on 5-point Likert scales that range from 0 (“none of the time”) to 4 (“all of the time”), yielding a summed total score from 0 to 24. Participants were assessed as having an SMI if they scored 13 or above, the optimal cut-score based on general population studies. They found that 18% of the sample (300/1,684) participants with a past-year arrest had a K6 score of 13 or higher, indicating that in the past year they had experienced symptoms of severe psychological distress consistent with the presence of SMI. They concluded the K6 scale was accurate in identifying offenders with SMI, was simple to administer and score, and was particularly appropriate for use by non-clinicians.

The Emergency Screener for Psychiatry

The Emergency Screener for Psychiatry (ESP) has been developed by interRAI, an international collaborative of healthcare researchers (www.interrai.org) to complement the Mental Health and the Acute Care systems assessment tool (see section 5.4.1). The ESP is designed to be used in adult, acute mental healthcare settings with patients experiencing a broad range of mental and physical health needs, including those with dual diagnoses. The ESP includes 13 domains (Figure 5).

Figure 5. ESP Domains

Identification information	Mental state indicators
Substance use or excessive behaviour	Harm to self and others
Behaviour	Cognition and communication
Functional status	Medications
Unsettled relations, supports and life events	Environmental assessment
Psychiatric summary information	Disposition
Assessment information	

The ESP has been adapted into a screen tool for police personnel to enable officers to articulate reasonable grounds for referral to emergency room staff (Hoffman & Brown, 2009; Figure 6). The screener is designed to identify individuals in need of more complete mental health assessment. The screening tool is not used to predict dangerousness; rather it is to be used to flag the need for more complete examination. Needs are identified as high/medium/low which are the matched to appropriate response protocols (i.e. high – institutionalisation; medium – referral to community service etc.)

Figure 6. RAI-MH Emergency Screener for Mental Health Status

ELECTRONIC TRIGGER FOR COMPLETING ES-MHS UNIQUE DATA LINKAGE IDENTIFIER FOR interRAI

Emergency Screener for Mental Health Status

ARREST # _____ OCCURRENCE # _____ DATE: _____ TIME: _____

INDIVIDUAL NAME: _____ D.O.B.: _____ SEX: M F

ADDRESS: _____

OCCURRENCE LOCATION: _____

CONTACT INFORMATION: (i.e. family / friends / mental health worker, etc.) _____

MENTAL STATE INDICATORS

Disordered Thought	Harm to Self	Other
<input type="checkbox"/> Delusions [B1w] (<i>unshakable false belief most common being that they are a famous person or that some other person or entity is conspiring against them or attempting to control them in some way</i>)	<input type="checkbox"/> Attempt to Harm Self [D1a]	<input type="checkbox"/> Evidence of Alcohol Use
<input type="checkbox"/> Hallucinations [B1u] (<i>information from senses is not grounded in fact, e.g. they hear, see, smell, feel, taste, things that cannot be substantiated</i>)	<input type="checkbox"/> Considered Harming Self in past 30 days [D1c]	<input type="checkbox"/> Evidence of Drug Use
<input type="checkbox"/> Command Hallucination [B1v] (<i>hallucination directing the person to do something or to act in a particular manner, e.g. to harm self or others</i>)	<input type="checkbox"/> Others are concerned that person is at risk of harming self [D1d]	<input type="checkbox"/> Recently stopped taking prescribed medication
<input type="checkbox"/> Abnormal Thought Processes [B1x] (<i>rapidly jumping from one subject to another with little connection, unable to complete thoughts</i>)	<div style="background-color: #cccccc; text-align: center; padding: 2px;"> <p>Harm to Others</p> </div> <input type="checkbox"/> Violence to Others [D2a] (<i>acts with purposeful, malicious, or vicious intent, resulting in physical harm to another e.g. stabbing, choking or beating</i>)	<input type="checkbox"/> Personal Hygiene (dirty, body, odour)
<input type="checkbox"/> Cognitive Skills [F2] (<i>difficulty making decisions regarding tasks of daily life e.g. when to get up or have meals, which clothes to wear or activities to do</i>)	<input type="checkbox"/> Intimidate /Threatened Violence [D2b] (<i>threatening gestures or stance with no physical contact, shouting angrily, throwing furniture, explicit threats of violence</i>)	<input type="checkbox"/> Weapons
<input type="checkbox"/> Insight into mental health [B2] (<i>unaware of own mental health problem</i>)	<input type="checkbox"/> Verbal Abuse [E1b] (<i>others were threatened, screamed/cursed at</i>)	<input type="checkbox"/> Environment
	<input type="checkbox"/> Violent Ideation [D2c] (<i>reports of pre-meditated thoughts, statements, or plans</i>)	<input type="checkbox"/> Community Treatment Order
		<input type="checkbox"/> Irritability [B1j] (<i>marked increase in being short tempered or easily upset</i>)
		<input type="checkbox"/> Socially Inappropriate / Disruptive Behaviour [E1d] (<i>disruptive sounds, noisiness, screaming, smeared food/feces, hoarding, rummaged through others belongings</i>)
		<input type="checkbox"/> Inappropriately dressed for the season

COMMENTS

FACILITY TAKEN TO: _____ ARRIVAL TIME: _____

ACTION TAKEN BY FACILITY: _____ DEPARTURE TIME: _____

OFFICER/BADGE # _____ FACILITY STAFF: _____

With regard to diagnosis-specific screening tools, Hewitt, Perry, Adams & Gilbody (2010) conducted a systematic review of screening and case finding for depression in offender populations. They identified 13 studies which validated case-finding/screening instruments against a recognised diagnostic gold standard. The most frequently used generic instrument was the General Health Questionnaire (GHQ; *op. cit.*) and the offender-specific Referral Decision Scale (RDS; Teplin & Swartz, 1989). The authors examined the properties of these instruments with respect to their ability to identify depression (sensitivity) and their ability to exclude those without depression (specificity). They concluded that instruments could be made more sensitive by choosing a low cut-off point, but this was at the expense of reducing specificity, therefore resulting in more false positives. They found that the GHQ could produce good values of sensitivity and specificity (0.88 and 0.84 respectively) at its optimal cut point.

Similarly, Perry, Marandos, Saulton & Johnson (2010) conducted a systematic review of screening tools for assessing risk of suicide and self-harm in adult offenders. Five studies were included in the review looking at four different tools. However, based on such a small number of studies the authors concluded that no recommendations could be made as to which tools should be used. They highlighted the need for additional psychometric research on the validity of suicide and self-harm behaviour screening tools in offender populations.

5.3 Triage and onward referral

Mental health triage refers to processes undertaken to assess and categorise the urgency of mental health needs. Triage aims

- to determine the nature and severity of the mental health problem;
- determine which service response would best meet the needs of the person; and
- how urgently the response is required.

The Sainsbury Centre for Mental Health (2009) noted that the relatively low numbers of clients with SMI meant that the predominant activities of all diversion schemes were actually assessment and liaison, rather than diversion in its most narrow sense (i.e. the facilitation of urgent hospital admission as an alternative to continued progress through the CJS). This viewpoint was supported by our visits to the Pathfinder schemes. All schemes reported that the people they saw were more likely to have common mental health problems than SMI; commonly had dual substance misuse or personality disorder; and frequently had co-existing social problems which may be contributing to their continued contact with the CJS, for example issues around accommodation, employment and financial stability.

This high proportion of people requiring primary, rather than secondary, mental health care input, supported by social care, is potentially problematic to ensuring appropriate follow-up for diversion scheme clients if, following effective screening to identify likely mental health and social care needs, an efficient triage process is lacking. The negative effects upon service provision associated with a lack of adequate triage of mental health needs has been illustrated by the national evaluation of prison mental health services (Shaw et al. 2009). Clinicians interviewed for this evaluation commonly reported the inappropriate referral of people with common mental health problems to in-reach services designed for people with SMI. As a result, they identified that in-reach services were operating ineffectively in treating their core client group (those with SMI) through having to fulfil seemingly relentless requests for assessments of people with minor mental health problems. This was further compounded by pressure to inappropriately accept such people onto caseload due to undeveloped or absent primary care mental health services and/or inadequate levels of general pastoral support available from non-health agencies.

Whilst the apparent lack of a clear triage process following a standardised, direct screening may not cause the same issues as within the prison system, our Pathfinder site visits highlighted certain areas for concern. As discussed above, most screening is currently done indirectly, through checking clinical and criminal justice data sources for evidence of past service contact etc. Wider use of direct screening with a standardised tool would allow for an initial face to face contact with a prospective client to allow a rapid identification of any likely mental health needs.

The initial screen would both (i) identify those likely to require fuller assessment and (ii) allow a prioritisation for that assessment, informing a decision about whether the assessment is, most commonly, one to identify common mental health and social needs to inform the liaison aspect of the Pathfinder schemes' work or, less commonly, an assessment designed to determine an immediate or medium term plan of action to proactively divert someone with SMI into an in-patient setting. Identifying the likely course of action required earlier, rather than later in the process, allows for the mobilisation of the additional staff required if a person may need detention under the MHA, notably a MHA Section 12 approved doctor and an Approved Mental Health professional (AMHP). Additionally, formalised triage following face-to-face screening may result in fewer people of concern being missed as screening results can be obtained and subsequently prioritised more rapidly than the indirect screening process which often leaves

liaison and diversion staff waiting for information back from other sources, thus delaying face-to-face contact with detainees for fuller assessment.

5.4 Assessment

"Assessment refers to the professional activity undertaken by a clinician or other forensically qualified individual with the aim of developing a fuller picture of mental health and other needs and risks."

(Winstone & Pakes, 2010)

Following indirect and/or direct screening discussed above, a number of people are identified for a full face to face clinical assessment of mental health and associated needs. Services reported that such assessments took a varied amount of time based on the complexity of the case.

Assessment tools submitted to the research team by the Pathfinder sites had many features in common. Many teams used their mental health trust's Care Programme Approach (CPA) assessment template, commonly addressing past and current symptoms of mental ill health; substance abuse; risks of self-harm, suicide and violence to others; and social needs, for example housing and employment. Most assessment tools allowed clinicians to conduct a semi-structured interview, with the comprehensiveness of the information gathered resting largely upon individual clinicians' interviewing styles and skills.

Winstone and Pakes (*op.cit.*) note that

"it is essential that (assessment) tools are in use that have been psychometrically tested and have been demonstrated to have a high level of inter-rater reliability"

This recommendation is thus not met currently by the wide use of the semi-structured CPA-type assessment forms. They go on to suggest the use of the HoNOS (Health of the Nation Outcome Scales, 1996). The HoNOS is a twelve-point scale rating specific mental health, substance misuse and social indicators. At first sight, HoNOS items seem appropriately targeted to facilitate comprehensive assessment of clients seen in police or court settings addressing, addressing substance misuse, mood, psychotic symptoms, living conditions and activities of daily living.

However, Dyer (2011) sounds a sensible warning, noting that the HoNOS was designed for clients with severe mental illness, a group not wholly analogous to diversion scheme clients *"with more vague or borderline mental health problems, substance misuse, personality disorder and learning difficulty"*, a finding borne out by other researchers (e.g. Sainsbury Centre for Mental Health, 2009; Shaw et al. 1999). Dyer rightly points out that *"care must be taken to identify if this is the most appropriate tool"*.

5.4.1 Research evidence for assessment tools

We conducted a brief investigation into validated mental health assessment tools which appear to have potential for adoption by liaison and diversion services

The Camberwell Assessment of Need (CAN)

The Camberwell Assessment of Need, Forensic Version (CAN) was developed to assess the needs of the severely mentally ill (Phelan et al. 1995). As with the HoNOS, the CAN therefore may not be suitable to assess the primary mental healthcare needs presented by the majority of liaison and diversion clients although the authors do state that the CAN is suitable for use in primary care settings (Slade, Thornicroft, Loftus, Phelan & Wykes, 1999). The CAN was developed on the premise that everyone has needs and that although people with mental illness have some specific needs, most of their needs are similar to those of people not suffering from mental illness. The CAN reflects this notion by requiring the assessment of a range of 22 varied needs, such as shelter and the company of other people, as well as issues more specific to people suffering from mental illness. The CAN was designed to identify, rather than assess in depth, significant deficits, thus prompting the conduct of more detailed and specialist assessments in specific areas when required. The CAN may be completed by staff from a range of professional backgrounds, and a complete assessment takes, on average, 25 minutes.

Figure 7. CAN Items



Accommodation	Food
Household skills	Self-care
Occupation	Physical health
Psychotic symptoms	Information about condition and treatment
Psychological distress	Safety to self
Safety to others	Alcohol
Drugs	Company of others
Intimate relationships	Sexual expression
Child care	Basic education
Telephone	Transport
Money	Welfare benefits

The CAN follows a fixed process for each area of need. The first section establishes whether a need is present or absent, and then measures severity by asking about specific difficulties in that area. Responses are rated on a three-point scale: 0=no serious problem; 1=no serious problem or moderate problem because of continuing intervention (met need); 2=current serious problem (unmet need). Section 2 asks about help received from friends, relatives and other informal carers. Section 3 asks about help received or need from local statutory services. All ratings of level of help are on a four-point scale (0=none; 1=low; 2=moderate; 3=high) with guidelines to assist accurate rating. Phelan et al. (1995) assessed the validity, reliability and inter-rater and test-retest validity of the CAN with a sample of 49 patients and 60 staff. The mean number of needs identified per patient ranged from 7.55 to 8.64. Correlations of the inter-rater and test-retest reliability of the total number of needs identified by staff were 0.99 and 0.78 respectively. The percentage of complete agreement on individual items ranged from 100-81.6% (inter-rater) and 100-58.1% (test-retest). They concluded that the CAN was a valid and reliable instrument for assessing the needs of people with severe mental illness.

The CAN has been adapted for different groups, most notably for people with learning disability (CANDID; Xentidis et al 2000) and for forensic populations (CANFOR; Thomas et al 2008). The adaptations have similar psychometric properties to the CAN.

The Assessment Health Needs of Offenders (ASHNO)

Brooker, Fox, Barrett and Syson-Nibbs (2008) developed The Assessment Health Needs of Offenders (ASHNO), a questionnaire designed to be completed by service users to assess health needs. The questionnaire includes a formal health needs assessment based on self-report (Short Form 36 (SF 36) Version 2; Ware, Kosinski & Dewey, 2000). The SF36 is a widely used measure of health across a range of eight domains: physical functioning; role limitation related to physical health; social functioning; vitality; pain; general health; mental health; and role limitation related to mental health. In addition, the ASHNO incorporates the CAGE (Ewing, 1984), a four question tool to screen for alcohol problems and the UNCOPE (Hoffmann, 2007), a six item tool to screen for substance abuse or dependence. Further questions relating to smoking, sexual health, mental health and frequency of access to healthcare are included. This wide range of questions is reported as enabling a thorough assessment of all aspects of health related information to be assessed, thus providing a comprehensive picture of the offenders' health. To date there has been no external validation of this tool reported.

The interRAI Mental Health system (RAI-MH)

The Mental Health system (RAI-MH) was developed in Canada by the international interRAI health research collaborative (*op. cit.*) The RAI-MH is designed to support care planning, outcome measurement, and quality improvement. It is suitable for all adults aged 18 and over, located in acute, chronic, forensic (including prison) or geriatric in-patient psychiatric settings.

The RAI-MH has been in use in Ontario, Canada since 1999, initially as a research instrument, but increasingly as part of normal clinical practice. In 2005, the Ontario Ministry of Health and Long-Term Care mandated the use of the RAI-MH as the basis of the Ontario Mental Health Reporting System, for all patients in Ontario hospitals with designated adult in-patient mental health beds. The RAI-MH instrument has also been implemented in Galicia, Spain since 2000 and in Finland since 2007. The RAI-MH includes 21 domains (Figure 14).

Figure 8. RAI-MH Domains



Identification information	Intake and initial history
Mental state indicators	Substance use or excessive behaviour
Harm to self and others	Behaviour
Cognition	Functional status
Communication and vision	Health condition
Stress and trauma	Medications
Service utilization and treatments	Control of procedures and observation
Nutritional status	Social relations
Employment, education and finances	Resources for discharge
Diagnostic information	Discharge
Assessment information	

The RAI-MH system includes 30 Mental Health Assessment Protocols to inform care-planning; 25 draft Quality Indicators for Mental Health; and outcome measures related to depression, aggression, psychotic symptoms, negative symptoms, cognition, disability, addictions and extra-pyramidal symptoms. Hirdes et al. (2002) assessed the inter-rater reliability and convergent validity of the RAI-MH. Independent assessors twice assessed a sample of 261 psychiatric patients in acute, long-term, geriatric, and forensic mental health beds in 14 Ontario hospitals. Average inter-rater reliability ranged from 0.39 to 0.79 and the RAI-MH showed evidence of internal consistency against selected outcome measures (0.77-0.90).

5.5 Onward referral

Following screening and assessment, all Pathfinder schemes offered information back to referring agencies and, where appropriate, provided information to magistrates' courts. A number of schemes had a template form upon which they provided information to referrers and magistrates, whereas others gave feedback by letter.

For the majority of schemes, if further input from mental health services at either primary or secondary care level was indicated, the procedure was to make a referral to service in the locality. Schemes were asked which services they routinely referred people to; most frequently mentioned were community mental health services, drug and alcohol services, secure and open in-patient settings, GP and primary care services, prison in-reach teams and dual diagnosis services. Referrals were most often made by letter with the client being told that they would receive contact from the receiving service within a period determined by local waiting list times. Referrals were noted as being a mix between referrals of people new to services and attempts to re-engage people who had previous, but now lapsed, service contact.

Teams routinely regarded a case as closed once any onward referrals had been made. It was not common practice for Pathfinder services to contact the accepting services to establish whether the person had either attended an initial appointment or, indeed, had engaged successfully for a longer period. No team stated that they had clearly identified, mutually agreed referral protocols between themselves and services to which they frequently referred in terms of what type(s) of clients/needs a receiving service could offer a service for; how proactively a service would attempt to engage with a client over how long; and/or that a receiving service would automatically inform the referring Pathfinder service that the client had failed to attend/engage. In terms of evidence of service efficacy and measurement of the impact of liaison and diversion services upon a number of outcome measures, for example improved health or social outcomes, effect upon re-offending etc, this knowledge gap is of major concern.

A small number of the Pathfinder services held a caseload of clients themselves. The rationale for these caseloads varied but were generally related to retaining clients thought to present some specific risk(s); offering a service for those who were judged as unlikely to maintain contact with mainstream services; or to offer a "holding" function short-term before appointments for mainstream services came through. See Figure 15-17 for examples of schemes who carry a caseload.

Figure 9. Manchester Offenders: Diversion Engagement Liaison (MO:DEL)

Manchester Offenders: Diversion Engagement Liaison (MO:DEL)

The MO:DEL team have an agreed maximum caseload of 150 and therefore an agreed capacity. If the MO:DEL caseload reaches maximum capacity then the referring agency is informed of this on or as close to receipt of the referral as practicable, a waiting list is maintained and commissioners informed formally in writing.

The level of contact with each service user is decided by the team and the rationale clearly documented in the care plan. Levels of contact are to be responsive and subject to continuous review within the team. Where the level of contact is greater than weekly and this is due to mental health and associated risk factors then consideration should be given as to whether the service user requires a different mode of intervention i.e. Inpatient, Forensic service. This should be agreed on a case-by-case basis.

The MO:DEL team provide tailored interventions for service users interventions are tailored to the needs of the individual and reflected in the agreed care plan. Interventions can be broken down into several key areas:

- *Engagement and Diversion from custody*
Through proactive engagement and liaison with custody suites and the court system MO:DEL supports the diversion of service users away from custody by agreeing and developing comprehensive packages of care.
- *Pharmacological*
Evidence based pharmacological interventions are used for both mental health and substance misuse via direct prescribing and liaison/advice to other prescribing services.
- *Psychological*
A range of evidence based psychological interventions are available including Motivational Interviewing, Cognitive Behavioural Therapy, The International Treatment Effectiveness Pilot Mapping, Problem Solving, psychosocial education. These are utilised depending on the needs and preferences of the individual service user.
- *Family and Carers*
Where appropriate, families and carers are involved in the assessment and care planning process. In addition, the service aims to comply with Greater Manchester West's Care Programme Approach Policy and ensure that all carers have access to a carer's assessment. In addition the service will link into local carer and family forums and third sector providers. Where gaps in provision for families and carers are identified it will be a role of the service to highlight these to commissioners.
- *Daily activities of living*
All service users are assessed with regards to daily activities of living. This assessment informs the care plan and interventions. As social instability especially in terms of accommodation is a significant issue for this group this is a particular focus of care plans, liaison and the activities of STR workers.

- *Education and Occupation*
All service users are assessed with regards to education and occupational aspirations and all service users have a care plan related to identifying the service user's aims, the process for working towards achieving these and who is best placed to provide these services.
- *Co-morbidity*
All service users will be assessed for co-morbidity and will have an agreed care plan that reflects these needs. Examples of common co-morbidity are substance misuse, personality disorder, anxiety and depression. Where appropriate the service will refer to specialist services but maintain responsibility for co-ordinating the service users care.
- *Risk Assessment and Management*
The team have risk assessment and management as a priority in all clinical activities. All service users will have an up to date risk assessment and management plan and this will form the basis for clinical decision-making and care planning. All reviews and handovers will reflect risk assessments and communicate any changes to risk management plans.
- *Crisis Intervention*
All service users have a regularly updated crisis plan. This is agreed with the service user and shared with all agencies working with the individual.

Under normal circumstances where a service user is not effectively engaged with another service and they do not have a care co-ordinator then they will be allocated a care co-ordinator and a co care co-ordinator within MO:DEL. This should only be as an interim arrangement until such time as care co-ordination responsibility is accepted by district services.

The MO:DEL care co-ordinators are responsible for case management and ensuring that each service user has an individual care plan that is agreed with the service user within one week of assessment. The service user will be given the opportunity to sign and to have a copy of their care plan. Care plans will be reviewed and updated a minimum of monthly.

The care co-ordinator has an essential role in ensuring that the long-term focus of the MO:DEL intervention is to access mainstream services and as such requires a significant liaison and case management focus.

As long as there is evidence that MO:DEL is meeting a need that is not being addressed through another route then contact will be maintained. However the service will aim to establish packages of care that facilitate discharge from MO:DEL's caseload within a six month period from the initial assessment of the latest treatment phase.

Figure 10. Nottinghamshire Criminal Justice Liaison Service

Nottinghamshire Criminal Justice Liaison Service

The Nottinghamshire CJLS make onward referral to community mental health services on the day they see a client. In the period between the referral being made and an appointment received (approximately 3-4 weeks), the team maintain contact with the client. In particular a support worker within the team works with the person to address any practical and social deficits, for example housing, benefits and/or employment issues.

Figure 11. Barnsley Criminal Justice Liaison Service

Barnsley Criminal Justice Liaison Service

This team takes on a small caseload of service users on probation with high risk offences. When the person is assessed as ready, they will be passed onto the CMHTs. They take on those with high gravity crimes and marked mental health problems as much as possible because these are the people that other services are described as wary of engaging with. Post-sentence, the team may take on someone for at least 12 months.

5.5.1 Care Pathways

There is a need to develop structured pathways into care for the variety of mental health problems identified, taking into account the severity of the offence. To illustrate the likely differential responses required for those with common mental health problems vs. SMI, substance misuse and learning disability a series of suggested care pathways are offered here.

Figure 12 shows a suggested care pathway for SMI. For those with SMI where a custodial remand or sentence is likely, due to the serious nature of the offence, a bed at an appropriate level of security could be identified immediately and subject to the court's permission, admission to hospital could follow. More commonly, where a suitable bed is not immediately available, or where courts are not amenable, teams should liaise with prison-based services to pass on detailed assessment information to ensure the person's safe detention and to influence the speed of subsequent transfer to hospital where appropriate. For those with SMI commit less serious offences, courts may not allow for discontinuation of the criminal case. In these cases, teams have a role to best facilitate diversion *within* the CJS, attempting to ensure that any CJS sanctions are balanced with meaningful, and accessible, alternatives to punishment and/or mental health treatment intervention. Where complete discontinuation of charges is achieved, teams should pro-actively pursue appropriate treatment interventions and link clients with other relevant agencies, for example housing, social support etc. Consideration should be given to admitting the person to the liaison team's own caseload, or in some other way maintaining contact with them, until engagement with mainstream services is achieved.

Figure 13 shows the care pathway for common mental health problems. For people who are remanded into, or sentenced to, custody due to the seriousness of the offence the team's function should be a liaison role whereby they send information to prison-based services to ensure safe detention and active sign-posting into primary care mental health services. For less serious offences where a community sentence is likely to be received, the team should offer courts recommendations for suitable treatment and/or available support services as additions to any sanction. Where discontinuation of all criminal justice processes is possible, teams should pro-actively liaise with appropriate community primary care mental health services and/or consider a transitional holding arrangement and/or short-term treatment intervention within their own service.

Figure 14 illustrates a care pathway for people with stand-alone substance misuse problems. At all stages, the role of liaison and diversion schemes, broadly defined, for this client group is that of facilitating referral and access to specialist substance misuse services. If a person is remanded or sentenced to custody and no specialist service has been engaged, liaison services should notify the receiving prison of a person's problems to ensure their safe management. For less serious offences where a community sentence is likely to be received, the team should again refer to specialist services or, where not available, offer courts recommendations for suitable treatment and/or available support services as additions to any sanction. Where discontinuation of all criminal justice processes is possible, teams should pro-actively liaise with appropriate community substance misuse services.

Where a substance misuse problem exists alongside other mental health morbidities, it may be preferable to link a person into dual diagnosis services. Co-morbid mental health and substance misuse issues are common in people in contact with the CJS and liaison services should guard against people being rejected from mental health services because of a co-existing substance issue or, conversely, rejection from substance misuse services because of mental health issues. In these cases, teams should consider a transitional holding arrangement and/or short-term treatment intervention within their own service.

Figure 15 shows the care pathway for individuals with learning disability (this care pathway may be required alongside other care pathways). For those with learning disability who will be remanded or sentenced due to the seriousness of the offence, the teams should commence either a diversion process of transferring the person away from prison into specialised services, where the learning disability is severe enough to require hospitalisation or, where diversion is not possible immediately, liaise with prison reception and mental healthcare staff to ensure safe detention and inform any subsequent transfer process. For less serious offences where a community sentence is likely to be received, again the team should commence a diversion role of recommending suitable treatment and support additions to community sentences. Where CJS processes cease, teams should commence a liaison role to signpost to relevant community services, considering on-going contact with the person until they are engaged with specialist services.

Figure 16 shows the care pathway for individuals with personality disorder (this care pathway may be required alongside other care pathways). For people who are remanded or sentenced to custody due to the seriousness of the offence, the team's function should be a liaison role whereby they inform prison healthcare of assessments completed on the individual's reception. Where a community sentence is likely to be received, the team should commence a diversion role of recommending suitable additions to community sentences which have a condition specific element. For very minor offences where the CJS outcome is likely to be released without charge or no further action, the teams should commence a liaison role to signpost to relevant community services, considering on-going contact with the person until they are engaged with specialist PD, or other community mental health, services.

Figure 12. Care pathway for SMI

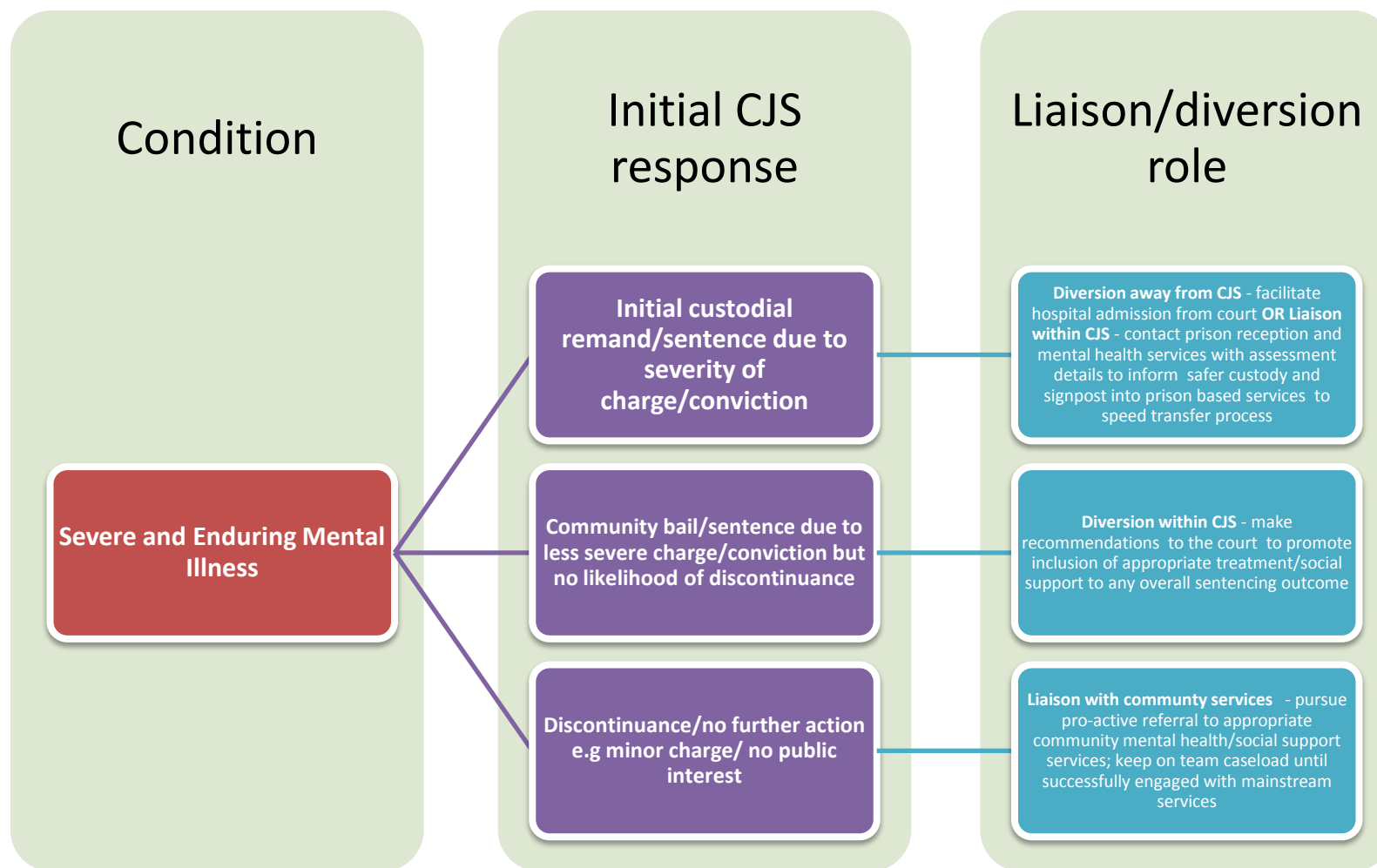


Figure 13. Care pathway for common mental health problems

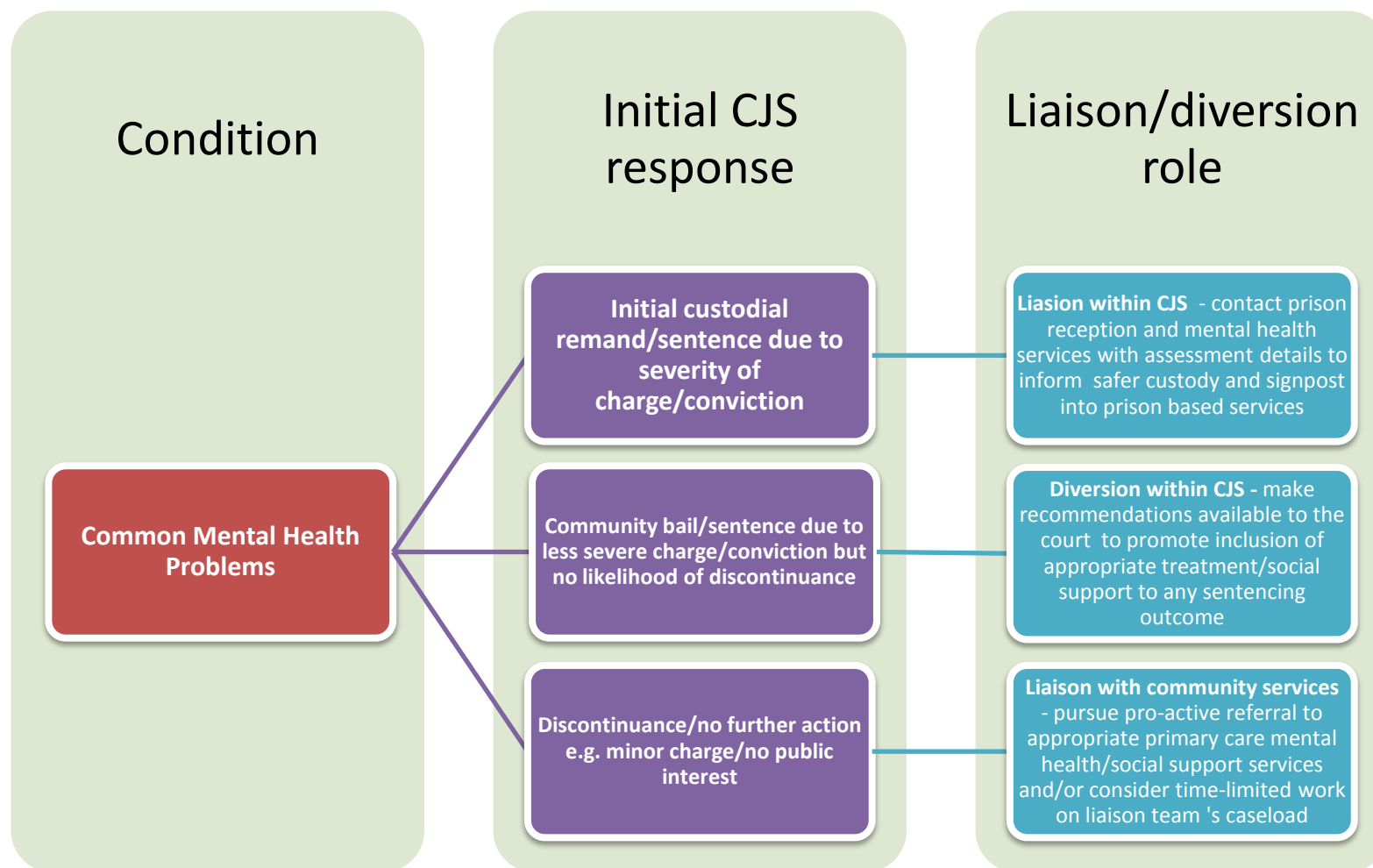


Figure 14. Care pathway for substance misuse

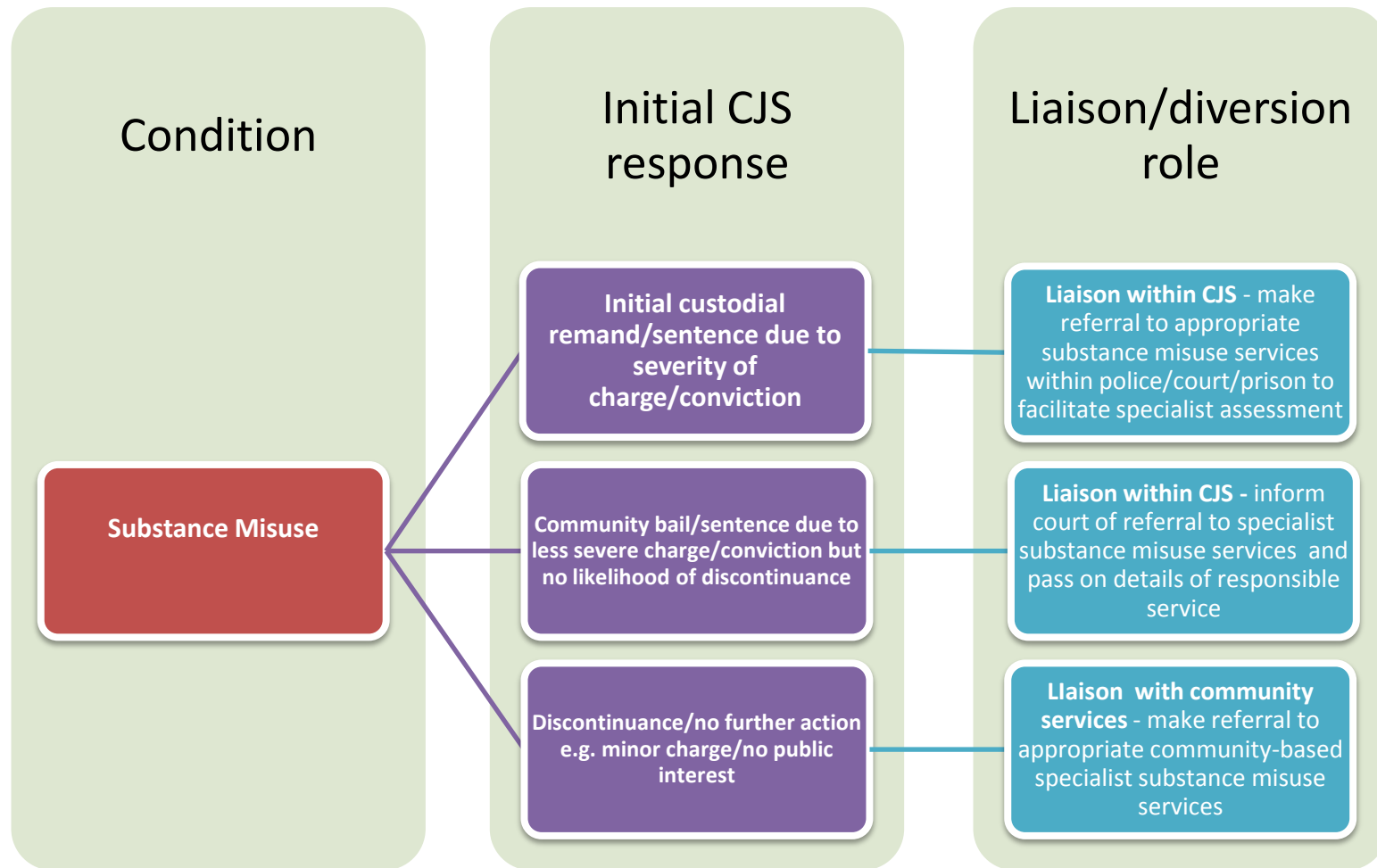


Figure 15. Care pathway for learning disability

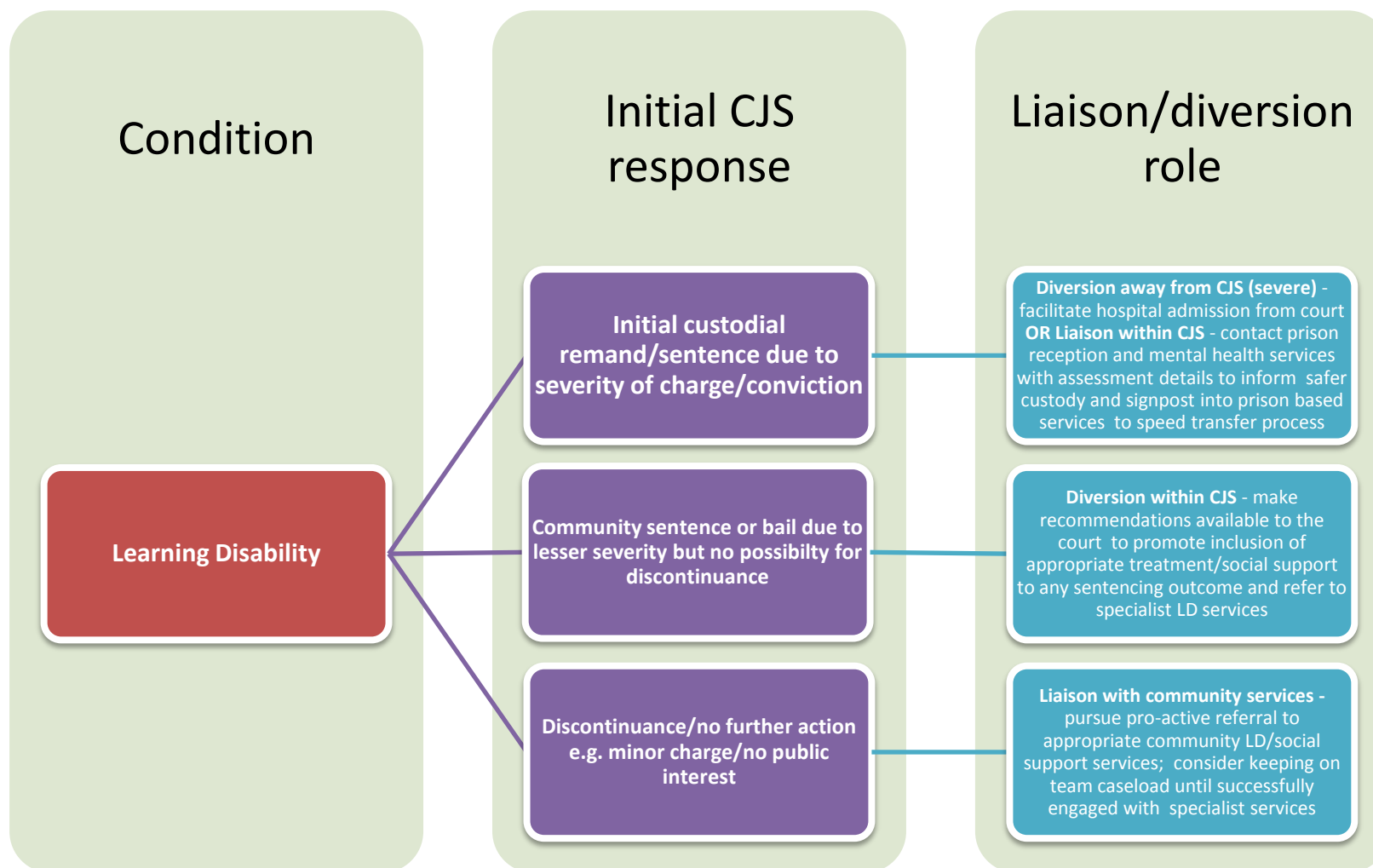
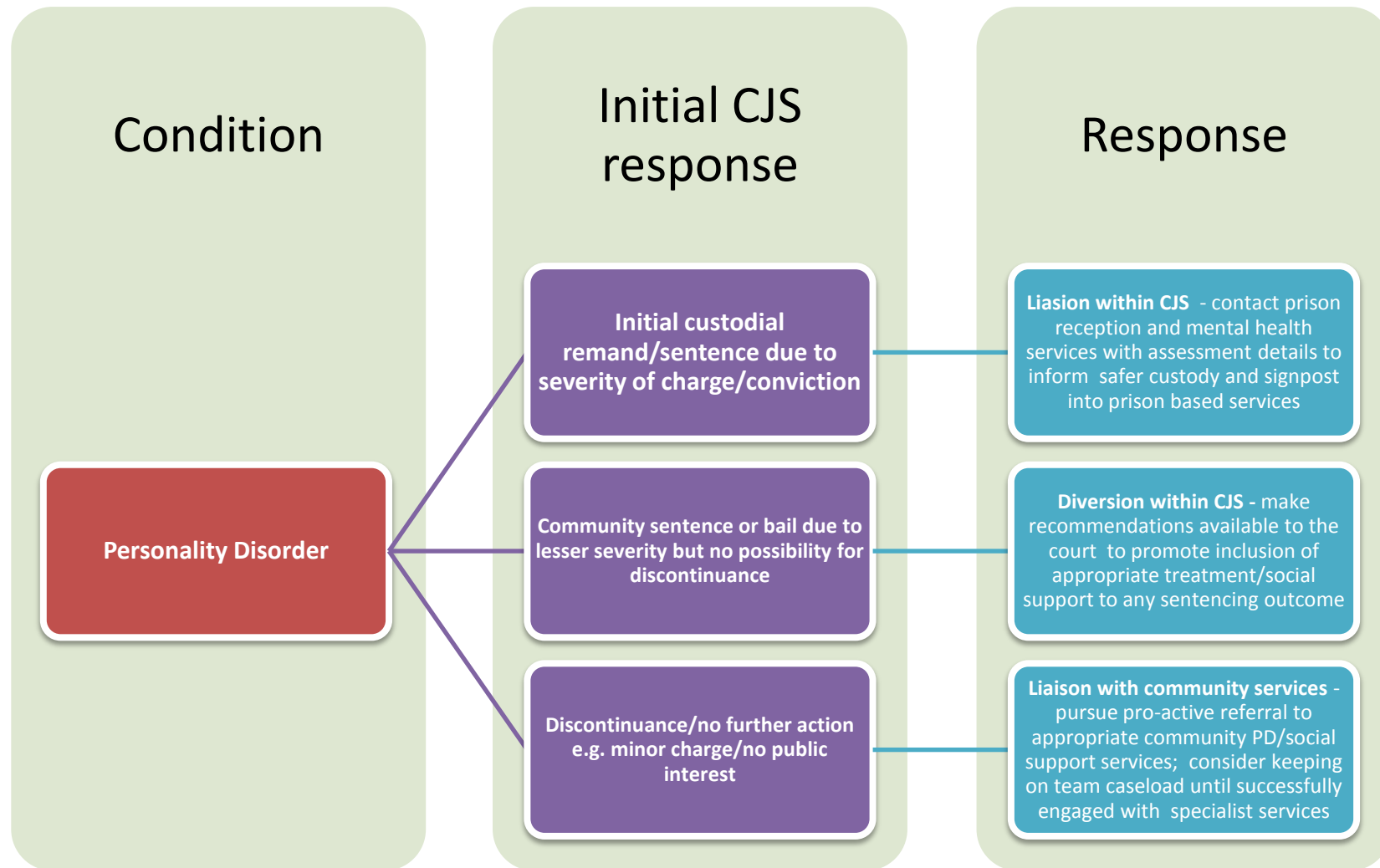


Figure 16. Care pathway for personality disorder



5.6 Data collection, recording and minimum datasets

In their previous work, Winstone and Pakes (2008) noted that most services record some of their activities some of the time. Dyer (2011) highlighted issues around the recording of CJS specific details using the example of the North East region where activity remained unrecorded because the generic NHS mental health trust information systems the teams used did not contain the fields which would be required for such data. We found a similar picture still in operation across the Pathfinder schemes.

The schemes still vary in the amount and nature of data they collect and a number of reasons were offered for this. A number of the Pathfinder schemes lacked any dedicated administration support, or stated that the amount of support available was insufficient for the workload of the team, thus limiting the amount of data recorded. Where data were recorded electronically, staff were routinely constrained by the data systems and configurations of the standard IT system templates of the parent mental health or primary care trust, with no locally adapted versions to allow, for example, the recording of criminogenic data items. The majority of teams were allied to secondary mental health trusts services; however the majority of clients routinely seen had primary care needs. This led to a number of differing responses, uncertainties and ethical issues around whether teams should open a specialist mental healthcare record for someone with no specialist mental healthcare needs.

As a pragmatic solution, a number of schemes had developed and continued to run standalone databases/spreadsheets, recording certain demographic and client contact data. The types of data recorded are similar across schemes, but overall differences in the data recorded and methods of coding would make using these databases for cross-scheme comparisons highly problematic. The use these databases are put to vary from internal team monitoring of new and repeat contacts, numbers of contacts and workloads to more nuanced activity and some, limited, outcome reporting to service commissioners. It appeared to be true that, for a significant number of services, the reporting of even basic team activity levels to commissioners was a relatively new phenomenon, perhaps indicative of the apparent gap between liaison and diversion activity and other activities within the same NHS organisation which commissioners have a more "hands-on" approach to performance management and service expectations.

The production of meaningful data will impact on many of the issues central to a successful scheme, including agreeing inclusion and exclusion criteria and the aims and objectives of service provision: "*we need to know what we are counting, what we can legitimately measure, and how this might be achieved*" (Winstone & Pakes 2010). Consistent screening and assessment processes will go some way to achieve this, however the schemes urgently need bespoke electronic templates within their organisations' IT systems and they need criminal justice agencies to recognise that they routinely need access to outcome/disposal data. They also

need to overcome the issue of primary care/secondary care recording of information.

The Sainsbury Centre for Mental Health (2009) highlighted that schemes were able to provide relatively little hard information on the extent to which their clients engaged with local services after referral. Schemes do not currently see their role as managing the relationship between their clients and local services following referral, except in some cases to ensure that a first appointment is taken up. Schemes do not generally collect any systematic follow-up data on their clients, including on any meaningful engagement with receiving services.

Schemes intuitively believed they have a positive effect on recidivism, but the absence of follow-up data means that they are not generally able to currently substantiate this assertion. Success in reducing recidivism clearly depends, among other things, upon engaging clients with appropriate services on a continuing basis. A lack of engagement is as relevant to re-offending as it is to improving clients' mental health. Therefore assertive follow-up to promote engagement and compliance is required. Access to criminal outcome data was an issue for a number of schemes; those that worked closely with/funded by probation services had much easier access to this data.

Winstone and Pakes (2010) recommend a minimum dataset with core variables which should be present in a core dataset (see Appendix 9.3). These may or may not be exactly the right data to collect, but they are a good starting point upon which to agree and roll-out a mandatory minimum dataset; the DH should, with clinical partners from the national diversion development network, fine-tune such a dataset, based on an adaptation and fine-tuning of Winstone and Pakes' suggested template.

The introduction of such a dataset would necessitate national agreements around definitions of service users and the aims and objectives of service provision to clarify what is being counted and what can be measured and compared across schemes and longitudinally. To achieve this logically dictates that screening, triage, assessment and referral processes need to be, if not nationally standardised, at least directly comparable. Additional thought needs to be given to ease of sharing the information with other organisations, especially in terms of multi-agency management of ongoing interventions.

6 Discussion

The programme of visits and telephone conferences with the 21 Pathfinder liaison and diversion sites allowed us to amass a wealth of information about both the day to day operation of the schemes, augmented by background details about how schemes were commissioned, created, developed and their place within their wider organisation structures.

We have tried, in this report, to concisely identify where practices across schemes are broadly analogous and where any notable differences of approach exist. What we have documented in terms of the challenges faced by liaison and diversion services echoes the findings of other reviews into the subject (Sainsbury Centre for Mental Health, 2009; Winstone & Pakes, 2010; Dyer, 2011).

Perhaps most importantly and again identified by earlier studies, the lack of a national co-ordinating model of best practice for liaison and diversion appears to have hampered standardisation across England and contributed to a lack of attention to the impacts liaison and diversion initiatives may be having upon a range of health, social and criminogenic outcomes. As noted by Bradley (2009), belief in the positive value of liaison/diversion actively is widely and deeply held, but currently not supported by a convincing body of empirical evidence.

What is clear is that the all the Pathfinder liaison and diversion schemes are staffed by dedicated and skilled individuals, working across the interface of a number of complex, and sometimes very fractured, health, social and criminal justice systems which are all experiencing acute pressures in the current economic climate. Their client group often have complex, multi-faceted needs which cannot be satisfactorily addressed by a single agency. Their acceptance by, and engagement with, services are frequently affected adversely by co-existing drug and/or alcohol misuse, personality difficulties, unstable lifestyles and social exclusion. The needs of the individual in contact with the CJS need to be carefully balanced at all points with issues concerning wider public interest and protection.

The Ministry of Justice Green Paper *Breaking the Cycle Effective Punishment, Rehabilitation and Sentencing of Offenders* (MoJ, 2010) acknowledged the need for an evaluation of the liaison and diversion services, with the clear implication that continued funding of services would depend upon proof of positive outcomes in terms of their impact upon re-offending. Such an evaluation should also consider wider outcome measures, including impact upon indicators of improved health, effect upon levels of social exclusion and modelling around the health economics of liaison and diversion provision.

It is within this context that we make the following recommendations for practice.

7 Recommendations

1. A national model for the delivery of liaison and diversion services should be formulated and published by the Department of Health, in co-ordination with other relevant central government bodies.
2. The national delivery model should be accompanied by national service commissioning guidelines.
3. Schemes should support offenders with mental health problems at all stages of the criminal justice pathway.
4. Scheme should be adequately funded with sufficient appropriately trained professionals for the population needs.
5. All defendants in the police station/court should be screened face-to-face for mental illness. We recommend that the DH co-ordinates a trial across the Pathfinder and Development schemes using PrisnQuest, the K10 and the ESP, with the relative merits of each examined in the evaluation of the schemes.
6. All schemes should develop an effective triage process for prioritising those screening positive.
7. All schemes should conduct a full assessment on all those who screen positive. We recommend that the DH co-ordinates a trial across the Pathfinder and Development sites using the RAI-MH, the CANFOR and the current semi-structured clinical assessment approach, with the relative merits of each examined in the evaluation of the schemes.
8. All schemes should develop protocols for pathways to care for all types of mental disorder.
9. Liaison and diversion teams should work more closely with substance misuse teams in co-ordinating care.
10. All liaison and diversion teams should have agreed protocols with community services in their area which outline what receiving services will offer a liaison and diversion client referral, with clear communication pathways to report back successful contact or non-engagement.
11. All liaison and diversion teams should provide a transitional service to offenders with mental health problems pending engagement with the accepting service.
12. Community-based mental health services should ensure that a potential client's offending history does not act as a barrier to receiving services.

13. Criminal justice agencies should make greater use of conditionality in sentencing to promote engagement with mental health services. This would include more use of the Mental Health Treatment Requirement (MHTR) as a sentencing option.
14. The DH, with input from liaison and diversion clinicians should develop a nationally standardised minimum dataset, including demographic, clinical and criminological information, outcome of screening and assessment, care pathway and outcome in terms of engagement with the accepting service.
15. All services should develop information sharing protocols with all relevant agencies.

8 References

Association of Chief Police Officers (ACPO). (2006). *Guidance on the Safer Detention and handling of Person in Police Custody*. Produced on behalf of ACPO and the Home Office by the National Centre for Policing Excellence. Bedfordshire: Centrex.

Bebbington, P. & Nayani, T. (1995). The Psychosis Screening Questionnaire *International Journal of Methods in Psychiatric Research*, 5(1): 11-19.

Bradley, K. (2009) *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.

Brooker, C., Fox, C., Barrett, P., & Syson-Nibbs, L. (2008). *A health needs assessment of offenders on probation caseloads in Nottinghamshire and Derbyshire: Report of a pilot study*. Criminal Justice and Mental Health, CCAWI, University of Lincoln.

Centre for Public Innovation. (2005). *Review into the current practice of court liaison and diversion schemes*. London: The Centre for Public Innovation.

Chung, C. M., Cumella, S., Wensley, J., & Easthope, Y. (1999). A follow-up study of mentally disordered offenders at a court diversion scheme: six-month and one-year comparison. *Medicine, Science and the Law*, 39(1): 31-38.

Department of Health. (2009). *Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Boards*. London: Department of Health.

Dyer, W. (2011). *Criminal Justice Diversion and Liaison Services: Post-Bradley update on 'best practice' developments*. Report for the North East Offender Health Commissioning Unit.

Ewing, E. M. (1984). Detecting alcoholism: the CAGE Questionnaire. *Journal of the American Medical Association*, 252: 1905-1907.

Goldberg, D. (1992) *General Health Questionnaire (GHQ 12)* Windsor: NFER-Nelson

Gunn, J., Maden, A., & Swinton, M. (1991). *Mentally disordered prisoners*. London: Home Office.

Health of the Nation Outcome Scales (HoNOS)© (1996). London: Royal College of Psychiatrists.

Hewitt, C., Perry, A., Adams, B., & Gilbody, S. (2010). Screening and case finding for depression in offender populations: A systematic review. *Journal of Affective Disorders*, 128: 72-82.

Hirdes, J. P., Smith, T. F., Rabinowitz, T., Yamauchi, K., Perez, E., Curtin Telegdi, N. et al. (2002). The resident assessment instrument-mental health (RAI-MH): Inter-rater reliability and convergent validity. *Journal of Behavioral Health Services and Research*, 29(4), 419-432.

Hoffmann, N.G. (2007). UNCOPE.
http://www.evinceassessment.com/UNCOPE_for_web.pdf

Hoffman, R., & Brown, G. (2009). interRAI-MH Police Screener for Mental Health Status. Law and Disorder – Creating Momentum for Change, Niagara Falls, 2009.
<http://www.hsjcc.on.ca/Uploads/3D%20-%20The%20Use%20of%20a%20Frontline%20Screener.pdf>

Home Office. (1990) *Provision for Mentally Disordered Offenders: Circular 66/90* London: Home Office.

Home Office. (1995). *Mentally Disordered Offenders: Inter-Agency Working: Circular 12/95* London: Home Office.

Howard, J. (1777). *The state of the prisons in England and Wales, with Preliminary Observations, and an Account of Some Foreign Prisons*. London: William Eyres

James, D. V. (1999). Court diversion at 10 years: can it work, does it work and has it a future? *Journal of Forensic Psychiatry*, 10: 507-524.

James, D. V., & Harlow, P. (2000). Increasing the power of psychiatric court diversion: a new model of supra-district diversion centre. *Medicine, Science and the Law*, 40(1): 52.

Kingham, M., & Corfe, M. (2005). Experiences of mixed court liaison and diversion scheme. *Psychiatric Bulletin*, 29: 137-140.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L., Walters, E. E., & Zaslavsky, A. M. (2002), Short screening scales to monitor population prevalence and trends in nonspecific psychological distress. *Psychological Medicine*, 32: 959-976.

McKinnon, I. & Grubin, D. (2010). Health screening in police custody. *Journal of Forensic and Legal Medicine*, 17(4), 209-12.

Ministry of Justice. (2009) *A compendium of research and analysis on the Offender Assessment System (OASys) 2006-2009*. London: Ministry of Justice.

Ministry of Justice. (2010). *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders*. London: The Stationery Office.

Nacro. (2005). *Mentally Disordered Offenders: Standard 1 initial contact with the police*. London: Nacro.

National Policing Improvement Agency. (2010). *Guidance on Responding to People with Mental Ill Health or Learning Disabilities*.

http://www.npia.police.uk/en/docs/Mental_ill_Health.pdf

Perry, A., Marandos, R., Coulton, S., Johnson, M. (2010). Screening tools assessing risk of suicide and self-harm in adult offenders. *International Journal of Offender Therapy and Comparative Criminology*, 54: 803-828.

Phelan, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., Strathdee, G., Loftus, L., McCrone, P., & Hayward, P. (1995). The Camberwell Assessment of Need: the validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry*, 167: 589-595.

Reed J (Chair) Department of Health and Home Office. (1992). *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services*. London: The Stationery Office.

Sainsbury Centre for Mental Health. (2008). *From the Inside: Experiences of prison mental health care*. London: Sainsbury Centre for Mental Health.

Sainsbury Centre for Mental Health. (2009). *A better way for criminal justice and mental health*. London: Sainsbury Centre for Mental Health.

Singleton, N., Meltzer, H., & Gatward, R. (1998). *Psychiatric morbidity among prisoners*. London: The Stationery Office.

Shaw, J., Creed, F., Price, J., Huxley, P. & Tomenson, B. (1999) Prevalence and detection of serious psychiatric disorder in defendants attending court. *The Lancet* 353: 1053-1056.

Shaw, J., Tomenson, B. & Creed, F. (2003) A screening questionnaire for the detection of serious mental illness in the criminal justice system. *Journal of Forensic Psychiatry and Psychology*, 14(1): 138-150.

Shaw, J. et al. (2009). *A National Evaluation of Prison Mental Health In-Reach Services*. University of Manchester: Offender Health Research Network.

Slade, M., Powell, R., Rosen, A., & Strathdee, G. (2000). Threshold Assessment Grid (TAG): the development of a valid and brief scale to assess the severity of mental illness. *Social Psychiatry and Psychiatric Epidemiology*, 35: 78-85.

Slade, M., Cahill, S., Kelsey, W., Powell, R., & Strathdee, G. (2002). Threshold 2: the reliability, validity and sensitivity to change of the Threshold Assessment Grid (TAG). *Acta Psychiatrica Scandinavica*, 106: 453-460.

Slade, M., Cahill, S., Kelsey, W., Leese, M., & Powell, R. (2002). Threshold 4: an evaluation of the Threshold Assessment Grid as an aid to mental health referrals. *Primary Care Mental Health*, 1: 45-54.

Slade, M., Gask, L., Leese, M., McCrone, P., Montana, C., Powell, R., Stewart, M., & Chew-Graham, C. (2008) Failure to improve appropriateness of referrals to adult community mental health services - lessons from a multi-site cluster-randomised controlled trial. *Family Practice*, 25: 181-190.

Slade, M., Thornicroft, G., Loftus, L., Phelan, M., & Wykes, T. (1999) CAN: Camberwell Assessment of Need. London.

Swartz, J. A. & Lurigio, A. J. (2005) Screening for SMI among criminal offenders. *Research in Social Problems and Public Policy*, 12: 137-161.

Teplin, L. A. & Swartz, J. (1989) Screening for severe mental disorder in jails. *Law and Human Behaviour*, 13, 1: 1-18.

Thomas, S.D., Slade, M., McCrone, P., Harty, M.A., Parrott, J., Thornicroft, G., & Leese, M. (2008) The reliability and validity of the forensic Camberwell Assessment of Need (CANFOR): a needs assessment for forensic mental health service users. *Int J Methods Psychiatr Res.* 17:111-20.

Ware, J. E., Kosinski, M., & Dewey, J. E. (2000). *How to Score Version Two of the SF-36 Health Survey*. Lincoln, RI: Quality Metric Incorporated.

Winstone J & Pakes F, (2008) *Report on national criminal justice mental health team audit (England)*. London: Department of Health.

Winstone, J. & Pakes, F. (2010) *Liaison and Diversion: Best Practice Assessment*. London: Department of Health.

Xenitidis, K., Thornicroft, G., Leese, M., Slade, M., Fotiadou, M., Philp, H., Sayer, J., Harris, E., McGee, D. & Murphy, D. (2000). Reliability and validity of the CANDID - a needs assessment instrument for adults with learning disabilities and mental health problems. *British Journal of Psychiatry*, 176: 473-478,

9 Appendices

9.1 Liaison and Diversion Evaluation Pathfinder Scheme Questions

Section One: Business Process

- 1.1 In order to understand your service can you briefly explain your business process?
- 1.2 Is the process the same for each type of referral?
- 1.3 Is the process the same for each service user referred?
- 1.4 What is the schemes first point of contact with the service user?
- 1.5 Where do you engage with service user?
- 1.6 What is the schemes last point of contact with the service user?
- 1.7 Do the scheme monitor/follow-up any next stage activity of the service user?
- 1.8 If yes, what is involved as part of this follow-up?
- 1.9 Does the scheme utilise care pathways?
- 1.10 Are these linked / agreed by PCT?

Screening

- 1.11 Who do you screen?
- 1.12 In what location do you screen?
- 1.13 Who (staff) screens?
- 1.14 What screen do you use?
- 1.15 What is the screen for?
- 1.16 What evidence do you have that supports it or identifies its effectiveness?
- 1.17 What do you do with the screening information?
- 1.18 Who collates the screening information?
- 1.19 Where is it recorded?
- 1.20 What triggers an assessment? Cut-off?
- 1.21 How is the screening information communicated to others and passed on?
- 1.22 Is it the same process in all sites? If not how do they differ?
- 1.23 Is there a set referral process?

Assessment

- 1.24 Who do you assess?
- 1.25 In what location do you assess?
- 1.26 Who (staff) does the assessment?
- 1.27 What does the assessment cover?
- 1.28 Is there a specific mental health assessment?
- 1.29 Is it the same person who does all the assessments? i.e. do different staff do a mental health and drug and alcohol
- 1.30 Do any of the assessments include social care i.e. housing needs?
- 1.31 Do you have specific assessments for different people i.e. women, BME
- 1.32 What evidence do you have that supports it or identifies its effectiveness?

- 1.33 Who collates the assessment information?
- 1.34 Where is this documented?
- 1.35 Who has access to the assessments?
- 1.36 Who and how do you communicate the results of the assessment?
- 1.37 Do you provide reports for courts?
- 1.38 Do these include recommendations for sentence options?
- 1.39 What do you do with the results of the assessment? Just referral decisions or more than that?

Section Two: Data sharing, collection and usage

- 2.1 What data is passed from and to each interface as part of the process?
- 2.2 Is this defined in a data sharing agreement?
- 2.3 What data is collected and stored as part of the management process?
- 2.4 What do you need data for?
- 2.5 What value does this add to the provision of the service?
- 2.6 Are you ever required to refer back to data?
- 2.7 Is this data used for reporting?
- 2.8 If so, who to?
- 2.9 What data do you need for commissioners?

Section Three: Pathways

- 3.1 What does the term diversion mean to your service?
- 3.2 Do you know how many people have their cases discontinued?
- 3.3 Do you see the team as having more of a liaison/referral/intervention role, than diversion?
- 3.4 What community options do you have for people? i.e. bail hostels, MHTR, 3rd sector organisations
- 3.5 If more people were to remain in the community i.e. not remanded/sentenced, what additional services would you need access to?
- 3.6 How and who joins your service with the wider CJS?
- 3.7 Are you notified of prison discharges?
- 3.8 Are you notified of court decision?
- 3.9 How do you know your scheme is successful?

9.2 List of sites and documents supplied

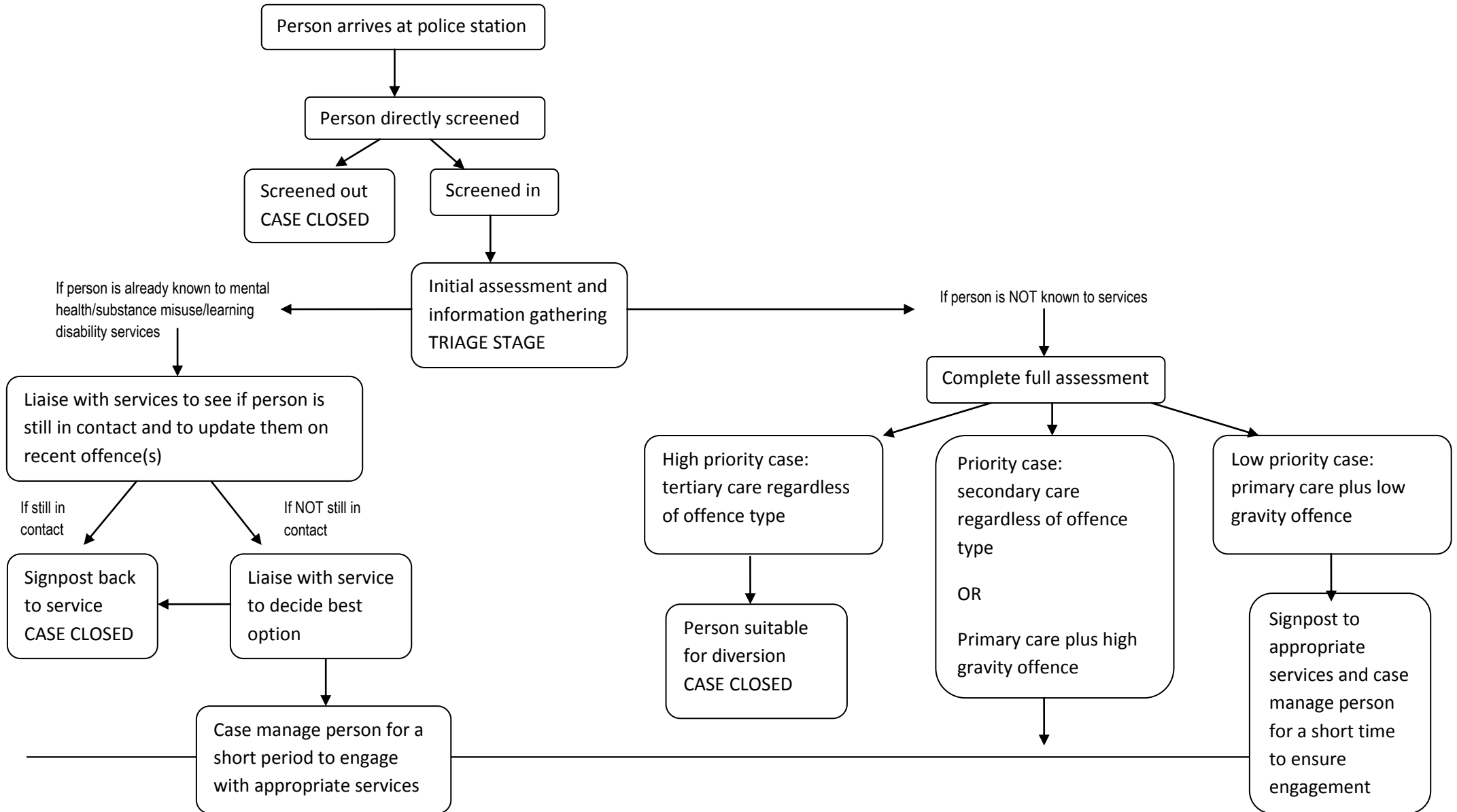
Site	Method	Operational Policy	Referral tools	Screening tools	Assessment tools	Outcome reports
Avon and Wiltshire Diversion Service	Face-to-face	Yes	Yes	Yes	Yes	Yes
City of Westminster Court	Face-to-face	No	No	No	No	No
Norfolk CJMHT	Face-to-face	Yes	Yes	Yes	Yes	Yes
Derbyshire CJMHT	Face-to-face	Yes	Yes	Yes	Yes	Yes
Barnsley CJLT	Face-to-face	Yes	Yes	Yes	Yes	Yes
Merseycare CJMHT	Face-to-face	Yes	Yes	Yes	Yes	Yes
Lancashire CJMHT	Face-to-face	Yes	Yes	Yes	Yes	No
Sandwell CJMHT	Phone	Yes	No	No	No	No
North East CJMHT	Face-to-face	Yes	Yes	Yes	Yes	Yes
Hampshire Court Liaison and Diversion Scheme	Face-to-face	Yes	Yes	Yes	Yes	Yes
Manchester MO:DEL	Face-to-face	Yes	Yes	Yes	Yes	Yes
North East Lincolnshire Forensic Mental Health Services	Face-to-face	Yes	Yes	Yes	Yes	No
Nottinghamshire Criminal Justice Liaison Service	Phone	Yes	Yes	Yes	Yes	Yes
Reading Divert Team	Face-to-face	Yes	Yes	Yes	Yes	Yes
St Albans	Phone	Yes	Yes	Yes	Yes	No
Sussex CJLS	Face-to-face	No	No	Yes	Yes	Yes

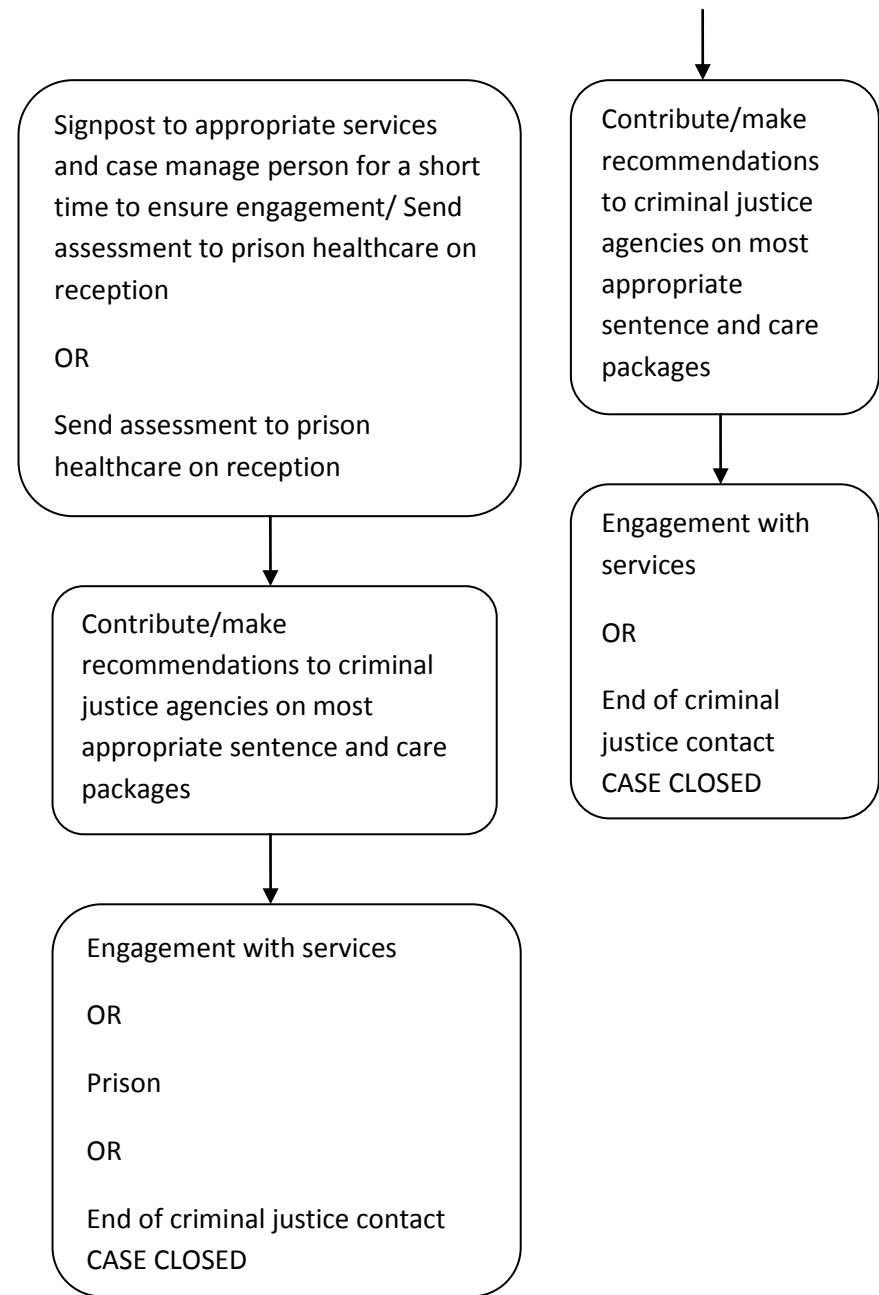
Together Forensic MHP Service Lambeth & Southwark	Face-to-face	Yes	Yes	Yes	Yes	Yes
Warwickshire CJMH Liaison Service	Face-to-face	Yes	Yes	Yes	Yes	Yes
West Dorset Custody Liaison	Face-to-face	Yes	Yes	Yes	Yes	No
West London Magistrates Court CJLD Scheme	Face-to-face	Yes	Yes	Yes	Yes	Yes
Westminster Police Liaison Nurses	Face-to-face	Yes	Yes	Yes	Yes	No

9.3 Winstone & Pakes (2010) Minimum Data Set

DIVERSION AND LIAISON MINIMUM DATA SET (PRE-ARREST TO POST SENTENCING)				
Personal Data		Referral/Screening/Assessment Data		At Court and Sentencing
Personal PNC ID HMCS Case Number Health identifier Name/Address/Postcode Date Of Birth Gender Ethnicity General Practitioner Language (Spoken)/Interpreter Employment Status Employment Type Accommodation Status Benefit Type Relationship status Armed Services Veteran Offence History Number Of Previous Convictions Main Type Of Previous Convictions Index Offence Date Of Index Offence Police Station Existing licence or supervision requirements Mental Health History Diagnosed Condition Previous contact with mental health services (where/when/what) Previous hospitalisation Current contact with mental health services (where/when/what) Current care/treatment plan Risk of self harm and suicide Care co-ordinator (CPA) details	Learning Disability Nature of Learning Disability Previous contact with support services (where/when/what) Current contact with support services (where/when/what) Current medication Dual Diagnosis History Current Substance Misuse Issues Substances Misused Previous contact with support services (where/when/what) Current contact with support services (where/when/what) Current medication	Screening Source of screening Date of screening Outcome of screening Referrer Referral Date Liaison (where/when/what) Assessment Assessment Date Source of assessment Outcome of assessment Psychiatric Report Liaison (where/when/what) Onward Referral Signposting (where/when/what) Referrals/appointments (where/when/what) Liaison (where/when/what)	Plea Plea Date First Court Date Remand in custody/bail Special measures (best evidence) Type Of pre-sentence report Expert Reports/timeliness Sentence/Disposal/Outcome Sentence Start Sentence End Current Statutory Supervision Current engagement with health services Current engagement with other services Breach of Order/date of breach/new sentence/disposal/outcome	
		Police	Ongoing Engagement	
		Neighbourhood policing/intelligence vulnerability marker Number of previous convictions Main type of previous convictions Index offence(s) Date (time) of index offence(s) Date (time) of arrest Date (time) charged/cautioned/released Appropriate adult/interpreter/intermediary required Bail/custody to first court appearance Diversion service response time (or police to recorded time diversion service requested and diversion service to record time assessment undertaken)	Each review/contact/activity should be recorded including the following data: Contact (type) Review (type) Referral (type) Liaison (where/when/what) Other activity (where/when/what) Plan of work Risk Management (e.g. MAPPA) Next referral/contact date	

9.4 Service Model





Offender Health Research Network

Jean McFarlane Building (2nd Floor)
University of Manchester
Oxford Road
Manchester
M20 6TZ

Website: www.ohrn.nhs.uk
