Big Diversion Project
Current State Analysis of Diversion Services in the North East Region – Final Report

Revolving Doors Agency
13th April 2012

Acknowledgements

Abstract

This report forms part of the North East's Big Diversion Project. It outlines findings from an analysis of current regional provision of 'diversion' services for those with mental health problems or learning disabilities. As well as the six Criminal Justice Liaison and Diversion (CJLD) in the region, the research also considered a range of other practice and provision for the identification and support of those with mental health problems or learning disabilities across the criminal justice pathway. Research involved interviews with regional stakeholders and national experts, focus groups, surveys and an analysis of documentary evidence and available data.

Regional provision and key issues are mapped across the criminal justice pathway and overarching themes for service development were identified. CJLD services need to extend their coverage geographically, across the pathway and in terms of operational hours. They need to provide a broader response by opening up care pathways into a wider range of services. Courts need increased support and information from CJLD services to inform decision making. Responses to mental health crisis in the community require improvement through improved joint working between police and health agencies. There is poor awareness of service provision and referral pathways among a range of agencies. Data collection and monitoring requires significant improvement to inform service development. Finally, responses to learning disability, autism and related conditions need to be improved across the criminal justice pathway.

The research also maps regional provision for service user involvement across a range of services that might be utilised in forthcoming work and a financial analysis of the potential impact of particular service changes is provided.

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Executive Summary

Introduction to the Big Diversion Project

The Big Diversion Project (BDP) has been commissioned by the North East Offender Health Commissioning Unit (NEOHCU) with the aim of improving health and reoffending outcomes for offenders with a mental health problem, learning disability or a dual diagnosis of mental ill-health and substance misuse across the criminal justice pathway.

The first phase of this project was a literature review undertaken by Dr Wendy Dyer to consider best practice developments in diversion and liaison services following the Bradley Review (Dyer, 2011). The BDP has now entered phase 2, the development phase. Northumbria, Tyne and Wear NHS Foundation Trust (NTW) and its partners Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) and Revolving Doors Agency have been commissioned to deliver this phase.

This report constitutes the first part of this phase; an analysis of current provision within the region and a range of recommendations for further work and pilot development.

Approach to the analysis phase

The analysis took place between November 2011 and March 2012. Interviews were undertaken with regional stakeholders across a range of services, including health and criminal justice agencies. Stakeholder views were also gathered through focus groups, surveys and two events. Documentary evidence was reviewed where relevant. Significant attempts were made to obtain quantitative data regarding client needs and service use but current data collection processes and problems obtaining data within time constraints proved a significant barrier. A national perspective has been gathered through a literature review and interviews with experts.

Summary of key issues identified

Stage 1: Pre-arrest and the use of Section 136 of the Mental Health Act (MHA)

Finding appropriate alternatives to section 136

The analysis suggests that Section 136 of the Mental Health Act is being used inappropriately when an alternative, less restrictive intervention might be offered instead. 76% of s.136 detainees in Cleveland and 55% in Durham are released with no further action taken.

Health staff in both Trusts reported that inappropriate detentions were frequently alcohol-related. Both police and health interviewees suggested police can be too quick to use the section where they could be arresting for an offence. Funds have been obtained from the Department of Health to develop a First Response team in Cleveland in which a mental health professional will accompany the police when responding to s.136 incidents. It was also reported that there had been a significant and positive shift strategically from the police to focus on the appropriate use of s.136.

Transportation of detainees

All interviewees stated that, contrary to national and local guidance, transportation of a person detained under s.136 was almost always by police vehicle. Attendees at a service user focus group held in Newcastle reported that they had only ever been transported by police vehicle under section 135/6. There was a sense among strategic stakeholders interviewed that work was underway to improve this situation with multi-agency agreements recently put in place.

Increasing access to appropriate places of safety

In Cleveland 60% of s.136 detainees were detained in police custody in the period September 2010 – August 2011. In Northumbria just over half of the s.136 detentions were in police custody in 2011, while in Durham this was just 30%. While the preference should always be for detention in the designated s.136 suite, which 'place of safety' is deemed the most appropriate will inevitably be circumstance-specific. Despite joint protocols, interviewees revealed tensions between police and health staff over access to s.136 suites with particular tensions around intoxicated detainees and staff following agreed protocols.

Reducing waiting times for assessment

Interviewees from all areas reported issues over long waiting times for assessment by a section 12 doctor and an Approved Mental Health Professional (AMHP). This was also an issue raised by service users who reported that this added to their distress. Although multi-agency policies give clear time limits within which the assessment should take place (3 hours NTW, 4 hours TEWV), it was reported that assessments frequently failed to take place within these limits, especially out of hours. Police officers reported waiting with a detainee for long periods in the mental health unit, representing a significant use of police resources, which concerned police.

Reasons given for this delay included a lack of designated staffing to cover the s.136 suites and particular difficulties securing the attendance of an AMHP. It was reported that service restructurings had reduced the size or capacity of Emergency Duty Teams (EDTs) resulting in particular problems out of hours.

Strengthening partnership working in response to mental health crisis

Mental Health Crisis teams play an important role in supporting those with severe mental health problems in the community. Given the role of the police in handling crisis situations in the community where there is a risk of harm to the public, it is clear that effective joint working between the two agencies is crucial. This is not limited to practice around s.136 but also includes a range of other situations in which cooperation is needed to manage a patient with deteriorating mental health needs.

The view was expressed that current arrangements for joint working were not always as effective as they needed to be. Police officers expressed concern about a perceived lack of cooperation from mental health teams and a reliance on police officers to provide support that was perceived as out of their remit. Senior representatives from both health Trusts acknowledged that greater work had to be undertaken to increase understanding of each other's roles, remits and the demands on their service.

Stage 2 - Police custody

Improving identification without slowing down police process

Screening for mental health problems or learning disabilities forms part of the police's risk assessment when an arrestee is brought into custody. Concern was expressed by senior police officers and mental health leads from all forces that people with mental health problems or learning disabilities who were unwilling to self-report or who were not displaying very clear signs of mental distress were being missed. Particular difficulties were reported in identifying mild learning disabilities and conditions on the autism spectrum.

Police interviewees emphasised that their primary purpose in screening is to ensure that arrestees are held safely in custody and their rights are maintained; not to facilitate access into treatment. National and regional interviewees highlighted reluctance by police to make any adaptations that would lengthen their screening processes.

Ensuring adequate and timely provision of appropriate adults

All three police forces appeared to experience problems obtaining an appropriate adult within acceptable timescales. Inspectorate reports on custody provision across the region identify significant delays, difficulties with out-of-hours provision and refusals by the EDT to attend. The lack of an appropriate adult during police interview was also reported by service users.

Only Middlesbrough police custody suite has a dedicated appropriate adult service. Research suggests that areas without a dedicated appropriate adult service are particularly prone to under-identifying vulnerability. The concern was also expressed that medical professionals in custody suites act as gatekeepers to such support using their own higher thresholds for access to services rather than the lower threshold outlined in PACE legislation.

Better utilising existing resources within police custody suites

Interviewees repeatedly highlighted the potential to better utilise existing 'untapped' resources in custody suites to maximise those who are screened for mental health problems and learning disabilities as well as a much wider range of needs. In the North East there are a range of healthcare providers operating in police custody suites and regional coverage of drug and alcohol arrest referral workers.

The numerous professionals working within custody suites have a range of different backgrounds and skill-levels. Forensic Medical Examiners have all had some mental health training but not all are approved under s.12 of the MHA. Nursing staff are mostly registered general nurses (RGNs) with A&E experience.

Individual agency screening processes differed. Interviewees highlighted the need for a generic screening tool that could be undertaken by a range of practitioners to enable referral to the appropriate support service for a fuller assessment. This approach was being adopted in other areas of the country where services were contemplating how to reach more people in a time of diminishing resources.

Identifying clear care pathways and a single point of contact

Police officers in both Northumbria and Durham forces emphasised that pathways into care were confusing for police and that there needed to be a clearer structure for referral and assistance. Frontline police officers called for a single point of contact with mental health services.

Unclear care pathways for mental health were not identified as a significant issue by interviewees from Cleveland police, possibly due to the establishment of Mental Health Liaison Officers within the force. Gaps were identified in pathways for learning disability and it was suggested that more could be done by community learning disability (LD) services within TEWV to promote their service to the police and to strengthen care pathways.

Regionally, care pathways appeared clearer for support with drug issues due to drug arrest referral provision to all police custody suites. There was evidence of gaps in alcohol custody provision.

Ensuring officers receive regularly repeated, high quality training

Some mental health training had been provided across all three police forces. Typically, this was delivered as an e-learning package. There was concern that this training did not adequately equip officers to deal with people with mental health problems or a learning disability.

This training came at the detriment of training from local agencies which can provide an invaluable opportunity for the development of links into local services. Durham had undertaken some work with their local Mind around recognising mental health problems and referral pathways.

Stage 3 – Criminal Justice Liaison and Diversion (CJLD) Services

Re-focusing the services towards the front-end

There are six existing CJLD services which vary as to where they sit within the criminal justice pathway. Many national and regional stakeholders emphasised a need for the services to be focused at the front-end of the criminal justice system, i.e. in police stations and in courts.

Interviewees expressed considerable concern that without such a focus on the front-end, many people were being missed altogether or failing to have their needs identified until key decisions regarding their case had already been made. Particular concerns were raised about missing those who were quiet and compliant in custody or those who appeared at court on bail or on summons.

Although all interviewees agreed that catching people earlier was important, there was disagreement as to whether the court or the police station should be prioritised. The former offered an opportunity to catch the most people at the earliest stage, but the latter offered the greatest opportunity to impact on the legal decision-making process.

Improving information sharing with courts and other agencies

Positioned at the interface between health and criminal justice agencies, CJLD services were ideally placed to facilitate the flow of information between the two agencies. All CJLD workers reported feeling comfortable in sharing relevant information about clients, and all ask permission to do so at assessment. Nevertheless, despite strong information sharing with a range of agencies, information sharing with courts (as opposed to court custody staff) was underdeveloped. The Bedlington service is the only service in the North East region where a system is currently in place to systematically provide information to courts; this service will also be provided at the new Sunderland service.

Court probation staff and Deputy Justice Clerks consulted wanted greater provision of mental health information. Interviews with staff from the Crown Prosecution Service (CPS) indicated that they would also welcome more of such information to inform their decisions about whether it was in the public interest to proceed and culpability (*mens rea*).

Low involvement in diversion into alternative disposals

Most of the services played only a very limited role in the diversion of those with mental health conditions or learning disabilities into a range of alternative disposals such as alternative sentencing options and the arrangement of hospital orders under section 37 of the MHA. In part this low involvement in diversion reflects the rarity of cases where mental health conditions or learning disabilities are severe enough to warrant whole-scale diversion from the justice system into the health system.

None of the services reported involvement in the provision of formal psychiatric reports and only had access to a forensic psychiatrist informally through their links to Forensic Services. With the exception of South Tyneside (which is embedded in probation), no service had been involved in developing alternative packages of care that supported a non-custodial disposal. Experts highlighted the importance of having a service to divert someone into.

Maximising coverage

One concern across all of the services working in police custody, as well as some police staff, was incomplete CJLD coverage in terms of the criminal justice pathway, geography and hours of operation. The CJLD services all operated five days a week only and had different operating times; there was no CJLD coverage out of hours. Plans were in place in the TEWV-provided Cleveland, Durham and Darlington service to bolster staff numbers in the CJLD team during the high demand morning period through the introduction of staff sharing arrangements with the TEWV-run prison in-reach services. Plans are also afoot to develop a service in Sunderland with funding from Department of Health. Police custody suites in Newcastle and North Tyneside are not provided with a service.

Improving relationships with other health and criminal justice services

Relationships between CJLD services and services with which they worked closely on a daily basis were generally strong with a few service-specific exceptions. However, a range of other relevant agencies reported low awareness of these services or low clarity about the services being offered. Our survey of probation staff suggested extremely low awareness of the CJLD services among probation officers from both Probation Trusts within the region. 42% of respondents said that they were not aware of a CJLD service operating in their area (excluding those respondents known to be based in Sunderland). In addition, interviewees from other agencies such as the CPS or Her Majesty's Courts and Tribunals Services (HMCTS) were unaware of these services or unclear what they offered.

There was also a need in some areas (across both Trusts) to improve relationships between CJLD teams and secondary mental health services including access and recovery teams, crisis teams and primary care. Commonly identified problems included a poor awareness among community staff of the CJLD teams, their coverage, their role and the assistance that they may be able to provide. CJLD practitioners in both Trusts suggested that so far there had been a failure to adequately promote what they do, although some work was underway to address this. Significant problems also existed for some teams in facilitating access to community services for clients, with reported difficulties getting referrals accepted by other services within their own Trust.

Where good relationships did exist, these were associated with services that had currently or historically had close staffing or management links with the crisis teams. Concern was expressed about how these relationships might develop in the future due to recent changes in management

structure. The importance of personal links for CJLD work was stressed throughout the interviews. These could be facilitated through joint-working, inter-service cover and co-location of services.

Developing care pathways into the voluntary sector to meet a wider range of needs

For the most part referral pathways appeared to be into health services including those provided by the Trust, those in primary care and other services within police stations.

Although some of the clients seen by the services have severe and enduring mental health problems, it was reported that the majority suffer from common mental health problems or personality disorders interwoven with a range of other health and social problems including substance misuse. The region has a significant number of voluntary-sector services providing support for a range of needs but few of the CJLD services had developed strong links and resulting care pathways with these services. Housing and homelessness was cited as a frequent and significant problem. However, intervention was usually limited to signposting the client to the local authority housing options or homelessness teams.

A number of practitioners highlighted that it could be difficult to keep up-to-date what with regular changes in the service landscape.

Overcoming information technology barriers

Issues were identified regarding access to information held about clients on Trust records or those of other services. In areas with remote access to the Trust database, practitioners identified how helpful this was. Facilitating this access remotely will clearly be an important development step for the services without this provision.

Even those services with good access to their respective Trust databases faced the much more impenetrable problem that there is no one universal health database so that information is held across a range of different systems.

Monitoring activity and outcomes

Information regarding referrals to services were entered onto the respective Trust databases but there was only very limited monitoring of activity and no monitoring of outcomes at all undertaken by any of the services. This was partly due to the use of Trust systems, which lacked appropriate fields in which to enter criminal justice information and activity. Another central problem was a lack of staff capacity among any of the teams to undertake any proactive follow-up work of clients to determine whether a referral was successful and whether a client's mental health or re-offending rate improved.

Managers of all the services recognised that the current situation regarding monitoring of activity and outcomes was inadequate and some work was underway or anticipated in both areas to rectify this. There was also significant anticipation that the national Pathfinder programme, of which all the CJLD services in the region other than Bedlington form a part, might provide a standardised data set for diversion services nationally that the Trusts would then use.

Improving the service for those with a learning disability

None of the CJLD services had any dedicated input from a learning disability practitioner. Consequently there was no capacity to undertake a full learning disability assessment and no standardised screening tool validated for a custodial population was used. Practitioners within the services varied as to whether or not they considered current practices adequate in identifying and

meeting the needs of learning disabled offenders. However, a senior representative from Forensic Learning Disability Services in TEWV expressed considerable concern at the very low number of referrals to their community service received from the Cleveland, Durham and Darlington CJLD service.

In addition there were a number of other conditions such as autism, Attention Deficit Hyperactivity Disorder and Acquired Brain Injury where a lack of expertise, validated screening tools and knowledge of care pathways meant these were likely to go unnoticed by CJLD services.

Stage 4 – Courts

Strengthening sources of information to the courts

Limited CJLD coverage means that in most areas pre-conviction information about a defendant's health needs and their impact on the court process originates from the police via the prosecution, the defendant via the defence solicitor. Concerns were expressed that sources of information were indirect and often incomplete. Defendants might withhold information due to concerns regarding stigma or negatively impacting the outcome of the case and although perceived as a good source of information, defence solicitors usually only passed on information when it was preferable to the defence. For example, only favourable psychiatric reports were made available by the defence.

Deputy Judicial Clerks surveyed expressed near-unanimous desire for a mental health professional in court who could identify issues and provide immediate advice and support to the court. In addition, a number of interviewees requested written nursing reports that were made available to all parties in the process which could provide an indicator as to whether a full psychiatric report was necessary.

Identifying need in defendants on bail or on summons

It was emphasised that severe mental illness or learning disability was not confined to those who had committed serious offences and a number of Deputy Justice Clerks highlighted the lack of provision for identifying and informing the court of the mental health needs or learning disability of a defendant who appears in court on summons or on bail. This is because the focus of all the CJLD provision in the region is on those clients who are being held in police custody or in the cells attached to the court. However, many defendants were not held in either location or were only held for a short period, at a time when there was no CJLD service in operation. Again it was argued strongly that a mental health professional was needed in court to proactively screen this group and provide immediate advice to courts.

Reducing delays without reducing fairness of outcomes

Where possible, courts wish to avoid any delays to the court process. There has been a move towards Fast Delivery Reports from probation which can be turned around for the court on that day, An inevitable consequence of this shift is that there is a reduced opportunity to identify need and the court is provided with less detailed information; although if a mental health problem is identified full reports are usually requested.

Adjournments for further information, in particular for full psychiatric reports could add lengthy delays into the process that were not welcomed by the courts.

Improving current processes for obtaining formal psychiatric reports

Surveys of probation staff and Deputy Judicial Clerks as well as interviews with stakeholders, all identified clear discontent with current practice around the provision of formal psychiatric reports to the courts. Concerns focused around a number of key areas: finding a psychiatrist willing to produce the report within the statutory cost restrictions, time taken to complete these reports, communication between probation and court authors regarding the content of the report and sentencing implications, and quality and relevance of these reports.

Work is underway currently to ameliorate some of these problems. A draft Service Level Agreement (SLA) has been developed regarding the commissioning of psychiatric reports. There are also plans to develop a pro forma letter for the requesting of reports so that there is clarity about what is expected.

Increasing engagement with the court process

Interviewees at both national and local level identified the need to recognise the impact of mental health problems and learning disabilities on the defendant's engagement with the court process and how to maximise this engagement; an Easy Read pilot with bail forms was suggested.

There is a statutory requirement for the provision of appropriate adults to vulnerable adults during the police process but no accompanying provision for court support. Without support engagement with the court process was likely to be reduced and Magistrates might misinterpret certain behaviour associated with conditions as disrespectful.

Increasing awareness of impact and alternative options for sentencing

Even where mental health needs or learning disabilities were identified there remained a risk of Magistrates up-tariffing sentences for offenders in order to facilitate access into treatment. Equally problematic was the practice of down-tariffing sentences so that problematic behaviour went unchallenged (highlighted as a particular problem for those with learning disabilities). Finally, without awareness of the impact of sentencing decisions on these offenders there was a risk that sentences would be imposed that could not be complied with precisely because of health conditions or which could cause such conditions to deteriorate.

It was felt that Magistrates needed to have sufficient understanding of the interplay of health conditions, offending and sentencing options so that they could sentence appropriately. A strong case was made for CJLD-led training for Magistrates on mental health and learning disability awareness; this had been well received by Magistrates where it had been introduced elsewhere.

Clarifying processes around Mental Health Treatment Requirements (MHTRs)

Nationally research has shown that these requirements are used infrequently, in comparison both to the number of other orders used as well as the proportion of offenders who have mental health conditions. This picture is mirrored locally.

Our probation survey found that 72% of respondents said that they would infrequently or never consider recommending a MHTR to the courts for defendants with a mental health problem or learning disability. A range of barriers to the recommendation of such orders were reported: uncertainty over which mental health conditions it may be appropriate for, difficulties associated with obtaining psychiatric reports, and unfamiliarity of procedures associated with MHTRs in general. The survey also identified significant lack of knowledge around making, operating and enforcing a

MHTR among respondents: 51% said that they were fairly or very unknowledgeable in making; 56% in operating; and 63% in enforcing a MHTR.

Developing a range of alternatives to custody

Several national and regional stakeholders questioned whether MHTRs were the appropriate response to mental health problems among offenders. Specified Activity Requirements were highlighted by national experts as one alternative intervention. These were easier to arrange and implement and unlike the MHTR (a medium-higher level order) this intervention is suitable for those who might have complex needs but have committed less serious offences, reducing the risk of up-tariffing. London Probation is exploring this approach as part of their liaison and diversion strategy.

Another potential approach is to strengthen existing non-custodial disposals through the provision of a voluntary support component from another agency such as a voluntary-sector service. This support could be offered to accompany any disposal, including discharges or fines. The WOW! Project in Newcastle currently provides such support to women offenders.

Stage 5 – Probation

What service should CJLDs provides to probation?

Senior stakeholders from probation reported mixed experiences of CJLD services and expressed a desire for greater engagement with the services, such as having CJLD staff based in their offices.

One stakeholder from health suggested that it was stigmatising for offenders in the community to access assessment and treatment services differently (i.e. via the CJLD route) to other people in the community. Nevertheless, this stakeholder reiterated the view expressed by other interviewees that CJLDs do have a role to play in supporting probation to access help from mainstream mental health services through problem-solving when probation come across barriers to referrals. It is also clear that if CJLDs are to provide interventions to divert offenders from custody, close working between the teams and probation at the pre-sentence report stage will be crucial.

Engaging offenders in community treatment

Although diversion strategies frequently focus on keeping offenders out of custody where possible, there are some problems with attempting to engage this client group in the community where they are 'uncontained' and where frequently chaotic lifestyles can inhibit engagement. Interviewees emphasised the need for those planning services to be creative when developing strategies to engage with this client group in treatment.

A promising pilot has recently been launched in the Darlington area which will see clinics provided by Talking Therapies (the local IAPT service) in the offices of probation and the Youth Offending Service offering both assessment and Cognitive behavioural Therapy (CBT) -based therapeutic interventions. If successful, this pilot will be expanded to North Durham.

Improving confidence and competence in working with these groups

Confidence of survey respondents in identifying a learning disability was lower than confidence around identifying mental health conditions. Over two-thirds (67.5%) of probation respondents said that they felt very or fairly confident in identifying a mental health condition among their clients. 59.6% said the same about identifying a learning disability. 42.9% of respondents agreed or strongly agreed that they had the knowledge and skillsto meet the needs of their clients with a mental health

condition, while 40.2% of respondents agreed or strongly agreed that they had the knowledge and skills in terms of a learning disability.

While these results are promising, there is still work to be done to ensure that the whole workforce who may come into contact with these groups of offenders have the knowledge and skills to work effectively with them.

Knowing where to access a range of community based support

The majority of probation survey respondents reported that they knew where to access help to assist them in managing an offender with a mental health problem (64.8%), however fewer reported that this was the case for offenders with learning disabilities (40.5%). As well as social care support for their clients, survey responses suggested probation staff wanted advice on how to approach offending behaviour work with clients with learning disabilities.

Despite this positive response around accessing support for mental health, requests for training frequently focused on practical advice regarding service provision locally and referral pathways. A number of respondents also highlighted difficulties with clients falling through gaps in between different services or failing to meet high service thresholds, with dual diagnosis and personality disorder highlighted as posing particular challenges.

Balancing need to protect confidentiality and to enable effective working

Senior stakeholders from both Trusts reported that steps were taken to ensure client consent before information is shared with other agencies. Without clear accessible policies, probation staff are reliant on discretion in order to determine what to share. Almost two thirds of probation staff who responded to our survey said that they were not aware of any formal protocols regarding what information is shared about an offender's mental health problems or learning disability.

Strengthening partnerships

Partnership-working was important to this agenda. Interviewees from both Probation Trusts and health expressed the view that services were responding well to those who were considered to present a high risk of harm. Such offenders are normally subject to Multi-Agency Public Protection Arrangements (MAPPA). Integrated Offender Management (IOM) has been suggested as a potential mechanism locally with which to improve multi-agency support for repeat offenders with mental health problems or learning disabilities.

In such partnerships it was important to have the right people around the table both in terms of range of services and the level of seniority of attendees so that they were able to allocate resources where necessary. Health engagement was seen as crucial and a number of stakeholders expressed concern that health has not yet fully engaged with the IOM agenda in all areas.

Through the analysis phase we have not been made aware of any strategic partnerships in place involving probation that allow joint-commissioning of services to support offenders with mental health problems. Such a strategic partnership was perceived to have had a strong impact in London.

Stage 6 – Prison

Missed opportunities earlier in the system

All of the prison mental health team managers expressed concern that a number of people with severe mental illnesses who were inappropriate for detention in prison were still making it through the criminal justice system as far as prison undetected. Many reported difficulties finding bed spaces to enable prisoners to be transferred out. The view was expressed that sentencers needed to be provided with sufficient health information at the remand and sentencing stages so that they had other choices but to engage in the false hope of sending vulnerable people to prison for the purposes of getting their needs identified and met.

Improving the identification of mental health problems and learning disabilities

There were mixed views as to how well processes for identifying mental health need among prisoners were working. Mental health managers were generally positive about current processes but senior prison staff were concerned that prison officers were failing to identify unmet need in quiet and undisruptive prisoners. As elsewhere in the system, there was concern regarding poor identification of learning disabilities. Both prison service and mental health staff felt that this was an area for improvement.

Nationally, the absence of a learning disability component in the initial health screen (the 'Grubin' test) has been identified as a problem. Instead, there was a heavy reliance on the Basic Skills test in education to indicate a learning disability. HMP Durham was a site for the Department of Health pilot for the Learning Disability Screening Questionnaire (LDSQ) but this has not been rolled out. In the South-West, prisons had chosen not to use this screening tool but had instead opted for incorporating a number of the questions from this tool into the health screen.

Improvements with regards to services for learning disabilities had however recently been put in place with the temporary recruitment of a learning disability-trained nurse at HMP Northumberland and the commencement of weekly Forensic Learning Disability sessions at the other prisons.

Disjointed computer systems

Few of the mental health teams had access to community systems and were therefore reliant on phoning local teams to get notes on clients faxed over which was time-consuming. Additionally, this information is spread over a range of different computer systems held by different areas and agencies so that access to one system was unlikely to address the problem .

Work was in progress to increase access to Trust record systems in the prisons. Secure laptops have been secured for the teams (or to be shared between teams) but there have been some difficulties with these laptops periodically locking out of the system for security reasons and then having to be taken out and back in via prison security which is not a simple process.

Passing information without an identified contact

Processes for passing health and risk information to community agencies on release were frequently impeded by the lack of an identified contact to whom this information to be passed. If the prisoner was not registered with a general practitioner (GP) or if they were not leaving under the care of a community mental health service, prison mental health workers resorted to providing a letter for the prisoner to take on their person on release.

Improving information sharing within the prison

There were some indications of problems around the sharing of information within prisons themselves.

Offender Management were understandably concerned with assessing and managing risk and the view was expressed that mental health workers must have access to a range of information that could aid with these activities. From a health perspective, mental health managers expressed frustration that they had not been made aware of psychiatric reports commissioned for court purposes. Since these were commissioned independently they remained separate from the health system and so relied on other agencies to make them aware of their existence.

Prison mental health workers reported that they often only became aware of these when a prisoner was approaching release when probation staff or parole boards wanted to know why the needs identified within these reports had not been addressed.

Opening up direct referral routes into community provision

Just as CJLD teams sometimes struggled to get clients accepted by Mental Health Trust services, so too did prison mental health teams. Managers commonly reported the problem of being bounced between different teams and wanted to be able to bypass the access function to refer into the community teams directly. Problems were exacerbated by wide catchment areas for most of the prisons so that prison teams were frequently required to work across different teams and different Mental Health Trusts. These Trusts varied as to their models of community provision, their threshold for access to a service and their route into services. A wide catchment area also inhibited the development of relationships with relevant professionals in community teams.

Engaging community support prior to release

It was felt that when release planning went well, it was often when professionals from community agencies were encouraged to come into the prison and develop a professional relationship with the client prior to release or maintain an existing relationship while their client was in custody. In this way, they were able to meet with the prison mental health worker prior to the client's release and start preparations in the community where that client was being released to with a smooth handover of care.

However, it was reported that some community teams could be more reluctant than others to come into the prison. Distance remained one other significant barrier to encouraging community mental health staff and other professionals to enter the prison and undertake face-to-face release planning. Additionally, prison security rules which dictated that a professional could only come into the main body of the prison on three occasions before they had to go through the lengthy and off-putting prison security clearance procedures or else attend via the main (or possibly the legal) visiting system were identified as other barriers.

Prison Mental Health Team Managers emphasised the importance of maintaining Care Programme Approach arrangements for those who were subject to this prior to custody but reported that frequently patients were discharged from this on imprisonment. It was also suggested that greater work could be undertaken to maintain informal support of families and carers while the prisoner was in custody.

Lack of warning about release dates

Many prisoners had significant ongoing health needs and release preparation required considerable planning to ensure that a co-ordinated package of care was in place. Such planning was frequently impeded by a lack of warning about release dates; unexpected releases from court, dropped charges or release on licence at short notice. Mental Health Team Managers reported frantic calls to crisis teams requesting urgent visits to vulnerable clients whose release was imminent or had already happened. Senior health stakeholders reported frustration felt by crisis teams at such phone-calls.

One stakeholder suggested that the Prisoner Escort Record could be utilised to request notification of release by court custody staff. Alternatively, there appears to be a role here for joint-working with CJLD services based within courts.

Housing

Managers reported that it was common for post-release housing arrangements to be put in place at the very last minute or for prisoners to be released without housing altogether. Even the location of an approved premise for a high risk client might not be finalised until the day prior to release.

Lack of planned housing was a serious problem in itself and a significant barrier to continuity of mental health care. Without an identified release area it was impossible to refer a prisoner to a community team, pass on health information about the client or undertake any positive pre-release work around engaging community teams.

Joint working between housing advice services and mental health teams is needed. A pilot in Stockton that offered recidivist offenders temporary tenancies in private accommodation was also identified as good practice by a number of stakeholders.

Integrating mental health with other resettlement planning

Provision and practice for release planning varies significantly across the prisons. In many cases it appeared that resettlement planning by mental health services was separate from any resettlement planning by other agencies within the prison. In both HMP Low Newton and HMP Durham improved integration between healthcare and Offender Management was desired, in particular with regards to information sharing. Two of three Heads of Offender Management interviewed raised this is an issue. It was suggested that problems revolved around concerns regarding confidentiality and different views of what it was appropriate to share.

Specific responses to short-sentence prisoners

Short term prisoners were identified by the commissioners (NEOHCU) as one of a number of priority groups for this project. The high levels of need and difficulties in ensuring access to support for this group of prisoners are clearly identified by the literature and this was reinforced throughout our interviews with prison mental health team managers, all Heads of Offender Management and other stakeholders who suggested that this group frequently fall through the net. Integrated Offender Management was identified as a particular mechanism for improving responses to this group.

Priority groups

Young people at the interface between children's and adult services were confirmed as a priority for stakeholders. Links needed to be developed with local services for black and minority ethnic (BAME) groups. Gender-specific, age-specific and BAME-specific approaches all needed to be developed and there was a clear need for improved monitoring of service access and outcomes with relation to gender and ethnicity. Improved responses to those with a learning disability, autism, dual diagnosis or personality disorder were also seen as a priority by stakeholders.

Overarching themes and key recommendations

A number of overarching themes and focus areas emerged from the analysis phase of the Big Diversion Project (BDP). Recommendations were then developed to address these issues.

Overarching theme	Focus areas	Recommendations
Reaching more people	1. Maximising those screened and improving screening procedures. 2. Ensuring regional coverage of CJLD services.	i. <u>Development Proposal:</u> A "one conversation" service with improved integration of existing resources at Middlesbrough Custody suite to provide enhanced screening, triage and onward referral. ii. The evidence from the analysis, coupled with early learning from Middlesbrough may be used to make the case to DH for funding for a similar service in Newcastle, where there are plans for a 50-cell custody suite.
Broadening the Response	3. Opening up care pathways into a far wider range of services including primary care, housing and other support services.	iii. <u>Development Proposal:</u> Enhanced support for offenders with mental health problems and other needs is provided through the extension of a complex needs consultancy service to Integrated Offender Management (IOM) services across the NTW area. iv. All current CJLD services should work within the limitations of current capacity to build links with local services and develop pathways which enable clients to access a wider range of support services. v. Practitioners undertaking this role should also have a training brief to explain the role and function of mental health services to IOM colleagues.
Supporting Decision-making	4. Provision of nursing reports to courts. 5. Improvement of procedures for obtaining full psychiatric reports. 6. Development and promotion of alternatives to custody.	vi. Consideration is given to resourcing the extension of the provision of written reports to North Tyneside magistrates where the practitioner is closely linked with the probation service and the physical environment is more conducive than at Newcastle magistrates. vii. This pilot could work with the Sunderland and Bedlington CJLD and local partners to develop a format for nursing reports which could then be tested across the region.
Responding to Mental Health Crisis	7. Arrangements and practice in the use of s.136 across the region, with a particular hotspot in Cleveland.	viii. Consideration should be given to the provision of awareness training to police that involved service users, possibly facilitated through M&S Mind and TEWV. ix. In the event that commissioners proceed with the proposed development at Middlesbrough custody, clear links and pathways should be developed between that service and the First Response service.
Learning	8. People with learning	x. <u>Development Proposal:</u> A multi-agency partnership in

Disability, Autism and other related conditions	disabilities, autism and Asperger's syndrome were identified as a priority group.	Durham area works together to establish a replicable process which enables local police, courts and prisons to better understand learning disability and autism and to link effectively with local LD services. This learning is then shared with other areas across the region.
Increasing Awareness	**9.** Poor awareness of service provision, referral pathways and roles and responsibilities of different services.	xi. CJLD services have a vital role to play at the interface between criminal justice and mental health teams and must ensure that stakeholder management is a key facet of their work. They should lead on multi-agency training in the area, bringing key stakeholders together. xii. Stakeholders at a local and regional level are kept informed by the BDP team of work and learning via a series of local and regional thematic learning events over the lifetime of the project. xiii. CJLD teams in Cleveland, Durham and Darlington should make use of 'hot desks' across the TEWV area and other services should think about developing relationships through co-location of services.
Data and Information	10. Data collection to inform commissioning and service development.	xiv. The set up of all activities following this analysis phase should include robust mechanisms for data capture and the evaluation team should be involved at an early stage in the development of outcome monitoring tools. xv. The proposed development in Middlesbrough will benefit from the collection and detailed analysis of a range of data including identification and analysis of the needs of individuals who have been subject to repeat arrest and/or s.136 detention.

Service User Involvement and a Financial Analysis

The report also maps provision for service user involvement in the region which might be utilised in the forthcoming phases of the BDP and a financial analysis of the potential impact of any changes.

1
Overarching themes, focus areas and recommendations

Overarching themes

This chapter sets out a series of overarching themes emerging from the analysis phase of the Big Diversion Project (BDP). The work has taken place at a time of great change. The expansion and evolution of the Criminal Justice Liaison and Diversion (CJLD) services described, is set against a wider backdrop of financial constraint and seismic change in the commissioning and delivery of criminal justice, health and social care services. In each thematic area, we set out a précis of the analysis. This is followed by the current developments and concludes with recommendations.

1.1 Reaching more People

Each of the current CJLD services has highly-skilled and committed staff members who are well equipped to identify mental health problems.

However, it is clear that there are significant numbers of people with unmet mental health problems or learning difficulties/disabilities passing through the criminal justice system in the North East without their needs being identified. For example, there were concerns that those who remained quiet and compliant in police custody were unlikely to be referred to services by police officers. A survey of (deputy) judicial clerks highlighted particular concern among court staff about the lack of any process for identifying needs in defendants who appeared at court on summons or on bail. Prison mental health team managers were frustrated that individuals were still arriving in prison with very severe needs which required a transfer to hospital.

The lack of data held by providers makes it impossible to evaluate penetration rates or impact of existing CJLD services.

Regional coverage is patchy, including no service in Sunderland and limited services in Northumberland, Newcastle and North Tyneside. Even in areas where coverage exists this usually does not cover the full offender pathway.

The number of people seen by CJLD services was further restricted at various sites by:

- limited service-operation hours
- limited staff capacity
- a lack of proactive screening using Trust records in some services
- reliance on ineffective police screening procedures and observation from untrained officers
- emphasis on seeing those already known to Trust mental health services
- lack of mental health professionals at police stations and courts in some services
- court activity focused on those held in cells.

> **Focus Areas**
>
> 1. Maximising those screened and improving screening procedures.
> 2. Ensuring regional coverage of CJLD services.

1.1a Development work in progress

- Regional coverage of CJLD services is due to expand significantly following successful bids to the Department of Health (DH) to develop a service in Sunderland and to strengthen the existing Bedlington service.
- All other existing schemes are part of a DH national pathfinder programme, which is aiming to build an evidence base of effective liaison and diversion services and the outcomes they generate. This will include a greater emphasis on systematic data capture.

- A mental health screening tool has been developed by Newcastle University for the Metropolitan police and discussions regarding a potential pilot in Northumbria are underway, partially linked to the new Bedlington and Sunderland CJLD services.

1.1b Recommendations

i.   Development Proposal

Vision

A "one conversation" service with improved integration of existing resources at Middlesbrough custody suite to provide enhanced screening, triage and onward referral.

Rationale

Middlesbrough is a large custody suite with 20, 578 detentions in 2011 and a good range of existing or proposed services including both adult and youth CJLD services, arrest referral, custody nurses, Mind enhanced appropriate adult services and supportive forensic LD services.

Improved integration would maximise coverage, providing greater value for money and enabling exploration of opportunities for joint commissioning. The proposal fits with the national direction of travel towards an "all age" diversion model and integration of services. It also aligns with the Bradley vision of a service which identifies and meets a broad range of needs. Greater integration with drug and alcohol services was also a strong theme within the interviews of national stakeholders and other local sites.

There is also a move towards a centralised custody model across Northumbria. A heath needs assessment for custody healthcare is also in progress. The combination of these factors offers the potential for regional expansion following a successful pilot.

Methodology

This will require a system change approach; with resources to facilitate, develop and project manage greater integration across practice and commissioning with NEOCHU oversight. The work should include the development and implementation of a screening tool, improved screening procedures and the development of liaison support across a range of areas.

ii.   The evidence from the analysis, coupled with early learning from Middlesbrough may be used to make the case to DH for funding for a similar service in Newcastle, where there are plans for a 50-cell custody suite.

1.2 Broadening the Response

Much of the activity of CJLD services was focused on the immediate risks to the individual (including arrangement of Mental Health Act assessments), referral into other Trust services (predominantly secondary mental health care) and liaison with existing care coordinators and general practitioners. While all of the services include at least some signposting to a range of other services including local IAPT services, local authority housing options teams and some voluntary sector provision, this rarely involves active referral into these services and relies heavily on clients to follow up suggested links.

There was also significant focus by CJLD services on those individuals already know to Trust services (usually secondary mental health services) rather than those individuals who might have common mental health problems that interacted with a range of other support needs to reduce their ability to cope, bringing them into contact with the police.

Local and national expert interviewees emphasised that it was very rare for those passing through the criminal justice system to have mental health needs in isolation. Multiple and complex needs was reported to be the norm for these groups. Experts emphasised how a range of support needs including substance misuse, homelessness and unemployment interacted to increase the challenge of recovery for these individuals and a comprehensive package of support needed to be identified if individuals were going to avoid re-entering the justice system. Personality disorder was also reported as a common issue and care pathways have to be established to support this group.

Representatives from CJLD services in London, Brighton and the South West (highly regarded schemes among national experts) described how their services had invested significant energy in opening up a wider range of support pathways for their clients. Concerted efforts had been made by these services to map local service provision and to develop links with both statutory and voluntary sector partners. The opening up of new care pathways into a much wider range of support services was identified as an important development objective for CJLD teams in the region. This should include opening pathways to services addressing needs such as substance misuse, housing, finances, family and relationships, meaningful activities and mentoring as well as mental health support from both primary care and the voluntary sector.

Similarly, prison mental health teams reported that the primary focus of their resettlement activity was linking prison leavers into secondary mental health care or at the very least, ensuring general practitioners had sufficient information to identify appropriate mental health care on release. While this is essential work, the mental health teams recognised that other resettlement needs such as a lack of housing could have a significant negative impact on mental health but there was little work undertaken by mental health practitioners to address these needs. It was clear that stronger integration of prison mental health teams with other prison resettlement services would be beneficial. Additionally, pathways into voluntary sector support such as the new Middlesbrough and Stockton Mind prison mentoring service should be considered.

Thinking about new care pathways is likely to be of particular importance given cuts within secondary mental health care and social care support. There is also likely to be a corresponding reduction in voluntary sector provision as funding cuts have far-reaching impacts on services. This will need to be considered as care pathways are developed.

Interviewees and regional stakeholders also highlighted the opportunity to provide a more constructive response to those repeatedly detained under section 136 (s.136), including those detained, perhaps inappropriately, due to heavy alcohol consumption.

> Focus Areas
>
> 3. Opening up care pathways into a far wider range of services including primary care, housing and other support services.

1.2a Development work in progress

- As members of the national pathfinder programme, CJLD services will benefit from national learning in this area and the evolution of diversionary pathways as the national programme progresses
- New and developing services at Bedlington and Sunderland are planning to engage local services as part of the set-up process
- Plans are already underway for the majority of referrals to the new WOW! Project for women in Sunderland to come through the new CJLD service.

1.2b Recommendations

iii.   Development Proposal

Vision

Enhanced support for offenders with mental health problems and other needs is provided through the extension of a complex needs consultancy service to Integrated Offender Management (IOM) services across the NTW area.

Rationale

The national roll out of IOM is a current government priority. The IOM model encourages a multi-agency approach and provides an opportunity to engage a wide range of stakeholders within and outside criminal justice.

Currently the South Tyneside CJLD offers a complex needs consultancy service to the local IOM and we heard evidence of its value to the IOM team. The model also offers the potential to strengthen relationships between IOM partners and mental health (MH) services in local areas.

Methodology

Given the limited capacity of CJLD services, we recommend that MH services are resourced to provide this service on a monthly basis for three hours and that the designated professional acts as a first point of contact for IOM colleagues outside of these meetings. This resource should be linked to the CJLD service.

iv.   All current CJLD services should work within the limitations of current capacity to build links with local services and develop pathways which enable clients to access a wider range of support services.

v.   Practitioners undertaking this role should also have a training brief to explain the role and function of mental health services to IOM colleagues.

1.3 Supporting Decision-Making

Crucial decision-making points in the justice system include the arrest stage, the charging stage, the finding of guilt and the sentencing stage.

Arrest and Charging

Key decision-makers in the first two stages include the police and the Crown Prosecution Service (CPS). It is important that both groups know where to access advice quickly to inform these decisions. For example, it was reported that police need advice to know whether detention under section 136 of the Mental Health Act is appropriate or whether an arrest for a criminal offence could be the better option. Currently all police custody suites have access to Forensic Medical Examiners (FME) while some also have access to custody nurses and CJLD practitioners to provide them with additional information about health needs. The CPS reported heavy reliance on information passed on by the police (and occasionally the defence). They emphasised the importance of receiving adequate information as early as possible in this process to support their decision-making. There appears to be room for greater involvement of CJLD services in the provision of appropriate information.

Courts and the provision of information

An overarching theme of the interviews was the need for courts to be supplied with relevant, timely information to inform and support decision-making.

There was concern that without such information there was an unhelpful practice of up-tariffing sentences in the (misplaced) belief that this would facilitate access into treatment and appropriate support, in particular for women. The provision of information to courts was frequently seen as a central component in the diversion of offenders from custody. Crucially, information has to be relevant to the courts. As well as making courts aware of needs and risks, courts need to be aware of the impact the court process itself can have on an individual's mental health as well as identifying options for treatment moving forward. Psychiatric reports were perceived as variable in quality, frequently failing to provide the information that the courts needed. There was also very limited communication between psychiatric report authors and probation pre-sentence report authors to enable informed consideration of sentencing options.

Deputy judicial clerks surveyed expressed near-unanimous desire for the presence of a mental health practitioner in court. CJLD services in London and the South West had incorporated nursing reports (or reports by another mental health professional) to provide immediate advice to courts and to triage all requests for full psychiatric reports with the aim of reducing requests for such costly reports. As a result; in London requests for full reports had reduced by between a third to two-thirds in courts where such a scheme had been introduced. Immediate advice in courts is also seen as a way of reducing the expensive and undesirable practice of inappropriately remanding someone

to hospital (or indeed prison) to await psychiatric reports. Current processes around the requesting of psychiatric reports were almost universally considered to be hugely problematic both nationally and regionally with difficulties around how these might be improved due to statutory restrictions.

Improving the provision of information to courts was a significant theme nationally and of particular importance in the North East where there is currently only very limited provision of advice to courts by CJLDs across the North East region. With the exception of the Bedlington service, all of this limited information is through verbal reports (frequently given to probation and not the court itself). Much of the North East CJLD schemes are focused at the police custody stage or in the cells at court. Where schemes were focused on the cells beneath courts, the immediate focus was on risk and there was no systematic process in place for the provision of information to the court room itself. In the absence of information from CJLDs, courts were reliant on third-party reports from untrained professionals such as the defence solicitor, the prosecution and probation (usually post-sentence).

Nationally there are examples of good practice on this theme. Through the development of the Mental Health Courts in Sussex and Stratford, London, a strong network of mental health practitioners working closely with courts has been established, although the Sussex project receives referrals directly from the police (prioritised through a matrix scoring system). DH representatives described the model adopted by some CJLD services, as including identification and assessment along with close working with probation to promote use of alternative sentences and the identification of other services to divert clients into. This was suggested as the ideal for CJLD services (although without a commitment as to where these services should be based).

Engaging sentencers

As in Bedlington, the Sussex and South West CJLD schemes had undergone an engagement process with magistrates to incorporate their views about what information they required about defendants coming before the court. They had subsequently received strong buy-in from magistrates. Central to this buy-in was the development of trust between CJLD practitioners and the magistrates so that magistrates feel confident to ask for advice.

Alternative sentencing options

The development and promotion of alternative sentencing options was also seen as crucial. Treatment requirements (including the Mental Health Treatment Requirement) and Specified Activity Requirements were seen as useful vehicles for helping someone to access support. The promotion of these alternatives to key decision-makers (magistrates and probation) was critical (in particular, awareness of the processes around Mental Health Treatment requirements among probation was very poor). However, the critical feature was the wrap-around package of care developed for the individual that needed to be in place at the point of sentencing and perceived as a robust alternative sentencing option by magistrates.

> Focus Areas
>
> 4. Provision of nursing reports to courts
> 5. Improvement of procedures for obtaining full psychiatric reports
> 6. Development and promotion of alternatives to custody.

1.3a Development work in progress

- The development bids for Bedlington and Sunderland include the provision of written reports to courts by practitioners working within these schemes.
- A service level agreement for the provision of psychiatric court reports has been developed by a representative of HMCTS regionally and is currently awaiting sign-off by the judiciary.
- It is hoped that the forthcoming secondment of the psychiatrist to Newcastle Crown court one day a week will improve the provision of psychiatric reports for this court.
- The WOW! Project team have also undertaken significant work in Newcastle to develop and promote alternatives to custody for women offenders in Newcastle which includes a strong mental health element, particularly around personality disorder and this work is to be extended to Sunderland.

1.3b Recommendations

vi. Consideration is given to resourcing the extension of the provision of written reports to North Tyneside magistrates where the practitioner is closely linked with the probation service and the physical environment is more conducive than at Newcastle magistrates.

vii. This pilot could work with the Sunderland and Bedlington CJLD and local partners to develop a format for nursing reports which could then be tested across the region.

1.4 Responding to Mental Health Crisis

A number of attendees in both service user focus groups around s.136 (in TEWV and NTW) reported positive experiences with the police who were described as "sensitive" and "kind". However, others reported negative experiences, such as a lack of empathy and understanding from police towards people experiencing mental health crisis. Several reported that they were laughed at, which they found particularly distressing. Stakeholders expressed significant concern that police responses in mental health crisis (such as around suicide attempts) or to those with learning disabilities could escalate the situation and provoke a reaction that might subsequently lead to criminal charges.

Use of s.136

Mirroring findings from the national literature, current practices in the use of s.136 of the Mental Health Act were identified as a particular concern by both health and justice agencies. This was a problem across the whole region, but with a particular hotspot in the Cleveland police force area. Reported problems cover all aspects of the s.136 process including:

- the appropriateness of the use of s.136 in the first instance
- the mode of transport to the place of safety
- the access to the s.136 suites and resulting high use of police custody as a place of safety (Cleveland)
- staffing issues for the s.136 suites and use of police time.

Transportation

Across the region ambulances were rarely, if ever, used to transfer a s.136 detainee to a place of safety. The use of police vehicles was reported to add to service users' distress in times of crisis. We were informed that newly established joint-protocols are in place between the three police forces and the North East Ambulance Service, however as yet these protocols do not appear to have filtered down to changes in practice on the ground.

Place of Safety

In Cleveland, there was evidence of disagreement and of significant tension between the police and health services regarding access to the s.136 suites. Police reported that detainees who had consumed even a small amount of alcohol were being turned away by staff at s.136 suites, a claim that was flatly denied by mental health services. Mental health services in turn were concerned about detainees who were too drunk to assess and perceived to need medical care to meet their physical needs (which it was felt could better be provided at A&E).

Within the Northumbria force area, concerns centred around lack of staffing for s.136 suites and the time taken to assemble professionals to undertake assessments. Psychiatrists had to be pulled away from their substantive duties and across the region accessing AMHPs from increasingly stretched Emergency Duty Teams was a particular challenge. Consequently, police were required to remain with s.136 detainees for lengthy periods once they had arrived at the place of safety. Service users reported that the long wait to be seen increased anxiety levels. Both health and police interviewees were frustrated by this situation and the resource implications for their service. It was argued that to run section s.136 suites effectively, money was needed to staff these facilities (whereas central government funding was only for the capital costs of the facilities).

Use of Police Custody as a place of safety

Such difficulties accessing s.136 suites and assessment services promptly within such suites may be a reason for high usage of police custody as a place of safety for these two police forces (Cleveland, 60%; Northumbria 57%). Use of police custody was much lower for Durham Constabulary (29%).

Inappropriate use of s.136

There was concern among a range of stakeholders that the section was being used inappropriately. It was reported that s.136 was being used illegally by police on private premises. In other cases there was concern that those detained did not in fact have a mental health need but that their presentation related to heavy alcohol use. High proportions of those subject to s.136 are currently being released without follow-up; 76% (n. 388) of s.136 detainees in Cleveland (August 2010-August 2011) were released immediately after assessment, with no further action taken. Durham Police Force reported that 55% of s.136 detainees were released with no further action, while in Newcastle it was reported that a quick check had revealed that only around 50% of s.136 detainees were deemed appropriate for further mental health service follow-up. Interviewees suggested that many of these people had needs relating to alcohol misuse but concern was expressed that – for those entering police custody in Cleveland at least – drug and alcohol arrest referral workers were not routinely being offered appointments with these detainees.

Links with crisis services and single point of contact

Both police and service user interviewees felt that an enhanced response from mental health crisis teams and closer joint-working in times of crisis might lead to better outcomes for those in mental health crisis, with the possibility of less restrictive approaches being adopted than a s.136 detention. Criminal justice agencies were keen to have a single point of contact with mental health services to facilitate access to mental health support and problem-solve in order to overcome barriers when needed (including out of hours).

> Focus Areas:
>
> 7. Arrangements and practice in the use of s. 136 across the region, with a particular hotspot in Cleveland.

1.4a Development work in progress

- We heard evidence from police and health sources regarding recent work to address the issues described in both Cleveland and Northumbria. A multi-agency group has been convened by TEWV to review policies related to s.136
- Development funds have been secured for a First Response Team in Cleveland in which a mental health professional and a police officer attending mental health incidents together. If successful, it is hoped that this model can be rolled out to the Durham police force area as well
- There are plans for this service to include close working links with alcohol and substance misuse services.

1.4b Recommendations

viii.   Consideration should be given to the provision of awareness training to police that involved service users, possibly facilitated through M&S Mind and TEWV.

ix.   In the event that commissioners proceed with the proposed development at Middlesbrough custody, clear links and pathways should be developed between that service and the First Response service.

1.5 Learning Disability, Autism and other related conditions

A consistent theme and a priority group identified throughout the interviews was the paucity of response to learning disabilities across the criminal justice pathway.

Understanding and Awareness

Stakeholders and experts reported a poor understanding of learning disabilities among criminal justice staff with particular confusion about the difference between learning disabilities, learning difficulties and poor literacy. One stakeholder also highlighted that the high prevalence of poor literacy and low education levels among offenders masked the presence of genuine learning disabilities as these failed to stand-out as they perhaps might among the general population.

Identification and Screening

Stakeholders from both health and justice agencies working within the system highlighted strong concerns around poor identification of those with learning disabilities. One challenge to the identification of learning disability in criminal justice settings is the lack of a verified screening tool that is acceptable to both learning disability specialists and to criminal justice agencies. The latter are sometimes required to administer such tools within time constraints and in busy custodial environments, whereas clinical assessments for learning disabilities could be lengthy. Department of Health pilots have recently focused on the Learning Disability Screening Questionnaire (LDSQ) but reports from our interviewees suggested that teams in police stations and in prisons found it time-consuming to administer. Other options include the HASI (Hayes Ability Screening Index) but a stakeholder from learning disability services suggested that this tool was over-inclusive.

Prevalence

Research suggests that people with learning disabilities are over-represented in the justice system but that as a proportion of the total number of people seen are still low. Research undertaken in three prisons (a local prison, a women's prison and a young offenders' institution) found that 6.7% were assessed as learning disabled. However, prison studies have indicated a much higher level of 'borderline' learning disabilities; those who have IQ levels over 70 but may struggle with adaptive functioning or may face particular challenges in their passage through the criminal justice system. In the same study, an average of 25.4% of those assessed across the three sites had an IQ between 70 and 79 (compared to a total of 8% learning disabled and borderline 8% in the general population). It is clear that – as is the case in the general population – prevalence of learning disabilities is far lower than prevalence of mental health problems among offenders.

Engagement with the Justice Process

There were also concerns about this group's ability to engage with the justice system and procedural justice for this group. Experts highlighted a potential willingness to please among some people with learning disabilities that might lead them to wrongfully incriminate themselves. A number of stakeholders were concerned about the practice of inappropriate informal diversion of this group by police and courts that did not recognise the importance of challenging behaviour at an early stage to prevent it escalating.

Pathways

Improving screening for learning disability or borderline learning disability alone does not solve the problem. Substantial concern was raised about subsequent care pathways for these groups. High thresholds to receive learning disability services were highlighted as a barrier nationally for clients with a learning disability, let alone those in the borderline group. Other areas reported difficulties engaging with learning disability services, although they identified that these difficulties could be overcome with concerted efforts at engagement. There were felt to be very strong ethical concerns regarding identifying need without establishing clear care pathways. Other services outside of the statutory sector may be needed for those who fail to meet thresholds for social care support.

In common with the national picture, CJLD services in the North East have tended to focus on those with mental health concerns with practitioners in CJLD and prison mental health in-reach teams predominantly recruited from the mental health field. Currently none of the CJLD services has any learning disability support except for the Newcastle service which is provided on a rotational basis by staff from the Forensic Community Team in which there is a learning disability nurse. Similarly, only HMP Northumberland mental health team has a learning disability nurse within the service (although the other prisons do have access to Forensic Learning Disability sessions).

Borderline learning disability, autism and Asperger's groups

Regional stakeholders and national experts also consistently highlighted that the scope of any work going forward must not be limited to learning disabilities only. Particular difficulties interacting with the justice system faced by those with autism or related conditions such as Asperger's syndrome and ADHD were identified. In particular concerns were expressed about those with autism who were high functioning and therefore might be more difficult to identify as having an unmet need. It was highlighted that even for those with high intelligence, their condition might lead them to interact with the justice system in a way which might incriminate them further or appear disrespectful to courts and there was a need for awareness of this by court staff. There are also other related difficulties to be considered including learning difficulties. Again, care pathways have to be established if clients with such needs are going to be identified through screening.

> Focus Areas:
>
> 8. People with learning disabilities, autism and Asperger's syndrome were identified as a priority group.

1.5a Development work in progress

- There is a current national drive to increase awareness and promote best practice in tackling hate crime against disabled people. We heard evidence of local work in this area including the provision of user-led training by Your Voice to Northumbria Police
- The North East Autism Consortium (NEAC) has been working to build links with the police and to raise awareness of autism.

1.5b Recommendations

x.   Development Proposal

Vision

A multi-agency partnership in Durham[1] area works together to establish a replicable process which enables local police, courts and prisons to better understand learning disability and autism and to link effectively with local LD services. This learning is then shared with other areas across the region.

Rationale

The work will build on the DH handbook for professionals in the criminal justice system working with offenders with learning disabilities.

Durham has already developed a single point of contact system for police, has good links with the local authority, a local prison and a commissioning manager for health and social care with links to the NEAC. There is a relatively new autism service within TEWV. Finally, there is also a people's parliament of people with learning disability to facilitate a user perspective.

Methodology

A working group is established to include key stakeholders as above plus HMP Holme House, Durham Police and TEWV CJLD services. This group is financially supported to develop a model in the Durham area. It is then shared across the region through a series of events with NEOCHU support.

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[1] Following consultation with partners, the case was made that this pilot should be located in the NTW area and would build on good existing work in the area.

1.6 Increasing Awareness

A consistent theme throughout the analysis phase was the need for health and justice agencies (including CJLD teams) to promote their services to each other in order to enhance understanding of service provision, referral routes, roles and responsibilities.

CJLD services needed to undertake considerable work to promote their services and to clarify what they were able to offer to a range of agencies. There was extremely low awareness of the CJLD service among probation officers from both Probation Trusts within the region. 42% of respondents to our survey said that they were not aware of a CJLD service operating in their area (excluding those respondents who said they were based in an office in the Sunderland area). Particular confusion surrounded the Cleveland, Durham and Darlington service which had undergone substantial service restructuring leaving a number of stakeholders from courts, probation and police healthcare services confused as to service activity and coverage. Low awareness was not limited to criminal agencies. Concern was also expressed by CJLD practitioners from a number of the services that community treatment teams and crisis teams were unaware of the CJLD service or were unclear regarding the role performed by the service; although South Tyneside and Gateshead had strong historic links with these teams and the Bedlington service had undertaken a range of promotional activities at the outset.

More generally, criminal justice agencies were confused by referral pathways into services for those with mental health problems and learning disabilities and wanted a single point of contact into services and clarification over appropriate pathways. A single point of contact with learning disability services in the Durham police force area was reported to be working well.

In addition, interviewees frequently suggested that tensions between health and criminal justice agencies and communication difficulties could be improved through a better understanding of respective roles. It was felt that CJLD services had an important role to play in terms of brokering relationships between health and justice agencies as they were ideally placed at the interface between the two. In other areas nationally, CJLDs had undertaken significant training with a range of criminal justice agencies that brought professionals from different disciplines together.

Multi-agency training and co-location of services were also seen as important tools in the development of informal relationships. Many of the interviewees highlighted the importance of interactions 'at the coffee machine' in developing knowledge, awareness and allowing informal requests for help and case discussion.

> Focus Areas:
> 9. Poor awareness of service provision, referral pathways and roles and responsibilities of different services.

1.6a Development work in progress

- At a regional level, the BDP and events such as the stakeholder meetings in February 2012 raised awareness of the project and through this, the role of CJLD services. It is important that this momentum is maintained as the project moves forward to the next phase.

- The new Sunderland service and the improved Bedlington service will include awareness raising and training as a key part of the service, with training in respect of mental health issues provided to police, probation and magistrates.

1.6b Recommendations

xi.   CJLD services have a vital role to play at the interface between criminal justice and mental health teams and must ensure that stakeholder management is a key facet of their work. They should lead on multi-agency training in the area, bringing key stakeholders together.

xii.   Stakeholders at a local and regional level are kept informed of work and learning via a series of local and regional thematic learning events over the lifetime of the project.

xiii. CJLD teams in Cleveland, Durham and Darlington should make use of 'hot desks' across the TEWV area and other services should think about developing relationships through co-location of services.

1.7 Data and Information

The collection of evidence through the analysis phase was hampered by the absence of data, most strikingly in relation to the CJLD services. The existing Trust recording systems do not support the recording of certain activities such as liaison, which is self-evidently a key role of liaison and diversion services.

As noted above, the lack of data held by CJLD services made it impossible to evaluate penetration rates or impact of these services. In turn, we heard evidence of only limited engagement by commissioners in review of these services which tended to form part of wider contracts.

One manager from a Community Safety Partnership highlighted that without local data identifying prevalence of health conditions in custody and courts to include within Joint Strategic Needs Assessments that the commissioning process was hampered.

Prison mental health team managers and CJLD workers highlighted the significant problem of housing, particularly for those with a dual diagnosis. Data to evidence this need, which could be used to present a case to commissioners, was not collected.

> Focus Areas:
>
> 10. Data collection to inform commissioning and service development.

1.7a Development work in progress:

- Discussions are underway in Cleveland, Durham and Darlington to look at how data on activity and outcomes might be better captured
- All Pathfinder CJLD sites will be required to collect a minimum data set.

1.7b Recommendations

xiv.   The set up of all activities following this analysis phase should include robust mechanisms for data capture and the evaluation team should be involved at an early stage in the development of outcome monitoring tools.

xv.   The proposed development in Middlesbrough will benefit from the collection and detailed analysis of a range of data including identification and analysis of the needs of individuals who have been subject to repeat arrest and/or s.136 detention.

2
Introduction and approach

2.1 Introduction to the Big Diversion Project

The Big Diversion Project (BDP) has been commissioned by the North East Offender Health Commissioning Unit (NEOHCU) with the aim of improving health and reoffending outcomes for offenders with a mental health problem, learning disability or a dual diagnosis of mental ill-health and substance misuse, at any stage in the justice system but with an emphasis on early intervention:

> *"Our vision is to ensure that offenders who enter the criminal justice system [CJS] (or are at risk from entering the CJS) are identified and provided with appropriate services, treatment and any other support that they may need at the earliest possible stage."* (NEOHCU, 2011, p.5).

The project is a regional response to Lord Bradley's (2009) review of people with mental health problems and learning disabilities in the criminal justice system which took a similar 'whole pathway' approach to diversion. The BDP commenced with stakeholder consultation, the formation of an advisory group consisting of key regional representatives from a range of relevant agencies and a literature review undertaken by Dr Wendy Dyer to consider subsequent best practice developments in diversion and liaison services (Dyer, 2011).

The BDP has now entered phase 2, the development phase, which will include an initial analysis of current provision within the region and the development of a range of potential service specifications, a number of which will then be piloted in the remaining 18 months of this phase.

Northumbria, Tyne and Wear NHS Foundation Trust (NTW) and its partners Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) and the charity, Revolving Doors Agency, have been commissioned to deliver the development phase of the BDP. Since many of the services in the region for these groups are currently delivered by NTW or TEWV, Revolving Doors Agency has led on the analysis phase, which has the aim of identifying gaps in current provision and regional and national best practice.

2.2 National context

Following the publication of Lord Bradley's review in 2009, the Labour government established the Health and Criminal Justice Programme Board comprising relevant government departments and agencies across health, social care and criminal justice. This was tasked with developing a national delivery plan to implement Bradley's recommendations including the development of liaison and diversion services. The resulting plan, *Improving Health Supporting Justice* (Department of Health, 2009a), included five key cross-departmental objectives: Improving the efficiency and effectiveness of systems, working in partnership, improving capacity and capability, equity of access to services and improving pathways and continuity of care.

The direction of travel started by this work was supported by the incoming coalition government, and support for the roll-out of liaison and diversion schemes in particular, has continued. The October 2010 Spending Review document stated:

"The Government will…take forward proposals to invest in mental health liaison services at police stations and courts to intervene at an early stage, diverting mentally ill offenders away from the justice system and into treatment" (HM Treasury, 2010, p.55).

In the 2010 green paper *Breaking the Cycle*, the Ministry of Justice committed to complete the national roll-out of liaison and diversion services by 2014, and in March 2011, £5 million was committed to take this forward in 2011-12. A national pathfinder programme consisting of 94 adult and youth pathfinder sites was established. Working as a liaison and diversion network, the pathfinders will build an evidence base of how services can be developed and the costs and benefits they generate. This will be used to inform a business case for the roll-out of liaison and diversion services across the country.

In January 2012, Minister of State for Care Services, Paul Burstow MP, announced that investment in liaison and diversion services would be increased to £19.4 million for 2012-13 (Hansard HC Deb 12 January 2012, C22WS). The funding will support a plan to include guidance on good practice, quality standards and outcomes, and a workforce development and training plan, and will allow pathfinder sites to test different elements of service provision, including "treatment-based options for sentencers as an alternative to custody for those with health needs or vulnerabilities" (Hansard HC Deb 12 January 2012, C22WS).

The development of liaison and diversion services is being undertaken alongside work to explore the transfer of commissioning responsibility for health services in police custody suites to the NHS. 10 "early adopter" police forces are contributing learning to the liaison and diversion network along with the 94 pathfinders outlined above.

The BDP therefore comes at a time when a significant body of work is being undertaken nationally around the future development of liaison and diversion services across the whole of England. This provides an outstanding opportunity for regional and national work to complement one another and affect real improvements in provision regionally around liaison and diversion services.

However, the BDP also comes at a time of unprecedented change in the public service landscape. Within this there are a number of highly significant changes that are likely to impact on the provision of support for people with mental health problems or learning disabilities both within the criminal justice system and in wider society.

2.2a Structural reforms in the NHS

Since coming to power in 2010, the coalition government has embarked on the largest scale reorganisation of the NHS in its history. Primary Care Trusts (PCT) and Strategic Health Authorities (SHA) are being abolished, with commissioning responsibilities transferred to clusters of GP practices known as Clinical Commissioning Groups (CCGs). Due to the Health and Social Care Act 2012, these will be accountable to a new national NHS Commissioning Board, currently operating in shadow form. The commissioning of most local health services, including mental health services, will be delegated to Clinical Commissioning Groups, with the Commissioning Board retaining responsibility for services deemed most efficiently provided at a national or a regional level. This will include responsibility for commissioning offender health services in prisons and police custody and criminal justice liaison and diversion services. In light of this, it will be crucial to ensure offender health services are linked to the new structures at the local level to ensure effective sharing of patient information and clear pathways between services.

Responsibility for public health is to be transferred from the NHS to local authorities, funded by a ring-fenced public health budget. This will include a transfer of responsibility for substance misuse services. All upper-tier local authorities will be responsible for setting up statutory Health and Wellbeing Boards, formed to include the director of public health, locally elected councillors and representatives of local Clinical Commissioning Groups, children's services, adult social services and local Health Watch, a new independent organisation representing the views of the public. Local authorities can invite additional members to join the board, although there is no obligation to widen membership.

The main aim of Health and Wellbeing Boards (HWBs) is to improve outcomes in health, care and wellbeing. Improving mental health will be a key component of this responsibility. Each HWB will be responsible for the development of the local Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy. HWBs will also have a key role in joining up commissioning across health and social care, although their agenda will extend to wider issues impacting on health such as housing, education and the environment (Local Government Group, 2011). Most areas have already established shadow HWB, with full boards envisaged in all areas by April 2013. 12 shadow boards have been established in the North East as part of the Department of Health's early implementers' programme.[2]

Finally, the Health and Social Care Act 2012 paves the way for increased competition in health services. It enables private sector companies and charities to compete with public sector to provide NHS services, enabling patients to receive treatment from "any qualified provider".

2.2b Reforms in criminal justice and policing

The government's public service reform agenda extends far beyond health and social care, and criminal justice has not been exempt.

The Legal Aid, Sentencing and Punishment of Offenders Bill is making its way through parliament. In addition to reducing in the availability of legal aid, the bill introduces a range of measures aimed at toughening community sentences, increasing public confidence in non-custodial sentences and reducing demand for prison spaces. Importantly for offenders with mental health problems, the bill includes measures to remove barriers to the use of the Mental Health Treatment Requirement (MHTR). The government plans to publish a consultation setting out proposals on reformed non-custodial sentences in the coming months.

This consultation will take place alongside a forthcoming review of probation services, which is likely to recommend a reduction in the number of probation trusts and a transfer of commissioning responsibility from central government to trusts.

Policing is also facing radical change. In November 2012, elections will be held across England and Wales for directly-elected Police and Crime Commissioners (PCCs). These are being introduced following the passing of the Police Reform and Social Responsibility Act in September 2011 and aim to provide stronger and more transparent accountability of the police. PCCs will cover current police force areas and will hold office for four years. Their responsibilities will include appointing the Chief Constable and holding them to account for the running of their force, determining local policing priorities, producing a five-year Police and Crime Plan and setting the annual police force

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budget. Police authorities, which currently hold police forces to account, will be abolished from November 2012.

PCCs will also be responsible for funding community safety activity to tackle crime and disorder by making grants to organisations that support their objectives. The Home Office expects to consolidate and transfer some existing grants for community safety and drug interventions to PCCs from 2013/14. The Community Safety Fund (formerly within the Area Based Grant) has already been reduced by 20% in 2011/12 and will be reduced by a further 40% in 2012/13, before being transferred from local authorities to PCCs from 2013/14 (Clinks, 2011b, p.2). In England, PCCs will also receive funding for services to address violence against women and girls and a proportion of Drug Interventions Programme Funding, with the remainder going to new Health and Wellbeing Boards. (Clinks 2011b, p.3)

Criminal justice, like other public service areas, has seen an increased drive towards outcome-based payment structures. The Coalition Agreement (HM Government, 2010a, p.23) promised "we will introduce a 'rehabilitation revolution' that will pay independent providers to reduce re-offending, paid for by the savings this new approach will generate within the criminal justice system." This has since been put into practice in a number of experimental approaches including:

- "Payment by results" pilots in a number of prisons including HMP Doncaster
- Probation-led Financial Incentive Models, which aim to provide financial returns to local communities that have reduced demand on the criminal justice system
- Drug and alcohol recovery pilots
- The flagship social impact bond at HMP Peterborough, where bond investors will receive a return on their investment if services provided by voluntary sector providers achieve a reduction in reoffending of 7.5% or more (Social Finance, 2010, p.5).

The government is also focused on reducing demand on the prison system by improving confidence in community sentences.

Finally, in reform of the court estate, the government has undertaken to improve court facilities, make more efficient use of court time and reduce running costs. In response to a 2010 consultation, 93 magistrates' courts and 49 county courts have been or will be closed by July 2012. This includes 10 magistrates' and six county courts in the North East.[3]

2.2c Deficit reduction

Underlying all these changes is the deficit reduction programme. Cuts are being seen across all public services, at a national and local level. The removal of the ring-fence on Supporting People funding alongside a cut to local authority funding has resulted in some areas diverting funding away from client groups for whom there is no statutory responsibility. The £20m Homelessness Transition Fund, launched in July 2011 aims to support a smooth transition for existing homelessness services to sustainable funding arrangements following the removal of the ring-fence. However, some commentators have expressed fears that availability of services supporting excluded groups such as single homeless people will be reduced. This has an implication for excluded groups including people

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[3] For details of court closures see:
http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_1931 70.pdf

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with mental health problems, as support from these services can often act as an early intervention, preventing later contact with the criminal justice system.

As a result of these extensive reforms, the current environment in which this analysis work has been undertaken will continue to change over the course of the development phase. However, where these changes are relevant and can be anticipated, they have been identified in the analysis. Close consideration will need to be given to these changes when service specifications for piloting are selected and throughout the duration of the pilots.

2.3 Analysis Phase: Approach

The project is acknowledged to be an ambitious attempt to consider relationships and interdependencies in the whole system; across the whole criminal justice pathway and across a large and diverse region of England.

The aims of the analysis are to:

- Map current provision across the region for offenders and those at risk of offending with mental health problems or learning disabilities
- Identify gaps in current service provision across the region and the criminal justice pathway
- Identify national and regional best practice
- Provide strong grounds for evidence-based proposals for service specifications that will improve health and reoffending outcomes for those with mental health problems or learning disabilities in the justice system and will provide value for money for commissioners.

In developing our approach to the analysis phase of this project, we began through consultation with the Big Diversion Project Advisory Group (BDP AG) and the commissioners (NEOHCU). A careful reading of the specification was undertaken to identify priority areas and groups outlined by the commissioners at the outset (see figure 2.2 for details) and stakeholders were mapped across the region and the criminal justice pathway (see figure 2.3). Work has also been undertaken to map the existing regional provision for service user involvement that might be accessed by people with mental health problems or learning disabilities that are currently at risk of or have been involved in the justice system. This has been an ongoing process throughout the analysis phase.

These processes were undertaken in order to identify and prioritise key strategic regional stakeholders for interview from each stage of the pathway. Throughout the analysis phase further interviewees have been identified by existing interviewees or in response to emerging themes.

Due to time restrictions on the analysis phase (limited to five months), these interviewees have primarily included those positioned at a strategic level. However a number of those positioned at an operational management level have also been interviewed. Finally, given the particular focus of this project on Criminal Justice Liaison and Diversion (CJLD) services, practitioners from the six services currently in operation across the region have also been interviewed.

A mixed approach to the methodology has been adopted in order to maximise coverage of stakeholders across the whole system. As well as interviews with strategic regional stakeholders, the views of regional stakeholders (in particular service users) have been gathered through a number of focus groups, surveys and two stakeholder engagement events. Documentary evidence, including operational policies and procedures, has also been reviewed where relevant. Significant attempts have been made to obtain quantitative data regarding client needs and service use for analysis. However, we have consistently faced barriers around current data collection processes or problems

obtaining data within the time constraints. Finally, a national perspective has been gathered through a review of the literature and interviews with recognised national experts.

The full methodology is outlined in figure 2.1 below.

Figure 2.1 - Methodology		
National Picture		
Literature review	Review of national policy, guidance and research identified by experts, interviewees and from existing organisational knowledge. Time and budget constraints mean that this is not a comprehensive review of relevant literature.	*To identify common barriers nationally, best practice and the direction of travel in terms of national policy.*
Interviews with national experts	Identified from existing organisational knowledge and recommendations from interviewees and partners. (See Appendix A for list of interviewees).	
Regional picture		
Views of regional stakeholders		
Stakeholder interviews	Identified by commissioners, the BDP AG, through service mapping, other interviewees and in response to emerging themes. (See Appendix A for list of interviewees).	*To identify current practice regarding the identification and support of offenders with mental health problems or learning disabilities in the justice system, gaps in provision and regional best practice.*
Focus groups	1 focus group with managers of the Prison Inreach Services across the North East	*To explore problems in the flow of information across the prison-community boundary, barriers to resettlement and how current processes might be improved.*
Surveys	Survey of probation staff in both Northumbria Probation Trust and Durham and Tees Valley Probation Trust	*To establish confidence and skill levels around working with offenders with mental health problems or learning disabilities, training needs and current practice in working with other agencies. To establish current practice around obtaining psychiatric court reports and the use of Mental Health Treatment Requirements.*
	Survey of Justice Clerk or Deputy Justice Clerk from each justice area (administered by Ann Attwood on site visits)	*To establish current practice and requirements around the provision of information to courts (including obtaining psychiatric court reports), relationships with CJLD services and the use of Mental Health Treatment Requirements.*
Stakeholder events	2 events in Middlesbrough and Newcastle	*To engage a wide range of stakeholders whose views were not sought as part of the series of interviews.*
Site visits	Site visits to each of the CJLD services operating in the region	*To observe practice and environmental considerations and seek the views of practitioners and stakeholders.*

Views of service users		
4 focus groups	2 thematic groups exploring specific experiences of sections 135 and 136 of the Mental Health Act (one has been facilitated by Middlesbrough & Stockton Mind & TEWV)	*To explore the particular views of service users subject to s.136, acknowledging that many of these people are not and will not become offenders.*
	2 geographical groups (1 in Northumbria; 1 in Teesside)	*To explore service users' experiences of the criminal justice system in that area of the region*
Documentary and quantitative evidence		
Analysis of local operational policies and procedures	See Appendix A for list of local operational policies obtained.	*To allow comparison of operational policy and current practice regionally; operational policy and national/regional best practice; and to identify gaps in the coverage of operational policies.*
Review of service directories		*To map service provision and arrangements for service user involvement across the region and the criminal justice pathway.*
Collation of data from regional services		*To establish quantitative evidence of client need, current service use and gaps, and service outcomes.*

In Appendix B the proposed methodology is mapped against the key stakeholders across the criminal justice pathway.

2.4 Analysis Phase: Structure of the report

The findings from the analysis phase are presented in chapters that consider findings at each stage of the criminal justice pathway, although a number of themes reoccur throughout the report. The chapters are:

- Chapter 3: Pre-arrest, Neighbourhood Policing & section 135/136
- Chapter 4: Police custody
- Chapter 5: Criminal Justice Liaison and Diversion Services
- Chapter 6: Courts
- Chapter 7: Probation and community orders
- Chapter 8: Prison.

Given the centrality of Criminal Justice Liaison and Diversion Services to the Big Diversion Project, these are considered in a separate chapter although issues of relevance to these services are discussed throughout the report.

Each of the chapters presents findings in the following three areas:

- National Picture (including policy context, legal context, research and best practice)
- Regional Provision and Practice
- Key Issues for the North East.

Overarching themes, focus areas and recommendations are outlined at the beginning of the report in Chapter 1. There are also chapters on priority groups (Chapter 9); provision for Service User Involvement (Chapter 10) and a financial analysis of potential changes (Chapter 11).

Figure 2.2

The Big Diversion Project

CJLD Services

Probation

People with mental health problems or learning disabilities

Community → Police → Courts

Community

Prison

e.g.
•s.135/6
•Police screening

e.g.
•Court reports
•Information to staff working in courts
•MHTRs

e.g.
•Prison-community care pathways
•MAPPA

Priority issues:
•Information flow
•Identification (screening & assessment)
•Care Pathways
•Training
•Partnership arrangements

Priority groups:
•Dual diagnosis
•Minority groups (women and BAME)
•Young adults in transition
•Summary offenders
•Offenders subject to community sentences
•Short-term prisoners

Figure 2.3

The Big Diversion Project - Services

CJLD Services

Community / Pre-arrest → Police → Courts → Probation / Prison → Community

Community / Pre-arrest

Health
- Crisis (home treatment) teams
- Adult community mental health services including Early Intervention in Psychosis teams; affective teams; psychosis teams
- Community learning disability services
- Dual diagnosis support
- Ambulance
- Place of Safety managers
- Drug treatment services
- Alcohol treatment services
- Improving Access to Psychological Therapies (Talking Therapies)
- Primary Care Trusts
- Directors of Public Health

Other
- LA social care teams
- LA housing options teams
- Community Safety Partnerships
- Voluntary / Community Organisations

Police
- Police
- Arrest Referral providers
- FME services and custody nurses
- Reliance (Health & Custody)
- Appropriate Adult providers

Courts
- Court clerk
- Magistrate
- Defence
- CPS
- Probation
- GEOamey

Prison
- Probation staff
- Alcohol Treatment Requirement providers
- Drug Rehabilitation Requirement providers
- Mental Health Treatment Requirement providers

- Mental health inreach teams
- Heads of reducing reoffending/ resettlement
- Heads of healthcare
- Head of Safer Custody
- CARATs

Community
- Forensic learning disability services
- Forensic community mental health services
- Forensic personality disorder services
- VCOs (Through the gates /resettlement support)

3
Pre-Arrest: Neighbourhood Policing and Section 135 & 136

KEY ISSUES:

- **Finding appropriate alternatives to Section 136**
- **Transport of detainees**
- **Increasing access to appropriate places of safety**
- **Reducing waiting times for assessment**
- **Strengthening partnership working in response to mental health crisis**
- **Training**

The earliest opportunity for the identification and diversion of people with mental health problems and learning disabilities at risk of offending is in the community. This can take the form of proactive neighbourhood policing, working closely with other agencies to identify those at highest risk of offending and signposting them to appropriate services in the community. It also takes the form of ensuring officers are adequately trained in mental health and learning disability awareness, and to enable them to make the best decision when responding to an incident.

Getting it right at this stage provides an opportunity for tackling a potential offender's health needs; reducing offending and diverting those for whom it is appropriate away from the criminal justice system before they have even entered.

This chapter looks at national literature on community policing and pre-arrest, before turning to substantial national research and guidance on the use of sections 135 & 136 of the Mental Health Act. It will then present an analysis of procedures in the North East based on the problems, gaps and good practice identified through our various consultations with regional stakeholders.

3.1 National Picture

3.1a Pre-Arrest and Neighbourhood Policing

One major trend in offender health since the Bradley Report is the increased focus on early intervention. One of the central themes of his report is that "interventions as early as possible in the criminal justice system would provide the best opportunities for improving how people with mental health problems or learning disabilities are managed" (Bradley, 2009, p.29).

The earliest point at which criminal justice agencies become involved is in the community, at the pre-arrest stage. Bradley (2009) suggests that neighbourhood policing provides an opportunity for

police to work proactively in local communities, with local agencies helping to identify those with mental health problems or learning disability at risk of offending. In particular, close working with Safer Neighbourhood Team in local communities, as well as with Crime and Disorder Reduction Partnerships (CDRPs), would provide opportunities to identify and work proactively with those at highest risk of offending (Bradley, 2009, p.34-36).

A further opportunity for identification and diversion in the community arises when police officers are responding to an incident. As an emergency service, the police are involved in a variety of incidents that may not require an arrest, and there are a number of options open to a police officer attending an incident that appears to have a mental health dimension. As recent National Policing Improvement Agency (NPIA, 2010, p.39) guidance states:

> *"People with mental ill health or learning disabilities are much more likely to need access to social or healthcare services than to police services. If the multi-agency responses are working effectively, the police should seldom need to be involved."*

Effective multi-agency working in emergency responses provides an opportunity to deal with people in the community, without the individual entering the criminal justice system unless it is appropriate. Another key aspect of this proactive approach relies on the officers responding to incidents being aware of how to recognise mental health issues and learning disabilities, and aware of the options open to them. For this reason, one of Lord Bradley's recommendations is that "Community support officers and police officers should link with local mental health services to develop joint training packages for mental health awareness and learning disability issues" (Bradley, 2009, p.36).

3.1b Section 135 & 136

A closely linked issue is the use of sections 135 and 136 of the Mental Health Act (MHA), as these sections both facilitate police involvement in detaining people with a mental health need for assessment. These sections of the MHA require close joint-working between different agencies on the ground, and are a key example of the interface between police and health agencies in the community pre-arrest; or indeed where no arrest is required.

Section 135 (1) of the Mental Health Act 1983 allows police, accompanied by an Approved Mental Health Professional (AMHP) and a doctor, to enter a locked private premises and remove a person suffering from a mental disorder to a place of safety for assessment. This is a planned intervention and requires a magistrate's warrant. Section 135 (2) relates to police retaking somebody previously detained under the Mental Health Act, but who has gone Absent Without Leave.

Section 136 empowers a police officer to remove somebody who appears to be suffering from a mental disorder and is in immediate need of care and control from a public place to a place of safety. A mental disorder as defined by the Mental Health Act can cover affective disorders, psychotic disorders, personality disorders and learning disability (Department of Health, 2008a, p.19-20).

Despite being in force since the Mental Health Act 1983, national research and reports continue to point to problems in the functioning of section 135 and 136 protocols; although there are fewer issues reported in the national literature on the operation of section 135 (1) because although it

involves the co-operation of a number of different agencies and professionals, it is a planned intervention. S.135 is also used extremely rarely compared with s.136 (see figure 3.1).[4]

It is perhaps unsurprising, then, that the majority of the literature nationally has focused on the functioning of s.136. Concerns have been widely raised that the high number of s.136 detentions is due to inappropriate use of the section by the police. This links in closely with issues raised above, as there is a concern that s.136 is inappropriately used due to a lack of alternative community options, or a lack of police knowledge of these options where they do exist. A major report from the Independent Police Complaints Commission (IPCC) into the use of s.136 found that due to poor police training, the section was being used to detain people who were drunk and disorderly, rather than for its proper purpose (IPCC, 2008, p.viii).

Figure 3.1	Place of Safety Detentions under the Mental Health Act 1983 in NHS facilities and independent hospitals, 2006-07 - 2010-11[5]				
	2006-7	2007-8	2008-9	2009-10	2010-11
Place of Safety Orders – Total	6,387	7,538	8,759	12,300	14,399
Men	3,880	4,315	5,045	6,928	8,002
Women	2,507	3,223	3,714	5,372	6,397
Section 135 (1) – Total	383	503	264	262	288
Men	219	278	152	150	163
Women	164	225	112	112	125
Section 136 – Total	6,004	7,035	8,495	12,038	14,111
Men	3,661	4,037	4,893	6,778	7,839
Women	2,343	2,998	3,602	5,260	6,272

Another problem focused on extensively in the literature is the use of police custody as a 'place of safety'. Although the MHA includes police custody in its definition of a 'place of safety', there are widely acknowledged problems with its use. Firstly, it has the effect of seeming to criminalise people for what is a health need. Secondly, the environment may exacerbate the detainee's mental state. Thirdly it can lead to deaths in custody in the most tragic cases (IPCC, 2008, p.vi).

The IPCC report found that in 2005/6 police custody was used twice as much as a hospital setting as the place of safety, with 11,517 detentions in custody and 5,900 hospital detentions across the 43 police forces in England and Wales (IPCC, 2008, p.10). Since this research was conducted, the Department of Health have invested over £130 million updating the mental health estate and ensuring there is an appropriate place of safety for each Mental Health Trust (Bradley, 2009, p.46). This has undoubtedly contributed to the large year-on year increase in the use hospital-based places seen in table 2.1. Nevertheless, with no national statistics on the use of police custody to compare this to, the full extent of the drop in the use of police custody is unclear.

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[4] Indeed, the difference in the use of section 135 (1) and section 136 of the Mental Health Act is even larger in reality than this data suggests. The figures below do not include incidents where a non-hospital based place of safety (usually police custody) is used as this data is not routinely collated nationally. As such, they disproportionately under-represent the number of section 136 detentions nationwide.

[5] Source: Health and Social Care Information Centre, 2011. Note, data is based on hospital KP90 forms, and as such only represents those cases where a hospital was the 'place of safety'.

Other problems identified in the literature include:

- Black and minority ethnic groups are more likely to be detained under s.136, in particular black people were almost twice as likely to be detained as white people (IPCC, 2008, p.14)
- Detainees, and police officers accompanying them, could be subject to long waits before appropriate professionals arrived to perform the assessment. This was especially the case as many s.136 detainees arrived outside of office hours (IPCC, 2008, p.vii)
- Police officers and healthcare staff were often uncertain as to the level of information they could share (IPCC, 2008, p.ix)
- Police were often forced to transport detainees by police vehicle due to long waiting times for an ambulance and a lack of alternatives (IPCC, 2008, p.ix).

These problems were not universal, and the functioning of the act varied widely over different local areas. Where forces do not perform well, poor partnership arrangements and a lack of effective joint-working protocols are often found to be a major contributing factor (IPCC, 2008, p.20). Lord Bradley's (2009) report also recognised this problem, joining the IPCC (2008) report in calling for improved partnership arrangements and clearer local multi-agency protocols for the application of both section 135 and 136 (Bradley, 2009, p.45-47).

Where forces performed better, they generally had:

- Greater availability of alternative places of safety (psychiatric facilities or hospital emergency departments, rather than police custody) (IPCC, 2008, p.19-20)
- Better multi-agency working and agreements (IPCC, 2008, p.20)
- Support for multi-agency working at a senior level among police and NHS commissioners (IPCC, 2008, p.ix).

3.1c National policy and guidance

In response to the problems raised in the Bradley (2009) report, the previous government's *Improving Health, Supporting Justice* strategy promised to issue national guidance on the application of both these sections (Department of Health, DH, 2009a, p.38). The coalition government's *No Health without Mental Health* strategy has also reiterated that "it is particularly important to maintain a positive experience of care and support where people are treated under the Mental Health Act" (DH, 2011, p.25).

Updated national guidance on the Mental Health Act supports this message, and identifies five core principles in the application of the act:

- **Purpose principle** – Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.
- **Least restriction principle** – People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.
- **Respect principle** – People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are

reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

- **Participation principle** – Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.
- **Effectiveness, efficiency and equity principle** – People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

Specific guidance exists on all of the problem-areas noted above, including:

Transport

The key principle when transporting people under the act is that "Patients should always be conveyed in the manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people" (DH, 2008a, p.87). This makes an ambulance or other hospital transfer the preferred mode of transport in most circumstances.

When an ambulance is used, police must conduct a risk assessment to decide whether a police escort is required or if the police officer should accompany the detainee in the ambulance (NPIA, 2010, p.105). If a police vehicle is used, a member of the ambulance crew can be asked to be present in the vehicle or have an ambulance follow behind in case of a medical emergency (NPIA, 2010, p.104).

Moves between places of safety, as allowed by amendments to the MHA in 2007, may only occur in the interests of the patient and not for expedient operational reasons (NPIA, 2010, p.96).

Places of safety

The Mental Health Act Code of Practice 2008, alongside all other guidance, makes it clear that "a police station should be used as a place of safety only on an exceptional basis" (DH, 2008a, p.77). This is where a detainee's behaviour "would pose an unmanageably high risk to other patients, staff, or users of a healthcare setting" (DH, 2008a, p.77).

Where a hospital setting is not available, the police station should not be an automatic second choice; "Other available options, such as a residential care home or the home of a relative or friend of the person who is willing to accept them temporarily, should also be considered" (DH, 2008a, p.77).

NPIA (2010, p.96) guidance makes clear that not only should all forces have access to suitable non-police places of safety, but also that co-operation between police and healthcare trusts is needed to ensure that these are adequately resourced.

Assessments

Wherever possible, assessment should be undertaken by a doctor approved under section 12 of the Mental Health Act.[6] Where this is not possible, the reason for it should be recorded (DH, 2008a, p.79).

Assessment should take place as soon as possible on arrival in the place of safety. Although the Code of Practice sets no particular time limit beyond the 72-hour limit for detention under the section, the Royal College of Psychiatrists (2008, p.6) suggest that assessment should begin within three hours where clinically appropriate.

Partnership working

Underlying all of this, national guidance makes clear that "it is important to ensure that a jointly agreed local policy is in place governing all aspects of the use of sections 135 and 136" (DH, 2008a, p.75).

3.2 Provision and practice in the North East

The North East region is divided into three police force areas and two mental health foundation trust areas. Cleveland police and Durham constabulary operate within the south of the region in the area covered by TEWV NHS Foundation trust (excluding North Yorkshire which is also covered by TEWV). Northumberland Police force area is coterminous with the area covered by NTW. Social care services are provided by each of the 12 unitary local authorities in the region.

Figure 3.2

Image from CPS (2012)

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[6]Under section 12 of the MHA 1983, one of the medical recommendations required for any application under the act is to be given by "a practitioner approved for the purposes of this section by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder".

3.2a Places of safety

Within the NTW area the designated places of safety include five mental health units with s.136 suites and seven Accident and Emergency (A&E) wards. The mental health units are:

- S.136 Suite at St Nicholas Hospital, Gosforth (for Newcastle, North Tyneside and Tynedale)
- Newton Ward, St Georges Park Hospital, Morpeth (for remainder of Northumberland)
- S.136 Suite adjacent to Dene Ward at Cherry Knowle Hospital in Sunderland
- S.136 Suite at the Tranwell Unit, Gateshead (for Gateshead and South Tyneside)
- S.136 Suite Bede Wing at South Tyneside (for Gateshead and South Tyneside).

TEWV provides four mental health units with s.136 suites. There are also five A&E wards in the area.

- Lanchester Road Hospital, Lanchester Road, Durham (for North Durham)
- West Park Hospital, Pease Way, Darlington (Darlington and South Durham)
- Sandwell Park Hospital, Lancaster Road, Hartlepool (Hartlepool and North Teeside)
- Roseberry Park, Marton Road, Middlesbrough (Middlesbrough, Stockton, Redcar and Cleveland).

3.2b Multi-agency protocols around s.135/136

Both mental health trusts have a comprehensive, multi-agency policy relating to both s.135 and s.136 although TEWV's is currently under review. Broadly speaking, these policies are in line with national guidelines and take the MHA Code of Practice 2008 as their starting point. Nevertheless, many of the problems in actual practice recognised in national research are present to varying degrees across the different force areas. They also reflect the problems of joint-working found more generally at the pre-arrest stage.

3.2c Use of Section 136

The following data was obtained from the three police forces for the 2011 calendar year (with the exception of data for Cleveland, which covers the period from September 2010-August 2011).

Figure 3.3	Cleveland	Durham	Northumbria
s. 136 detentions (overall)	511	165	247
s. 136 detentions (police custody)	307 (60.08%)	48 (29.09%)	140 (56.68%)
s. 136 detentions (hospital)	204 (39.92%)	117 (70.91%)	107 (43.32%)
Number released NFA after assessment	388 (76%)	91 (55.15%)	Not available

	Cleveland	Durham	Northumbria
s. 136 detentions (police custody)	307 (60.08%)	48 (29.09%)	140 (56.68%)
Overall number of people held in custody for any reason	31,332	20, 047	70,042
Police custody s.136 detention rate*	97.99	23.94	19.99

* section 136 detentions in police custody per 10,000 detentions

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3.2d Current strategic work to improve practice around section 136

NTW have recently developed a multi-agency s.136 policy, in line with national guidelines and agreed by the relevant police, acute trusts, PCTs, local authorities and the North East Ambulance service. It was also positively reported that there has been greater consistency in strategic governance from the police side in the last 12 months.

TEWV also has a multi-agency s.136 policy, although a multi-agency group has been convened to review this and make required changes. Multi-agency operational groups also operate in each different locality in the TEWV area. These enable representatives from all areas to convene and discuss operational problems; however it was suggested that greater engagement from acute trusts would be beneficial. We are not aware of similar arrangements in NTW.

3.3 Key issues for the North East

3.3a Finding appropriate alternatives to section 136

Concerns were expressed by both national and regional stakeholders that s.136 was being overused where officers could and should be using other options. One stakeholder reported

> *"You've got untrained officers, unfortunately, attending a scene and having to deal with something that, jack of all trades, master of none, have got to do the best of that job. And it tends to be that the default position is 136. And a place of safety. There are lots of other options open to them, but that tends to be the one that they choose. And that's what we've got to change."*

Interviewees from all areas reported concerns about the high attrition rate for the use of s.136. 76% of s.136 detentions in Cleveland are released with no further action and 55% in Durham. Data for Northumbria was not available on request, however an interviewee from NTW reported that a rough check of their data that had been undertaken previously suggested that only around 50% of those that came to Newcastle on s.136 were deemed appropriate for further mental health service involvement. We have been unable to find national figures for comparison.

It was suggested that people were being detained that did not require an assessment under the Mental Health Act. Although they may still have had some unmet mental health need, interviewees reported that in many cases the needs of the individual were alcohol-related. Consequently, although they might be appropriate for further involvement from alcohol services, they should not have been detained under the Mental Health Act. One interviewee also highlighted that despite the high incidence of alcohol problems among these detainees, those held in police custody were not being routinely linked with alcohol arrest referral workers.

Several stakeholders also reported that in many cases where a s.136 is being considered, an offence has also been committed and an arrest could be made instead. There are concerns that overuse of the section is linked to an under-reporting of crime. Evidence is not gathered for s.136 detentions, even though an offence is often alleged to have been committed. This then creates problems as evidence has not been recorded if it is decided to proceed with a prosecution at a later date or alternatively to provide adequate risk and historical information if that person comes into contact with the police again for more serious offences. It was reported that some progress had been made to address this issue:

"All of our local police forces, in the past, they've used 136 where there's clearly been an offence. And when the person is brought to the 136 Mental Health place of safety, we find actually that they're not mentally disordered, or they're not significantly mentally disordered, and the offence goes by-the-by…What they're trying to do now is if there is clearly an offence they will arrest for the offence, and then instigate the mental health assessment if it becomes apparent that the person has mental issues."

While this is a positive development since an arrest may be an appropriate alternative to s.136 in certain situations, it is undesirable and inappropriate for powers of arrest to be used as a welfare intervention.

As well as utilising arrest, national experts highlighted how other diversionary interventions could be offered, particularly for those repeatedly subject to the section (either appropriately or inappropriately):

"I think what we need to be doing more is having more professional strategy meetings with health or any other agency that has an interest in this person to try and come together with more of a plan as to what to do with them, rather than just keep bringing them in on a 136 for an assessment. They don't particularly benefit from and then just keep twirling around the system. I think we need to try and stop that and get more of a grip on it and look at what other interventions there might be that would be more effective than using 136s."

Joint-initiatives between health and/or social care agencies and Neighbourhood Policing Teams may be able to offer solutions for this group. A targeted support service for repeat recipients of s.136 is being developed in the South-West and the 'Revolving Doors Service' in Warrington provides a good model for those who are at risk of offending in the community (see good practice box on page 63). One stakeholder also suggested that a more joined-up approach with primary care would be beneficial so that GPs were made aware that their clients had been subject to s.136, even if no further action was taken.

There are particular concerns regarding the inappropriate use of s.136 in the Cleveland area. The number of detentions on s.136 by Cleveland police force over a year period (511) is twice the number in Northumbria (247) and three times the number in Durham (165) and the rate of attrition in Cleveland is significantly higher (76% Cleveland; 55% Durham). However, it was reported by a representative from TEWV that a change in personnel within Cleveland has led to a clearer message to officers that s.136 is purely for mental health concerns and any offence must be treated as such. It was reported that while this has not lead to a change in number of s.136 detentions it has led to a change in outcomes in that more people require, and are given, follow up.

Many stakeholders and experts felt that more informed decisions could be made by officers with better training. Other suggestions included improving the input of mental health professionals at this early stage, for example by contacting community mental health or crisis teams to see if the person is known to them, potentially allowing the issue to be dealt with in the community without the need for s.136.

One national expert discussed how a simple intervention with only very limited cost implications could achieve significant reductions in the use of s.136.They described a scheme in Bromley where police were encouraged to meet with practitioners from local health and social care services on a regular basis to develop strong working relationships which enabled more informal requests for help from these services to be made by police.

"Through that they developed relationships where one could call on the other and say, there's a bit of an issue here, would you mind coming along with me, this guy has agreed to open the door, I think he needs your help."

The national expert suggested that for that particular area, this simple intervention reduced admissions on a s.136 by 50% (no published data has been obtained on this scheme).

In Cleveland, a successful bid has been made to the Department of Health for development resource to address some of these issues. This pilot aims to promote joint working between mental health services and the police to reduce the use of s.136. A First Response Team would be established which would see a registered mental health professional accompany the police to provide a first response intervention to incidents where there are concerns about a person's mental health, dual diagnosis or learning disability. Once on the scene the mental health professional would be able to carry out a 'Street Triage' to assess whether it was appropriate for the police officer to detain the person under s.136 of the Mental Health Act. One stakeholder highlighted that there is a need to include strong drug and alcohol input into this service if an opportunity is not to be missed.

As well as reducing inappropriate use of s.136, it is hoped that by including a mental health professional at this early stage, it would also improve the efficiency and use of mental health units as places of safety. If successful, the pilot is to be rolled out to Durham and Darlington.

A further issue raised across all police forces was about the management of mental health incidents in a private property and the illegal use of s.136 by officers. Although the actual process of applying for, and receiving, a s.135 warrant appears to run smoothly enough, stakeholders reported that this section was rarely used (as nationally). One expert raised concerns about this underuse, suggesting that such warrants should be applied for in more home-based mental health assessments as they enable an attending police officer to manage risk more successfully. Without such a warrant, the police officer could only exercise very limited *legal* control over a person where a criminal offence had not been committed.

Police from all three forces reported a number of incidents whereby s.136 was used inappropriately and illegally by a detaining officer where a person was found to be in need of care and control *on private premises*. This contravenes national and local protocols, as detention of a person found on private premises is unlawful without the magistrates warrant as detailed by s.135 (1) of the Act, and the attendance of an Approved Mental Health Professional (AMHP) and doctor. It was suggested that police sometimes felt compelled to do this due to long delays in securing the attendance of an AMHP and significant concerns for the safety of the individual.

Good Practice Example:

A number of expert interviewees identified the 'Revolving Doors Service', **Warrington** as an example of good practice.

Funded by Warrington Borough Council, and situated within local mental health services, the 'Revolving Doors Service' is linking up people they believe to have significant unmet needs and moderate or common mental health problems with a full range of services in the community.

Referrals are received directly from Neighbourhood Policing Teams and those referred do not need to be arrested; they can be offenders, victims, or simply at risk or in distress.

All the person's needs are assessed, not just mental health, by one of the two full-time workers (a social worker who is an Approved Mental Health Professional (AMHP) and an unqualified care worker. They are then helped directly or supported to access and maintain contact with other agencies. Engagement with the service is for a period of approximately eight weeks.

The service has identified some of the most socially excluded and 'hard-to-reach' individuals, who might not normally receive help until their condition deteriorated much further. In its first 2½ years, it helped a third of its 1,100 referrals.

For those assessed and helped directly in the first year, the impact the year after they were helped was:

- Reported crime sustained a 78% drop on the pre-intervention rate
- 'Vulnerable Adult' reports fell by 71% – after an initial fall of 54%
- Anti-social behaviour was only assessed in months 2-4 but this also showed a 30% reduction. (Revolving Doors Service Warrington, unpublished data)

The service is overseen by a multi-agency steering group.

3.3b Transport of detainees

The policy for both trusts is clear and in line with national guidelines in stating that "transport by ambulance is preferred wherever possible, including from the place of arrest to the place of safety" (NTW NHS Foundation Trust, 2009, p.9). Cleveland police policy makes a particular note (in bold) that *"A detainee should never be conveyed in a police vehicle to a place of safety simply because it offers a quicker or more convenient method for the police"* (Cleveland Police, 2009, p.5).

Nevertheless, in practice, interviewees from across the North East reported that securing ambulance transport was problematic or simply never requested.

> *"Preferred place of safety transport is an ambulance. All of our national guidance and our local policies that we've just finished developing, they say that it should be an ambulance unless the person would require any control or restraint. Then the police would actually accompany the person inside the ambulance. In reality that doesn't happen yet. And it tends to be a police car when a person is transported to a place of safety."*

It was suggested that ambulances were reluctant to provide a blue light response to requests for transport to a place of safety although interviewees reported that this was changing:

> *"They don't see it as a massively high priority, so it's difficult to get a blue light ambulance to transport somebody under 136. They don't see it as one of their highest emergencies, so there might be a bit of a wait around an ambulance."*

> *"We've got agreement from the ambulance service who we've finally got on the table that they will now transport to a place of safety for us."*

However, a representative from the North East Ambulance Service suggested that their ambulance staff is aware of their obligation to transport persons detained under s.136 and do so when requested. It was reported that any time police call up for ambulance assistance, a blue light response is provided regardless of the situation. But it was suggested that requests for transport are not being made by the police:

> *"If requested we would transport to police station – but this isn't happening much. If at all."*

A representative from Durham police force confirmed that a police vehicle was always used to transfer a s.136 detainee to a place of safety. Additionally, in Cleveland, the common use of police custody as a place of safety meant police transport was usually used, although national policy does not support the routine use of police vehicle to any place of safety, even a police custody suite. The decision about appropriate transport should be made on an individual case basis. A representative from TEWV confirmed that the use of police vehicle is something that would be considered as part of their forthcoming policy review around s.136.

3.3c Increasing access to appropriate places of safety

Both trusts echo national guidance in stressing that a police station should only be used as a place of safety in exceptional circumstances, and that a hospital setting is to be preferred. Nevertheless, our research showed widely differing experiences by the different police forces in the region in accessing these designated places of safety.

Problems around access to s.136 suites were again particularly pronounced in Cleveland. In Cleveland 60% of s.136 detainees were detained in police custody in the period September 2010-August 2011. In Northumbria just over half of the s.136 detentions were in police custody in 2011,

while in Durham this was just 30%. A recent inspection report on police custody in Cleveland revealed that "since 2008, the number of s.136 detainees coming into police custody had reduced from 50 to, on average, 27 per month, which was still unacceptably high" (HMIP and HMIC, 2011a, p.25). The Inspectorate report (HMIP and HMIC, 2011a, p.9) recommended that "The Mental Health Trust should improve access to s.136 suites to minimise the extent to which people with mental health problems are held in police custody."

Police officers interviewed from the force reported that *"We would endeavour to keep 136s out of the custody suite where possible."* However, in practice it was suggested that they were often left with no choice but to use this option. Despite no issues being raised with the actual number of beds available for use as s.136 places of safety, staffing of suites was reportedly an issue. Interviewees reported that police might be turned away from hospital places of safety due to a lack of staff as they are reluctant to divert already limited resources from an acute ward to the 136 suite:

> *"The other problem we can have…some of our smaller units, where there might only be three or four wards, it can be difficult to release staff from those wards. That can be a problem because it [136 suite] isn't permanently staffed…and you don't have any additional staff sometimes."*

It was reported that previous experience of being turned away led to detainees being taken to police custody by officers as the first (and easiest) port of call.

Inadequate staffing and resources also mean that mental health units can be reluctant to accept any detainees considered a risk. Common reasons for refusal included:

- Consumption of alcohol
- The patient being agitated
- The detainee being under the influence of drugs.

Responses to intoxicated detainees were a particular source of tension between Cleveland Police Force and TEWV Foundation Trust. While both national and local policy state that a mental health unit may not be the most appropriate place of safety for violent or intoxicated detainees, police interviewees felt that the threshold at which a detainee was considered too 'risky' was often far too low in practice. Interviewees from Cleveland police consistently mentioned detainees being refused entry if it appeared that they had any alcohol in their system. One interviewee even recalled a recent incident where a male was taken to a place of safety by police, but was refused access because he had had a single drink at lunch time (many hours before).

This anecdote was flatly denied by interviewees from health, who instead reported that:

> *"They [the police] were bringing people to us that were absolutely so drunk, they were almost at the point of collapse. We couldn't assess them…but their view was, and the police guidance was, the fact that somebody is drunk doesn't mean they can't go to a mental health unit. So we had a bit of a stand-off at that point."*

While the preference should always be for detention in the designated s.136 suite, which 'place of safety' is deemed the most appropriate will inevitably be circumstance-specific. Other venues such as police custody (e.g. where there is a risk of severe violence) or Accident and Emergency [A&E] (e.g. immediate health risks such as risk of alcohol withdrawal) may be appropriate. The frequent problems in accessing the preferred place of safety are a source of frustration on the police side and there was fear that the detainee might experience health problems while in police care that the police were unable to manage:

"The thing, one of the issues is that, a lot of other medical emergencies can occur with that person. And the police station isn't the place to have them. A hospital is. That's the bottom line"

One senior stakeholder suggested that police might not fully understand the difference in staff skills at a mental health hospital and an A&E department and inappropriately take a detainee with significant physical health needs to the former. Another stakeholder suggested that there was a tendency for all agencies to focus on the needs and risks of the individual that their own service could not meet leading to a reluctance from all sides to accept complex s.136 cases.

Despite working with the same mental health trust (TEWV), and having similar staffing issues, interviewees from Durham reported fewer problems in gaining access to mental health units as places of safety, than Cleveland. One stakeholder pointed to a difference in attitude:

"Durham and Darlington don't have the problems that we have…There was very much a "will do" attitude. Here [Cleveland] it's more resistive. They are more who would rather push them away than have them in."

The main reason for the difference between Durham and Cleveland seems to be better working relationships on the ground. The importance of relationships and multi-agency communication has been stressed by national experts that we have interviewed, and is often cited as a key reason why there are differences in performance between areas, as well as gaps between policy and practice.

Although our data suggests that half of s.136 detainees were held in police custody in Northumbria analysis undertaken as part of a recent police custody inspectorate report suggested that inappropriate use of the section was rare.

NTW policy is much clearer than the TEWV protocols on when police custody should and should not be used. TEWV protocols state that police custody may be more appropriate for anyone "aggressive, violent or threatening" and/or "under the influence of alcohol, illicit substances, or where an incapacitant has been used", while the Mental Health Unit is to be used where the detainee is "not violent or likely to be violent" (TEWV NHS Foundation Trust, 2011, p.18). This leaves greater room for interpretation by place of safety staff. NTW policy, however, makes clear that the preferred place of safety must be used as long as the person "is in a rousable state and able to identify themselves, to walk and talk, and to respond to questions or commands" (NTW NHS Foundation Trust, 2009, p.5).

It was clear from interviews in all areas that where the s.136 suite or A&E were both deemed inappropriate, police custody was being used as the default place of safety. However, national experts reported examples of good practice in other parts of the country whereby agencies worked creatively with other agencies to use alternative venues where appropriate, such as a local Sure Start Children's Centre for a woman detained with her children or a residential care home for an elderly woman. Both the MHA code of practice 2008 and local guidance makes clear that even where a mental health unit is not available, police custody need not be the automatic second choice.

3.3d Reducing waiting times for assessment

The policy on assessments is clear within both Trusts, and in line with national guidelines. Assessments are to be conducted as soon as possible after detention; within three hours under the NTW policy and four hours for TEWV.

As with the places of safety, despite positive statements of policy there remain practical difficulties in joint working. Mental Health Act assessments require the co-ordination of a number of agencies and

professionals; the police, place of safety staff, Approved Mental Health Professionals (AMHPs) from local authority social services departments and registered section 12 doctors.

Problems were raised by both stakeholders from local agencies and service users regarding the length of time for s.136 assessments to take place:

> *"It wasn't a case of being in the 136 suite that upset me, it was the wait. If the crisis team had come down earlier, the police could have been out earlier. I could have been assessed sooner, on the ward sooner, home sooner…it was the anxiety that was building up."* (Service user)

Service users reported that the environment in the s.136 suites was "stark" and "undignified" while police reported serious concerns about the length of time for which officers were called away from their duties to remain with detainees.

There is a local agreement between NTW and Northumbria police that:

> *"Escorting Police Officers will remain in attendance at the Section 136 assessment unit until the assessment is complete. A Police Officer being called away to a greater emergency should only occur in exceptional circumstances"* (NTW NHS Foundation Trust, 2009, p.12-13).

However, this issue was identified as the primary source of tension between Northumbria police and NTW Mental Health Trust by interviewees from both agencies:

> *"The other area we commonly come across is the police being a place of safety for long periods of time waiting for the assessment to be completed. So if for instance we have difficulty getting the doctor, also we're getting an AMHP, the police might be keeping that person in custody in the place of safety for several hours. And really while they're doing that, they're not on the streets doing their other job, you know?"*

This was particularly problematic where detainees had consumed alcohol, as although NTW places of safety were far more willing to take intoxicated detainees than within TEWV, police still had to wait with health staff for the detainee to sober up before the assessment could take place.

This was also identified as a problem for Durham police force. Current TEWV protocols state that police must wait at the place of safety until a proper handover has been conducted with hospital staff. This handover includes a risk assessment, and police officers will remain in attendance for the assessment if they are required to alleviate risk. However, the police expressed concern that they were being asked to stay too frequently. In Durham it was reported that this would typically involve two officers waiting with a detainee for several hours for an assessment.

There is clear frustration over this issue from the police side who expressed a desire for effective arrangements for such assessments to avoid significant police-hours being used in this manner. One interviewee even stated that:

> *"It is easier if they [the detainee] are in Police custody – it is much less resource intensive for the Police if they are in a cell."*

This frustration from the police and a desire for a quick and simple resolution may lead police to inappropriately use police custody as a place of safety.

Interviewees from the two NHS Trusts shared police frustration. They highlighted that although money had been provided by central government to build s.136 suites there had been no accompanying funding to staff these suites. Instead consultants were being pulled away from their 'day job' (or 'night job') to undertake assessments.

Concerns were expressed by both health and police staff about the difficulties in securing the attendance of an AMHP, particularly out of hours. It was suggested that service restructurings that reduced size or capacity of Emergency Duty Teams (EDTs) had caused particular problems out of hours. Police officers from Cleveland and Durham reported particular challenges since there was only a single EDT covering Tees, Durham and Darlington and AMHPs within these teams had competing demands for their services:

> *"Within Tees, Durham and Darlington, there is one EDT that covers the whole of that area. And you may only have one, possibly two AMHPs on duty overnight. Those AMHPs are responsible not only for mental health, but for child protection and all the rest. Clearly if there is a child protection issue in Darlington, you aren't going to get an AMHP for a mental health assessment over in Stockton."*

As police custody is still often used as a place of safety in Cleveland, it usually falls to the custody sergeant to arrange the attendance of the AMHP and section 12 doctor. While there were some problems reported in securing the attendance of a doctor quickly, more problems were reported surrounding AMHPs for a s.136 assessment. One stakeholder reported many incidents where the detainee was seen only by a doctor, sometimes not a section 12-approved doctor, and released without even seeing an AMHP. This could mean the detainee was never assessed by a mental health specialist. Moreover, due to staffing shortages and a high number of other demands on their time, there is sometimes reluctance by AMHPs to attend at all unless a medical professional has deemed it necessary:

> *"Invariably what happens is, the AMHP will say, well get the doctor there first and see if they need me. And it's usually a phone call between doctor and AMHP. That's wrong. The AMHP should be there and do a joint assessment."*

Stakeholders called for resources to run s.136 suites and bolster EDT provision in order to tackle these problems and ensure that assessments take place in a timely fashion. One stakeholder highlighted the need to develop understanding that *"there are resources required to run effective 136 services really."* One national expert suggested that police could provide some funding to staff these suites since they would reap the financial benefits from reduced use of their officers' time.

3.3e Strengthening partnership working in response to mental health crisis

Crisis teams, often called 'Crisis Resolution and Home Treatment' teams, are teams based within each of the two Mental Health Trusts whose purpose is to provide assessment and where possible and necessary home treatment for those in mental health crisis who are at risk of admission to hospital, in order to avert such admission.

Crisis teams play an important role in supporting those with mental health problems in the community and in gate-keeping access to inpatient psychiatric beds. Given the role of the police in handling crisis situations in the community where there is a risk of harm to the public, it is clear that close and effective joint working between the two agencies is crucial. This is not just limited to practice around s.136 but also includes a range of other situations in which the two teams need to cooperate to manage a patient with deteriorating mental health needs in the community.

However, at an event held by the Safer Durham Partnership with a high presence of frontline and more strategic police officers, the view was expressed that current arrangements for joint working were not always as effective as they needed to be.

Police officers expressed concern about a perceived lack of cooperation from these teams and a reliance on police officers to provide support that was either out of their remit or that was perceived by police to be avoidable with a greater degree of planning.

Within the TEWV area which is co-terminus with Durham and Cleveland police forces, it was reported that there were particular problems with a lack of consistency with how crisis teams operated across the areas and with the out-of-hours response from the crisis teams:

> *"What we've got is a Crisis Team who currently work from a hospital base and they won't go out to see people in their own homes. People have got to be brought to them, and they say that is...a safety issue, out of hours. They will go down to custody or they will get people brought up to hospital. They won't go elsewhere from there. And that's not really effectively working."*

A review of crisis services within TEWV is currently underway and is addressing some of these problems.

Concerns by police officers from across the three police forces frequently centred on issues that are beyond the remit of the Big Diversion Project. Notable examples include the need for police to locate and detain someone who has gone absent without leave from a mental health hospital. However, these issues were important for the Big Diversion Project since they could sour relationships between health and the police.

Senior representatives from both health trusts suggested that greater work had to be undertaken to increase understanding of each other's roles. They understood police frustrations about the police time involved in the recall of absent s.136 detainees or other mental health inpatients. However, they felt that police needed to understand that mental health units were not prisons and that reintegration into the community for some long-term patients was likely to be a gradual process with inevitable setbacks:

> *"There's also the education around what we as a hospital are allowed to do or not allowed to do. The police are amazed that when they bring someone into us, we can't lock them in a room."*

> *"Again it's about understanding isn't it, quite often you have officers – their ideas are still that you lock people behind big walls and that's what should happen, so it's about a perception of the officers that we're somehow not diligent in terms of keeping people behind locked doors."*

Interviewees at both strategic and operational level from all agencies showed a clear awareness of the value of earlier intervention and improved joint-working in the community. As one interviewee put it:

> *"When they're in the community we can have the greatest impact, because there's more services able to function with people in the community than there are to engage with them at the other stages of the [criminal justice] pathway."*

Cleveland police employ four mental health liaison officers. These are operational police officers who are each assigned to one of the four local authority areas covered by the force. They have reportedly had some success with this system, as these officers are able to liaise with the various Community Mental Health Teams, identify people who are at risk of entering the criminal justice system, and put an intervention in place. In response to the Bradley review and the perceived success of this approach in Cleveland, a new Mental Health Liaison role has been established in Northumbria police force. However, there are significant differences with the Cleveland model since this post is at the rank of Chief Inspector who has oversight for the whole police force area.

However, while the mental health liaison officer system was reported to work well in Cleveland in terms of prevention, there remained problems with joint-working in responding to mental health incidents.

3.3f Training

Training of police is clearly a key issue in regards to improving practice around the use of sections 135 and 136 of the MHA. We will return to this issue in Chapter 3.

4
Police custody

> **Key Issues:**
>
> - **Improving identification without slowing down police process**
> - **Ensuring adequate and timely provision of Appropriate adults**
> - **Better utilising existing resources within police custody suites**
> - **Identifying clear care pathways and a single point of contact**
> - **Ensuring officers receive regularly repeated, high quality training**

4.1 National Picture

A growing literature treats police custody as a vital part of a more unified, whole pathway approach to offender health. A number of government publications, from the Bradley (2009) review to the current government's *Breaking the Cycle* green paper (Ministry of Justice, 2010), have argued that measures that improve the health and wellbeing of offenders can also reduce re-offending, inequality and social exclusion. The police stage is an important part of this approach: as the previous government's *Improving Health, Supporting Justice* strategy consultation paper stated:

> *"Working in partnership, the police service can provide the gateway to health engagement…As the initial point of contact with the CJS [criminal justice system] for most people, we will work with the police to implement a framework encouraging their role as a first gateway to health and social care"*
> (Department of Health, 2007, p.22)

This emphasis raises expectations as to what can be achieved in custody. As police are the first point of contact with the criminal justice system, identifying health needs at this stage could see offenders either diverted to a health setting if this is appropriate, or see information about health needs follow them onto the court stage to inform how the offender is charged and dealt with.

Focusing on custody itself, the national literature also raises a number of issues relating to the detention of those with mental health problems or learning disabilities in police custody. There is extensive guidance for police and custody officers on these issues. The Police and Criminal Evidence Act 1984 (PACE) provides the legislative framework for all police detentions, while PACE code C (last updated 2008, although a consultation on revisions to this code of practice closed in January 2012) and the ACPO guidance *The safer detention and handling of persons in police custody* (NCPE, 2006,) provide more detailed statutory guidance.

While this guidance covers procedures for identifying and responding to mentally disordered detainees, research shows that there continue to be problems in some areas with the actual functioning of the policy. This chapter begins with a summary of the national literature, focusing on three key areas:

- Screening and identification of mental health problems, learning disabilities and dual diagnosis
- Fitness to detain, police interviews and appropriate adults
- Healthcare in police custody suites.

4.1a Screening and identification of mental health problems, learning disabilities and dual diagnosis

The recent NPIA (2010, p.29) publication *Guidance on responding to people with mental ill health or Learning Disabilities* states that "early police recognition of the possible mental ill health or learning disabilities of people they come into contact with is crucial to ensuring an appropriate and effective response."

This reflects the importance placed on the early identification of offender's health needs in the post-Bradley policy context. The Bradley (2009, p.34) report made clear that early identification is important not only for an effective response in police custody, but has a knock on effect throughout the offender's journey through the criminal justice pathway.

Despite this, there are serious obstacles to the identification of mental health problems and learning disability upon arrest. Problems reported in the literature include:

- There is no standard mental health assessment or screening approach, with assessments by each force varying in how effectively they identify mental health or learning disabilities (Bradley 2009, p.39)
- A current reliance on self reporting (Bradley, 2009, p.39)
- A large proportion of detainees are intoxicated on arrival in the police station, masking mental health and learning disability needs (Bradley, 2009, p.39)
- There is often no access to information about previous involvement with services other than police (Bradley, 2009, p.39)
- A lack of training for police in mental health awareness (Bradley, 2009, p.39)
- Police generally have little recourse to advice or help on mental health issues (Bradley, 2009, p.39).

While there is no standardised screening tool used by police, extensive national protocols do exist surrounding the screening and assessment of detainees as part of their 'risk assessment' process. National guidance lists a number of general warning signs for custody staff to be aware of, such as irrational conversation or behaviour, self-neglect, impulsiveness, difficulty reading and writing and poor understanding of simple questions (NPIA, 2010, p.29). Any concerns raised over the mental health of the detainee must be recorded on the detainee's custody record as part of the risk assessment process, in accordance with PACE code C (Home Office, 2008, p.10). Nevertheless, this risk assessment relies heavily on the individual knowledge and experience of the custody officer to recognise the signs of mental illness or learning disability.

However, particular problems are highlighted in identifying learning disability in detainees. As part of the Prison Reform Trust's (PRT) *No One Knows* programme, a review was undertaken of prevalence

estimates for learning disabilities within different offender populations. This research reports on two studies from the early nineties which place the prevalence of learning disabilities among those detained in police stations as 5% (Lyall et al. 1995 as cited in Loucks, 2007b, p.12) and 9% (Gudjonsson et al. 1993 as cited in Loucks, 2007b, p.12). However, the prevalence of borderline learning disabilities and significant learning difficulties appears to be much higher from much of the research about offender populations and the PRT review concludes that "between 20% and 30% of offenders have learning difficulties or learning disabilities that interfere with their ability to cope within the criminal justice system" (Loucks, 2007a, p.1). It was reported that a lack of awareness and training as well as the inherent difficulty in recognising learning disability means that such difficulties often go unrecognised (Jacobson, 2008, p.vii). A recent pilot of the Learning Disability Screening Questionnaire (LDSQ) in police custody in West Yorkshire found that 3% of 224 people screened were identified as a high likelihood of having a learning disability. However, *"none of the people identified using the LDSQ tool had been identified as having a learning disability previously, despite some of them having a previous arrest record. In addition, none of them were identified by the existing police screening methods at booking-in"* (Middlemiss, 2012, p.9).

The *No One Knows* programme resulted in a number of suggestions made to improve on current processes for identifying individuals with a mental health problem or learning disability in police custody:

- A system should be introduced across all police forces for screening suspects for vulnerability, to include learning disability and issues around communication and comprehension. Training for custody officers on how to undertake the screening must also be put in place (Jacobson, 2008, p.39)
- There should be statutory provision to ensure that police officers can routinely access mental health and learning disability services to carry out assessments of mentally disordered offenders, and to liaise with local agencies with respect to suspects whom it is appropriate to divert for further assessment and treatment (Jacobson, 2008, p.38)
- Mechanisms for recording the results of the process and ensuring appropriate follow-up actions are taken should be devised and implemented (Jacobson, 2008, p.39).

4.1b Police Custody Healthcare

Where a 'mental disorder'[7], or indeed any other health need, is identified, custody officers have a statutory responsibility to arrange for appropriate clinical attention "as soon as reasonably practicable". This is required "even if the detainee makes no request for clinical attention" (Home Office, 2008, p.29).

Clinical attention must be provided by an "appropriate healthcare professional", as defined by PACE, code C, (Home Office, 2008, p.32). This can be a forensic physician, psychiatric nurse, custody nurse or paramedic depending on the situation (NCPE, 2006, p.73). It is up to individual forces to determine the most appropriate model of healthcare provision, taking account of quality of service provision and best value (NCPE, 2006, p.73). The model traditionally in operation sees Forensic Medical Examiners (FMEs) contracted by police forces from a private provider or a local NHS trust to provide on call services to the custody suite (de Viggiani et al, 2010, p.14). While this model has worked adequately in a number of areas, it also has a number of shortcomings:

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[7] A mental disorder as defined by the Mental Health Act can cover affective disorders, psychotic disorders, personality disorders and learning disability (DH, 2008a, p.19-20).

- A recent review carried out by the Offender Health Research Network found that medical care was not always available to police custody detainees when required, and often only within normal working hours (Rennie et al, 2008 as cited in Bradley, 2009, p.48).
- This means that there are often delays in health assessments in police custody, whether this is assessment of fitness to detain and fitness to interview, or assessments under the Mental Health Act. (IPCC, 2008, p.vii)
- A Revolving Doors Agency report from 2006 found that while many Forensic Medical Examiners (FMEs) are extremely experienced and committed, some private healthcare contractors relied on doctors on short contracts who were often less experienced or qualified than the traditional FME (as cited in Bradley, 2009, p.47-48). Other reports have suggested that FMEs need more specialist training in mental health and learning disability issues (Bradley, 2009, p.48).
- The Prison Reform Trust's *No One Knows* reports also found that some areas saw limited referral of suspects with learning difficulties for clinical attention. 'There are inconsistencies in the attention received from healthcare professionals' (Jacobson, 2008, p.v).

Currently, individual police forces have responsibility for commissioning the healthcare services provided within police custody suites in their police force area. However, following the successful transfer of commissioning and budgetary responsibilities for prison healthcare to the NHS, Lord Bradley (2009) recommended a similar transfer of commissioning responsibilities for healthcare in police custody with the aim of improving coordination of health and social care services in custody and care and treatment pathways. This is now national policy following the successful pilot in Dorset. This pilot utilised a nurse-led model and offered 24/7 coverage. It was found to have made a positive difference despite a number of practical difficulties in implementation (de Viggiani et al, 2010). It is expected that many forces will move towards such a model.

Ten forces have been selected to form the 'first wave' out of three. The two-year process which commenced in April 2011 provides support to these sites to prepare for transfer including engagement with the NHS Commissioner who will add value in terms of clinical governance. The transfer will take place at different times in each force according to the time remaining on their outstanding healthcare contracts. Lancashire has already undertaken the procurement process which was reported to have been successful by representatives at the Department of Health. Those police forces in the second wave will commence the two year process in April this year (2012) while the third wave will commence in April 2013.

4.1c Fitness to Detain, Police Interviews and Appropriate adults

Fitness to be detained

Once a possible mental health need or learning disability is identified in police custody, there are a number of immediate concerns for custody staff and Forensic Medical Examiners regarding support and the need for possible diversionary interventions. Firstly, decisions must be made as to whether the person is fit to be detained or should be diverted immediately to a hospital setting. For offenders, police and healthcare professionals must also determine whether the individual is fit to be interviewed. Statutory guidance states that considerations must include whether "conducting the interview could significantly harm the detainee's physical or mental state" (Home Office, 2008, p.82).

FMEs should be called to advise on fitness for detention and fitness for interview (NPIA, 2010, p.152). Research undertaken by the Offender Health Research Network looking at the general

healthcare needs of police custody detainees in London showed that the vast majority of those seen by the Forensic Medical Examiner (FME) were being assessed for fitness to detain or be interviewed. However, it also demonstrated the large array of medical conditions suffered by the detainees for which examinations took place (OHRN, 2009a). Mental health problems are only one consideration when determining someone's fitness to be detained.

British Medical Association guidance lists specific issues to be considered by healthcare staff in assessing fitness for detention as (BMA, 2009, p.5):

- assessment of illness (physical or mental)/injuries/drug and alcohol problems
- advice to custody officer on general care while in custody
- provision of necessary medication
- referral to hospital
- admission under mental health legislation.

Interviewing suspects and the need for an appropriate adult

Even where a person is found to be both fit to be detained and fit to be interviewed, police staff must also consider the competence of the detainee to understand and answer questions, and consider the particular problems in taking evidence from mentally vulnerable detainees:

> "Although people who are mentally disordered or otherwise mentally vulnerable are often capable of providing reliable evidence, they may, without knowing or wishing to do so, be particularly prone in certain circumstances to provide information that may be unreliable, misleading or self-incriminating. Special care should always be taken when questioning such a person…" (Home Office, 2008, p.80).

Part of this special care is the provision of an appropriate adult who should be in attendance for any police interviews, signing or reading of statements, charging and any intimate strip searches (Home Office, 2008, p 78-79). An appropriate adult can be a relative or guardian of the detainee, or indeed any responsible adult who is not a police officer or involved with the police, but it is advised that "in the case of people who are mentally disordered or otherwise mentally vulnerable, it may be more satisfactory if the appropriate adult is someone experienced or trained in their care rather than a relative lacking such qualifications" (Home Office, 2008, p.6).

PACE makes clear that an appropriate adult should be contacted for detainees who are *or appear to be* mentally disordered or otherwise mentally vulnerable, as well as for juveniles. The definition of 'mentally disordered' is determined by the Mental Health Act, while the term 'mentally vulnerable' is defined by PACE:

> "'Mentally vulnerable' applies to any detainee who, because of their mental state or capacity, may not understand the significance of what is said, of questions, or of their replies." (Home Office, 2008, p.6).

Meanwhile, PACE code C makes it clear that:

> "If an officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, in the absence of clear evidence to dispel that suspicion, the person shall be treated as such." (Home Office, 2008, p.2).

Consequently, the threshold for calling an appropriate adult is set lower than the threshold for interventions under the Mental Health Act. It is also likely to include those with other conditions such as autism, attention deficit hyperactivity disorder (ADHD) and acquired brain injury (ABI).

However, provision of such appropriate adults appears very inconsistent and even when needs are identified, there is a shortage of individuals who can perform the role effectively (Bradley, 2009, p.42; Jacobson, 2008, p.v). Although police are required to call an appropriate adult to support a mentally vulnerable defendant, there is no corresponding statutory duty on anyone to provide such a service. In many cases where there is no designated service, requests will be picked up by the Emergency Duty Team but this is not always the case.

There is also a particular lack of clarity around who should provide the appropriate adult service for a 17-year-old since 17-year-olds are treated as adults under PACE legislation. As a result, those services set up for juveniles may not accept requests to support mentally vulnerable 17-year-olds while services established for mentally vulnerable adults may also refuse to provide support for this group.

Research evidence consistently suggests that some vulnerable adults are not being supplied with an appropriate adult to support them through the process.

There is evidence that police may be under-identifying vulnerability given the disparity between the numbers of appropriate adult requests and research evidence regarding the number of people with mental health problems and learning disabilities that pass through the criminal justice system. A survey of police forces by the National Appropriate Adult Network (NAAN; Perks, 2010) found that the number of adults identified as vulnerable varied considerably across the country, and did not appear to be related to the population size of the area covered.

The research highlights particular concerns about the identification of vulnerability in areas where social services are used to provide appropriate adult services. The survey reported that on average, in areas where appropriate adult services were contracted out, 47 adults per month were identified as vulnerable whereas in areas where social services were used, only 26 were identified per month (Perks, 2010). The same survey revealed greater police satisfaction with appropriate adult provision where it was provided by a third or private sector organisation, especially regarding out of hours provision (Perks, 2010, p.8).

Unpublished research undertaken with the Metropolitan Police by Newcastle University has identified a range of problems with their current risk assessment processes (using the NSPIS [National Strategy for Police Information Systems] tool) and practice around the calling of appropriate adults for mentally vulnerable detainees. The research was undertaken primarily in one busy custody suite in the London Borough of Islington and involved clinical evaluations of detainees. They found that 19/248 of those for which data was analysed had a (affective or non-affective) psychotic illness, 8/248 had a learning disability and 1/248 showed signs of dementia[8]. The researchers felt that all of these 28 people were 'mentally vulnerable' and required an appropriate adult. However, it was found that for those 19 with a psychotic illness an appropriate adult was only called in 11 cases (in 3 cases an Appropriate adult was only called after the detainee was seen by the

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[8] Of 630 people detained under PACE passing through the custody suite during the research period, data was analysed for 248 (of which 237 had full or partial interviews and 11 were considered to lack capacity) – 191 were unavailable to approach as they were not in their cells; 110 declined to take part (importantly there appears to be some differences in this group that need to be analysed); 36 were too violent to interview; 22 had insufficient English; 12 were too intoxicated; 7 agreed but were bailed and 4 required urgent medical attention.

FME) which was a (statistically) significant result. For those with a learning disability an appropriate adult was called in 7/8 cases (again in 3 cases an appropriate adult was only called after the detainee was seen by the FME). In some of these cases, the FME only saw the detainee after a referral for an unrelated health condition. (All data obtained from the interview with Doctoral Research Fellow, Newcastle University).

A number of suggestions have been made to ensure detainees with learning disabilities or mental health problems are provided with effective appropriate adult services:

- There should be statutory provision of appropriate adults for vulnerable adult suspects, equivalent to the provision for suspects aged under-17. Funding should be made available locally for this. (Jacobson, 2008, p.38)
- Appropriate adults should receive training to ensure the most effective support for individuals with mental health problems or learning disability (Bradley, 2009, p.43). NAAN's National Standards recommend a minimum of 18 hours training and two shadow visits. The training should include a familiarisation visit to the local police station. (Perks, 2010, p.7)
- PACE Code of Practice C should be amended to make it mandatory for custody officers to call for an appropriate adult to attend the police station if they have sufficient concerns about a suspect's mental state or capacity to request a health professional's assessment of fitness for detention and/or interview. (Jacobson, 2008, p.38-39).
- Appropriate adult schemes should facilitate police access to their services by ensuring that all local stations have their contact details and details of their availability. This may require sending regular reminders and updates about their services, with requests that the information be clearly displayed in custody suites. (Jacobson, 2008, p.39)
- Liaison and Diversion services should work closely with local appropriate adult schemes. (Perks, 2010)

4.2 Regional Practice and Provision

There are three police forces in the North East region: Northumbria, Durham and Cleveland. As with other forces across England and Wales, these forces differ in the number of custody suites that they run, the processes undertaken within these custody suites and the provision available in these suites. Details of the custody suite provision in each police force area can be found in figure 4.1.

Cleveland operates a centralised system for custody suite provision for the whole police force area, with the majority of offenders passing through the large custody suite at Middlehaven, Middlesbrough. A decentralised management model of custody is in place in Northumbria and Durham. The recent inspectorate report suggested that this was being renewed in Northumbria with the intention of centralising custody resources. A new 40-cell facility opened in North Tyneside with a 50-cell suite planned to open in Newcastle in 2015 (HMIP and HMIC, 2011b, p.11).

Figure 4.1	Provision of support for mental health and learning disabilities in police custody suites in the North East						
Police Force	**Custody suites**	**Area command**	**Capacity**	**Healthcare**	**Arrest referral scheme**	**Appropriate adult provision**	**CJLD service**
Northumbria	Newcastle Etal Lane	Newcastle	28	Directly-employed FMEs only (no custody nurses)	In full-time suites: Turning Point (weekdays 9am-5pm; except 7.30am-8pm six days per week at Gillbridge, Gateshead and Clifford Street)	Provided by Social Services and Emergency Duty Team	None
	Newcastle Clifford Street (known as Byker)	Newcastle	8				None
	Sunderland Gillbridge	Sunderland	20				None currently
	Washington	Sunderland	14				None currently
	Southwick (part-time resilience suite)	Sunderland	29				None currently
	South Shields	South Tyneside	30				South Tyneside (NTW)
	Gateshead	Gateshead	18				Gateshead (NTW)
	Whickham (part-time resilience suite)	Gateshead	10				None
	Bedlington	Northumberland	20		NECA (weekdays 9am-5pm)		Bedlington (NTW)
	Hexham (part-time rural suite)	Northumberland	7				None
	Alnwick (part-time rural suite)	Northumberland	8				None
	Berwick (part-time rural suite)	Northumberland	7				None
	Wallsend	North Tyneside	40		Turning Point (weekdays 9am-5pm)		None
	North Shields (part-time resilience suite)	North Tyneside	20				None
Durham	Durham	North	15	Nurse and FME on-call 24/7, provided by County Durham and Darlington NHS Foundation Trust	Addaction	Provided by Social Services and Emergency Duty Team	Cleveland, Durham and Darlington (TEWV)
	Peterlee	North	14				
	Darlington	South	8		North East Council of Addictions (NECA)		
	Bishop Auckland	South	9				
Cleveland	Middlesbrough	Centralised system	50	Provided by Reliance (nurses and FME on-call 24/7)	Provided by Addaction (In the main Middlesbrough custody suite there is an arrest referral worker in the custody suite 24/7)	Middlesbrough & Stockton Mind (also social services and EDT)	Cleveland, Durham and Darlington (TEWV)
	Hartlepool	Centralised system	15				
	Redcar	Centralised system	6				
	Stockton (standby suite only – rarely used)	Centralised system					

4.2a Identification and screening practices

The 'screening' for mental health problems and learning disabilities forms part of the police risk assessment undertaken when an arrestee is brought into custody. These are undertaken by the custody officer and recorded on a computerised system, although Northumbria does not yet have fully computerised custody. Northumbria uses the Tandem assessment on the NPIX system, Durham the NSPIS system and Cleveland the NICHE system. In addition, observation of the detainee in custody, warning markers on the Police National Computer (PNC), previous custody records and problems raised by third parties (such as carers) would also assist in the identification of these issues.

In a number of the police custody suites in the region there is also access to a CJLD service (see figure 4.1 for details of custody suites which have access to this provision) who may proactively screen clients for those with a mental health problem or learning disability and undertake an assessment where necessary. The activity and coverage of the Criminal Justice Liaison Diversion services operating in the region is discussed in detail in Chapter 5. Additionally, clients who are arrested for certain 'trigger' offences and who admit to or test positive for drug use are also likely to be assessed by drug arrest referral workers (provided by either Addaction or Turning Point). While the primary focus of this assessment is to identify substance misuse issues, the assessment undertaken – the Drug Interventions Record (DIR) – also covers mental health issues and a range of social care needs.

4.2b Healthcare in police custody

All three police force areas had different arrangements for the provision of general healthcare in police custody. In addition, the areas varied in terms of their provision of Criminal Justice Liaison and Diversion Teams in police custody and this is discussed in detail in Chapter 5.

Northumbria

Northumbria police force area currently directly employ Forensic Medical Examiners (FMEs) who are a mix of GPs, retired doctors, locums and others (HMIP and HMIC, 2011b). These provided an on-call service to custody suites. (In addition, the contract for sexual offence examination is currently held by the independent-sector provider Reliance.)

Northumbria has been selected as one of the early adopter sites for the transfer of commissioning responsibilities from the police to the NHS, as proposed in the Bradley review. A partnership board (NEOHCU and Northumbria Force) is in place and there is now signed agreement between these two parties. The transfer process will complete after 2015 when allowed by the legislation, however processes are already underway to reach a stage where service delivery can be transferred to another provider following a health needs assessment commencing early in 2012 (February – early March) which will be undertaken by Improving Health and Wellbeing, UK. This needs assessment has been funded through the Department of Health. Their work will include looking at all custody suites, providers within each suite, gaps in provision and ultimately making recommendations. These recommendations are expected by the middle of May. It is intended that there will be a statement of intent ready (service specification) by April 2013.

It is hoped that the resulting service will be more responsive to people's needs and will provide better value for money. It is likely that Northumbria will move towards a nurse-led model in which nurses take on some of the responsibilities currently undertaken by FMEs.

Arrest referral services are currently provided by the North East Council for Addictions in Bedlington and Turning Point elsewhere in the region. A weekday office-hours service is provided in full-time custody suites with appointments with Drug Interventions Programme (DIP) workers made by custody staff for detainees passing through the cells out of hours. An intensive DIP service was run from 7.30am – 8pm six days a week at Clifford Street, Gateshead and Gillbridge Avenue (HMIP and HMIC, 2011b). The recent joint-inspectorate report on police custody suites in Northumbria found that although there was strong provision for drugs there were gaps in service provision for alcohol.

Durham

In Durham the 'Total Healthcare Partnership' has been established with County Durham and Darlington NHS Foundation Trust, an acute Trust who provide the healthcare within police custody suites in the Durham police force area. They cover physical needs, forensic needs, occupational needs within the force area and they have a role in assisting the police force to identify better mental health pathways for detainees.

There is a nurse on duty at all time and an FME, both of whom cover all four custody suites within the police force area. The nurse travels between these suites as required.

Although Durham is not an early adopter site for the transfer of commissioning responsibilities of healthcare in police custody to the NHS, it has been confirmed that Durham will fall into the second wave of sites.

Arrest referral services are provided by Addaction in the North and the North East Council of Addictions (NECA) in the South.

Cleveland

Cleveland police force area has commissioned healthcare services from the independent sector provider, Reliance Medical Services, with the contract due to run until 2017. For the Middlesbrough custody suite the model of provision includes permanent (24/7) cover by forensic nurse practitioners, all of whom are Band 6 Registered General Nurses (RGNs) usually with a background in A&E. Forensic Medical Examiners (FME) are on-call through the central call centre (the Medical Response Centre). The nurse based in the custody suite will undertake an initial assessment to determine whether or not a doctor is required. The other custody suites also have access to on-call medical cover through the Medical Response Centre which will then determine whether it is more appropriate for a nurse or a doctor to see that individual.

Drug and alcohol arrest referral services are commissioned through the DAAT and are provided by Addaction. There is currently 24/7 provision, however this is under review and it is anticipated that the twenty-four hour cover is unlikely to continue although it is hoped that a seven-day service will remain. In 2008, Cleveland was a pilot area for alcohol arrest referral that included alcohol-specific workers as part of a Home Office pilot. Following a one-year pilot, the service is now an integrated service for drugs and alcohol, although alcohol intervention is voluntary whereas drug intervention is mandatory for trigger offences.

4.2c Appropriate adult provision

In Northumbria and Durham there are no dedicated services to provide appropriate adults for vulnerable adults held in police custody. This is instead provided through the Emergency Duty Team and Social Services (while the Youth Offending Team provided the service for juveniles during office hours).

Middlesbrough and Stockton Mind provide an appropriate adult service for vulnerable adults being detained at Middlesbrough police station (as well as the smaller stations in the Tees area), funded by the Esmeé Fairbairn Foundation. The Mind service runs from 9am – 5pm and is currently staffed by volunteers. It was reported that out of hours they would ring the Emergency Duty Team in Social Services, however it was suggested that lack of capacity within this team meant that Mind often had to pick up out of hours work as well.

A bid to the Department of Health has been successful, providing development money to expand this appropriate adult service to provide support and navigation into services as well as support during detention and interview, as well as subsequently at court.

4.3 Key issues for the North East

4.3a Improving identification without slowing down police process

Interviews with regional stakeholders and a review of inspection reports revealed concerns regarding the current systems for identification of mental health problems and learning disabilities in police custody. The presence of mental health practitioners in police custody was extremely limited across the region (see Chapter 5) and heavy reliance was placed on police risk assessment procedures to identify mental health problems and learning disabilities among detainees.

Senior police officers and mental health leads from all forces expressed concerns that they were not picking up those who had support needs but were not displaying very clear signs of serious mental distress:

"If he or she doesn't cause other people grief then he just won't be flagged."

"[Custody staff] can recognise the obvious things but often miss learning disability and mental health issues under the surface."

"The concern for me is those people who do have an underlying mental illness that doesn't manifest itself in a recognisable way, unless you start probing deeper and pushing the right buttons, and we will come across a great number of people like that, especially if they have learning disabilities, because that can be masked."

The analysis suggests that identification may be hampered by inadequacies in the tool itself. For example, recent research on the NSPIS tool (as used by Durham) with the Metropolitan police had highlighted concerns about the tool's sensitivity to risk of suicide or alcohol withdrawal.[9]

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[9] Of 226 who completed the Beck's Suicide Scale, 11% had current suicidal ideation and 19% had previously attempted suicide. However, only ½ of the former group had been identified by the police and only 1/3 of the latter group. Of 230 who completed the alcohol assessment, 42 were considered to meet the criteria for being at risk of alcohol withdrawal (set by researchers at 14 units or more in the last 48 hours and a score of 2 or more on the CAGE test) but only 20 of these had alcohol mentioned anywhere at all on their completed risk assessment.

Additionally, identification could be hampered by problems with the way that the tool is applied and information recorded. Recent inspectorate reports from Northumbria and Cleveland identified a range of issues including risk assessments being completed inconsistently; the police national computer (PNC) may not always be being checked for warning markers or indeed have warning markers added where required; risk assessments were being rushed and concern was expressed about the quality of assessments and recording (HMIP and HMIC, 2011a; HMIP and HMIC, 2011b).

Risk-assessment tools relied on offenders to self-report but interviewees highlighted that some people might be unwilling to identify vulnerabilities to the police.

> *"People often hide their vulnerability deliberately or otherwise, and certainly people with borderline learning difficulties are quite, can be quite skilled at giving the right answers because they've spent a lifetime trying to hide the fact that they can't quite cope. And I think that you see that in police forces, you know, in police custody suites a lot."*

> *"There's trust issues [with both] males and females, but I think certainly with women they are afraid to disclose because of what the consequences will be. For example, if they've got children, social services, just the repercussions [of disclosure]. I think when a woman is arrested for example, they are so quick to get out of custody they won't disclose that they've got a mental health problem or any kind of health problem for that matter and they will agree to anything to get out. Usually often they are not even interviewed with a solicitor because they don't want to hold the process up any longer."*

In some custody suites, physical conditions in booking-in areas where risk assessments are undertaken such as areas offering very limited privacy may also reduce the willingness of detainees to self-report issues such as self-harm and mental health problems. Police custody site visits were not undertaken as part of this analysis however inspection reports highlight cramped conditions at Sunderland and Clifford Street in Northumbria Police Force Area (HMIP and HMIC, 2011b) and Durham and Bishop Auckland in the Durham Police Force Area (HMIP and HMIC, 2008), although the latter report relates to a visit from 2008 and may be out-of-date.

It was suggested that improvements could be made to existing risk assessment tools used by the police to increase those who screened positive for mental health problems and learning disabilities (as well as other health-related conditions), however many interviewees emphasised that the police's purpose in identifying mental health problems and learning disabilities is to ensure that arrestees are held safely in custody and that their rights are maintained. The police's primary focus is not, and is unlikely to ever be, identifying support needs in order to facilitate access into treatment.

Interviewees also highlighted reluctance by the police to make to make adaptations to their screening processes that would lengthen current processes. As well as concerns about slowing down the process in busy custody suites, one police interviewee emphasised that it was important that the risk assessment does not go into too great a depth as this risks custody officers reading directly from the card without using their observational skills and training. A team from Newcastle University have created a revised screening tool with the Metropolitan Police and discussions are currently underway with Northumbria Police Force regarding a local pilot of this tool. However, concerns have been expressed by the police about time implications; it was reported that such concerns had already resulted in a refusal to pilot this tool in Cleveland.

In addition, mirroring findings in the literature and from national experts, particular difficulties were reported in identifying learning disabilities and other conditions such as autism and ADHD. Poor

understanding and awareness of learning disabilities and other conditions such as autism was identified as one barrier to identification:

"I think that there is a very sort of broad issue around understanding the issues of learning disability, and I think, police officers understand them a bit more about mental health, but they don't understand the nuances around learning disability. And I think there is [a] problem around particularly the conflation of learning disability and learning difficulties that lots of people get stuck on."

One stakeholder also highlighted that the large prevalence of poor literacy and low education levels among offenders masked the presence of genuine learning disabilities as these failed to stand-out as they perhaps might among the general population.

A number of interviewees highlighted that *"one of the problems is there hasn't ever been a reliable screening instrument for learning disabilities"*. The organisation, Mencap, has been monitoring the trials of the Learning Disability Screening Questionnaire (LDSQ) in police custody. It was reported that while some people found this tool useful, others were again concerned about the length of time it takes to administer. A pilot in West Yorkshire had used trained cell workers to administer the tool instead of custody staff but mainstreaming such a project was acknowledged to require considerable resources and cost benefits had yet to be analysed.

However, it was highlighted that learning disability was just one concern and that there were a range of relevant conditions to be considered. Expert interviewees highlighted that there was frequently an over-reliance on screening tools to identify problems and that these tools provided no substitute for having trained professionals with a range of expertise present in police custody;

"There's a range of issues I think are relevant, it's head injuries, autistic spectrum. It's difficult to have a quick and dirty screening for things, so you need people with expertise. I think we're often fooled that you can do things through a tool – a tool being seen as a magic thing. What you need is knowledgeable people who might spot stuff. You know you can't spend an hour screening someone."

Limited CJLD coverage and a lack of learning disability input into these teams is therefore a particular concern (see Chapter Five).

Finally, although outside the remit of the BDP, concern was also expressed that there was absolutely no processes for identifying mental health problems and learning disabilities among victims and witnesses. This was felt by one police interviewee and future work in this area should be considered.

4.3b Ensuring adequate and timely provision of appropriate adults

All three police forces appeared to experience problems obtaining an appropriate adult within acceptable timescales. Recent inspectorate reports on custody provision in both Cleveland (HMIP and HMIC, 2011a) and Northumbria (HMIP & HMIC, 2011b) identify significant delays, difficulties with out-of-hours provision and refusals by the Emergency Duty Team to attend. The 2009 inspectorate report on custody provision in the Durham force area also suggested that out-of-hours provision of appropriate adults needed to be improved and yet it is not clear whether this has happened. Concerns regarding increasing demands on stretched Emergency Duty Teams have been reported.

Only Middlesbrough police custody suite has a dedicated appropriate adult service for mentally vulnerable adults. The 2009 Inspectorate report found that "custody staff [in Durham custody suite] raised no concerns about these [current] arrangements, and in the custody records we reviewed the

appropriate adult scheme was rarely needed, as in most cases parents or carers attended" (HMIP and HMIC, 2008, p.45). However, one national expert drew attention to research that suggests that areas without a dedicated appropriate adult service are particularly prone to under-identifying vulnerability:

"I think there are a number of reasons for that and one is that, consciously and unconsciously, if the police know they are not going to get an appropriate adult and that person is going to be in custody for lots of hours unnecessarily and they'll have the hassle of trying to get somebody and not being able to, the pressure not to pick up on signs, signals, hints that somebody is vulnerable is really quite strong. And I absolutely understand why the police do that…I think it's not even necessarily conscious from the police point of view."

This expert also expressed considerable concern at the proposals to allow the responsibility for identifying vulnerability, which currently sits with the custody officer, to be delegated to other staff in custody. It was felt that this would lead to further under-identification.

A number of service users who attended our focus groups reported being interviewed by police without an appropriate adult, despite having mental health needs. In one case, the service user reported that the offence in question was criminal damage to their psychiatrist's office so police were clearly aware of the presence of mental health needs. There was also concern that the time taken for an appropriate adult to arrive might discourage clients from highlighting their vulnerability.

Some experts also emphasised that the threshold for accessing an appropriate adult should always be lower than the threshold for accessing liaison and diversion services due to the low threshold set out in the PACE legislation. The concern was expressed that CJLD services or FMEs might act as gatekeepers to such support using their own higher thresholds for access to services.

In addition to concerns for vulnerable adults, both Northumberland and Cleveland police forces treat 17-year-olds as adults as they are currently defined under PACE legislation. This raises concerns that they may not be receiving adequate support. In particular, stakeholders highlighted that for those 17-year-olds who have either a mental health problem or learning disability may not be receiving any support; need may not be identified as they are unlikely to be seen by the CJLD service and even where need is identified there may be confusion about who provides the appropriate adult service for this group.

However, national experts highlighted that the provision of an appropriate adult in isolation was often inadequate in ensuring that justice was served when working with vulnerable adults:

"I think there needs to be much better understanding, particularly around interviewing. But it's not just about appropriate adults, but the appropriate approach. Understanding how the condition might affect how people behave during interview. People with a learning disability may be eager to please, keen to admit to things that they've actually not done. Often the fall guys for other things that are going on."

When the need for an appropriate adult is identified, consideration needs to be given to the defendant's ability to go through the criminal justice system with or without support and what other support that might include.

4.3c Better utilising existing resources within police custody suites

Interviewees highlighted a number of ways in which resource already available for healthcare provision in custody might be better used. In Northumbria, consideration was being given to how

better value for money could be achieved by utilising nurses to undertake some of the tasks currently performed by FMEs. This move towards a nurse-led model has already happened in both Durham and Cleveland, as well as other areas of the country and was perceived to be a success in areas where it had been introduced:

> *"Because the police forces Forensic Medical Examiner is not a cheap resource. But to be honest, these guys are in and out. They come along, take a blood, and are out again and they will just put in their fee for attendance. Whereas [with a nursing model] it was much more about having a physical presence and being with people over a period of time. Now some of that physical stuff still needs to happen, like takings of blood etcetera. But for a lot of it, in particular what we're thinking of – psychiatric and mental disability problems – just a quick in/out is not really going to be helpful to people."*

Although interviewees from Cleveland and Durham did highlight problems in lengthy waiting times for an FME where one was required as well as some confusion among officers about what roles nurse practitioners could perform.

National experts and regional stakeholders also repeatedly highlighted the potential to better utilise existing 'untapped' resources in custody suites to maximise those who are screened for mental health problems and learning disabilities as well as a much wider range of needs.

> *"There's sort of reservations that we've already got a lot of people going into police custody. So we've custody nurses provided by a range of different independent providers. We've got arrest referral workers going in there. I think we need to look at how we sort of bring those together so that we don't end up in having somebody sitting there with having about four or five assessments from different individuals. So I think we need to look at some sort of generic tool really. That's never going to be a good enough assessment tool, so it's going to throw up some false positives and it's going to ignore people as well, so you know, this is about the sort of filtering approach."*

In the North East there are a range of healthcare providers and regional coverage of drug and alcohol arrest referral workers provided by Turning Point, the North East Council of Addictions (NECA) and Addaction. As a large centralised custody suite, Middlesbrough is particularly well-resourced with 24/7 provision of both arrest referral workers and forensic nurse practitioners (supplied by Reliance).

In addition, the successful funding bid to the Department of Health for an enhanced appropriate adult service provided by employees from the local Mind will also be based in Middlesbrough custody suite with the aim of providing support and signposting to vulnerable adults in custody. This service will focus on 'sub threshold' mental health problems (at a mild to moderate level) who are not the primary focus of existing CJLD provision.

These professionals have a range of different backgrounds and skill-levels. Forensic Medical Examiners and forensic nurse practitioners within police custody suites respond to a wide range of healthcare needs and they require a correspondingly broad range of knowledge and expertise. Many of the services that they are expected to provide fall well outside of the remit of the BDP. They have a range of backgrounds and it would be unfair and unrealistic to expect all of these staff to be experts in mental health, although given the relatively high prevalence of mental health issues among those passing through police custody some training in mental health is likely to be advantageous. FMEs have all had some mental health training but not all are 'section 12 approved', i.e. approved under section 12 of the Mental Health Act. This is certainly the case for Northumbria and Cleveland (HMIP and HMIC, 2011a; HMIP and HMIC, 2011b).

Reliance reported that three of their FMEs are section 12 approved out of 3.25 full-time equivalent workers in the area. Nursing staff employed by Reliance usually have a background in A&E. It was reported that part of the training for custody work involves an overview on mental health. There is also one mental health nurse who is a bank staff member and is otherwise employed in a local crisis team who has recently provided some training for other nurses.

It was also reported that arrest referral workers provided by Addaction all have an NVQ Level 3 in Mental Health and have had training around suicide. It was reported that they do feel competent in working with mental health needs. This was not the case around learning disabilities where competence was felt to be significantly lower.

In terms of current screening for mental health needs or learning disabilities, forensic nurse practitioners utilise a checklist which assists them in identifying concerns for an individual's well-being. Arrest referral workers ask a range of questions as part of the Drug or Alcohol Intervention Record including one question on any mental health needs. Interviewees highlighted the need for a generic screening tool that could be undertaken by a range of practitioners that could then lead to the referral to the appropriate support service for a fuller assessment. This was the approach being adopted in a number of other areas across the country where services were contemplating how to reach more people in a time of diminishing resources. Interviewees from established and well-regarded CJLD services in Sussex and the South-West described the direction of travel locally:

> *"Because if you're setting up a [CJLD] scheme now without setup money, you need to decide where to put your resources. You need to – looking at what we're going to be doing in police stations, we're going to be working with the DIP teams – the CJIT teams – and the current custody healthcare providers to look at training to do mental health screening. The general basic screening. And then providing a mental health practitioner to go and do a full assessment where it's needed, if it's identified when it's needed. That will only be Monday to Friday, 9 to 5, so it needs to be, what you need is to use the resources that are already in the police station immediately."*

> *"What we've got is all those people coming around the table to sit and talk together…For example, we're looking at the DIP testing and CRI teams that we've got in Sussex, and seeing how we can integrate those services into the liaison and diversion services so that in the long run we save money overall, and we haven't got two or three different assessment services running. What we've got are the right people starting to come around the table, because in the long-term that's where we've got to be heading."*

It was clear from discussions with representatives from the Department of Health that such a model clearly reflects the direction of travel of national policy. Work currently underway to move the commissioning of healthcare services in police custody from the police to the NHS and the development of the business case for a roll-out of liaison and diversion services are seen as the first steps towards the ultimate goal of a regional commissioning body as a single point of commissioning for the full range of health services in police custody (including substance misuse). This was largely seen as a positive development although concerns were raised by experts regarding a delocalisation of commissioning for these groups that favours larger independent providers rather than local services. There was also concern that removing responsibility for these groups from community commissioning groups would remove expertise and interest in the needs of these groups and potentially allow the abdication of responsibility when they exited the justice system (or were subject to a community sanction).

4.3d Identifying clear care pathways and a single point of contact

Police officers in both Northumbria and Durham forces emphasised that pathways into care were confusing for police and that there needed to be a clearer structure for referral and assistance:

> *"[Staff] need better knowledge of services for referral – joined into pathway arrangement so it is all knitted together – not just disposing of them!"*

> *"A central point of contact is needed – someone to vet where we should send people."*

Similarly, the need for a single point of contact with mental health services was a clear and consistent theme among frontline police officers that emerged in the event held by the Safer Durham Partnership to consider offender pathways issues.

In the Durham local authority area at least, a single point of contact for clients with a learning disability had been established at the local authority. The adult vulnerability unit and adult social care within the local authority worked closely together and police officers were able to fill in a vulnerable adult referral form and send this to the adult protection unit who would pass this on to adult social care. It was described as a *"fantastic relationship"* by representatives from the force who felt that this was a much stronger and more effective working relationship than the force currently had with health services.

It was emphasised by interviewees that simply providing a service directory or advertising for services through leaflets and posters in police custody was not an adequate response to the problem of confusing care pathways. The view was expressed that this approach was not a structured process and was largely ineffective. There were concerns that police did not know which services were evidenced as effective. It was emphasised that stronger links and integrated working were important components in overcoming this barrier to providing support for these groups.

Unclear care pathways for mental health were not identified as a significant issue by interviewees within the Cleveland police force area. This may be due to the establishment of Mental Health Liaison Officers within Cleveland police force; these are operational officers who are attached to every basic command unit / unitary authority area who have developed strong links with local services:

> *"The Mental Health Liaison Officers link in with all sorts of partner agencies. They've got the local implementation teams and things like that that they sit in with and you've got representatives from third sector, from social care, housing, benefits, so all of the partners are represented at the local level."*

One interviewee from Cleveland suggested that no referral would be made for a client with a learning disability, despite there being a comprehensive forensic community learning disability service provided by TEWV. However, a senior representative from TEWV's Forensic Learning Disabilities expressed concern at the low level of referrals from police custody to their community services given the importance of preventative work to avoid escalating risk. It was suggested that more could and should be done to promote their service to the police and to strengthen care pathways.

It was also highlighted by a police interviewee in Cleveland that there was no clear pathway for those offenders diagnosed as having a personality disorder who posed a significant problem for the police. This may be a result of only limited provision for those with a personality disorder locally, and will need to be explored further.

Across the region, care pathways appeared to be significantly clearer for support with drug issues due to the provision of arrest referral services to all police custody suites. However, the recent Inspectorate report on police custody in Northumbria suggested that there were gaps in provision in custody for alcohol use.

4.6e Ensuring officers receive regularly repeated, high quality training

A consistent theme in the interviews with national experts was the need for high quality and regularly repeated training. It was reported that some training had been provided across all the police forces although again we were not made aware of any dedicated training around learning disabilities.

In the Northumbria police force area, the Inspectorate reported that custody staff training was adequate; "The NPIA 'NCALT' mental health awareness e-learning materials were available to staff online. Custody staff at Gateshead had received a more intensive update in the last eight months provided by the CPN and a custody sergeant with a special interest. As part of the Bradley response plan, a force-wide review of mental health awareness training was under way" (HMIP and HMIC, 2011b, p.29). Durham Constabulary had undertaken some work with their local Mind and other similar services around recognising mental health problems and referral pathways. They had also requested further training to be provided by TEWV through the 'Total Healthcare' Partnership in place in the area but this has been delayed as Cleveland has been prioritised.

The 2011 Inspectorate Report of custody provision in Cleveland (HMIP and HMIC, 2011a) reported that custody staff had not undertaken recent mental health awareness training, although interviewees from the force reported that training of officers had been provided. However concern was expressed that this training is driven by the legislative framework and not the practicalities of how to deal with and engage with someone with mental health problems or a learning disability, which is what interviewees felt that officers fundamentally need.

Even where training has been provided to police officers in custody suites there were concerns that this training had not been systematic but rather was provided on a one-off basis and not refreshed. Consequently, staff turnover means that only a small proportion of frontline police officers are being reached. As with the national experts who advocated for training to be supported by the development of strong links into services and changes to working practice, an interviewee from Durham Constabulary emphasised that *"this is more about integrated working practice than training"*.

One police interviewee highlighted that an emphasis on a national training programme and significant other training demands reduced the opportunity for training to be provided locally:

> *"All police training is done through a national programme, which I think is to the detriment of what we do. Because when local training is on offer, we should grab it. Especially if we could have mental health professionals or service users coming in and talking about their experiences in a one-to-one, and we seem to have lost our way with that."*

Local training was recognised to be crucial by a range of interviewees with national experts placing a particular emphasis on joint training with local health agencies to develop greater awareness of service provision, greater understanding of roles and responsibilities and to develop informal relationships. The development of personal links into local services was an important tool in clarifying and unblocking care pathways for offenders with mental health problems or a learning disability:

"I think inter-agency training is crucial really. And it's not just about – Bradley talked about everybody in criminal justice having mental health awareness training, but actually people in mental health need criminal justice awareness training too. It's a two-way street. And the more of them you get in the room together to talk to each other, the better that will work…we're doing some work on that about getting people in the room, giving them a case study, right what would you do? Do you understand why they have to do that?"

The need for inter-agency training and the mutual benefit that it can provide was a reoccurring theme across the criminal justice pathway and not simply limited to the police and health. Nevertheless, the strong demand for clear referral pathways by the police suggests that the provision of this training will be important.

As well as inter-agency training, interviewees and service users also suggested the need for training by service users who wanted to increase understanding of mental health issues and learning disabilities among the police in order to reduce stigma and negative attitudes. Although some service users who attended our focus groups reported positive experiences with the police who were described as both "sensitive" and "kind" by two interviewees following police response to a mental health crisis, many of the service users reported negative interactions with the police and very poor experiences in police custody. The researcher who led the service user groups reported a strong feeling that many of those with mental health problems felt violated by the police.

"The police were disgusting…when they picked me up, they were saying "oh look at her, she's puked up in the flat she's absolutely disgusting""

"They (the Police) just treat you like you just a bit of s**t off their shoe"

One national expert reported on arrangements in Bristol for student police officers in their probationary period to spend time on a ward in a mental health unit. This enabled young police officers to speak to staff and service users in order to develop relationships and break down stigma towards people with mental health problems. The interviewee described how:

"One of them wrote back to the managers of the hospital thanking them for allowing them to be there and said I'm not going to pretend that I learnt loads and I'm now an expert but one of the things I will say is that it has changed my perception of people with mental health problems and I hope I treat them better and don't see them negatively."

The organisation Your Voice Counts that advocates for people with learning disabilities in Gateshead and South Tyneside reported recent training that they had provided to the police (along with their users) around Hate Crime. They strongly felt that more of this training was needed to increase understanding and felt a similar model could be used to raise awareness around the needs of offenders with learning disabilities.

5
Criminal Justice Liaison and Diversion Services

> **Key Issues:**
>
> - **Re-focusing the services towards the front-end**
> - **Improving information sharing with courts and other agencies**
> - **Low involvement in diversion into alternative disposals**
> - **Maximising coverage**
> - **Improving relationships with other health and criminal justice services**
> - **Developing care pathways into the voluntary sector to meet a wider range of needs**
> - **Overcoming information technology barriers**
> - **Monitoring activity and outcomes**
> - **Improving the service for those with a learning disability**

5.1 National Picture

Despite the recently renewed policy emphasis on liaison and diversion services, the concept is over twenty years old. In 1990 court liaison and diversion was promoted by Home Office (1990 as cited in Bradley, 2009, p9). This was soon supported by the Reed Report (1992 as cited in Bradley, 2009, p.9), which called for nationwide provision of court assessment and diversion services.

Liaison and diversion services were set up in a number of areas following this; however a lack of any centralised strategy or guidance meant provision was patchy and inconsistent. The Bradley report, drawing on NACRO research, suggested that there were around 143 schemes in England and Wales (Bradley, 2009, p.81). Dr Wendy Dyer reported that as, at the time of writing, there were 335 magistrates' courts in England alone, this means that only around a third of courts currently have access to Criminal Justice Liaison and Diversion (CJLD) teams (Dyer, 2011, p.5).

These schemes vary hugely in their set-up, the role they perform, and their efficiency. Bradley identified four broad models in existence (Bradley, 2009, p.82):

- **Diversion schemes** – work to increase the identification of mental illness and facilitate and accelerate transfer to hospital where appropriate
- **Assessment schemes** – have more of a focus on identifying and assessing people appearing before the courts, in order to assist magistrates with disposal options
- **Liaison schemes** – have a wider role – rather than diverting people out of the criminal justice system into the health service, they offer support and liaison both to people with

mental health problems and to the agencies involved with them, so as to ensure they are treated appropriately

- **Panel schemes** – mentally disordered offender (MDO) panels formally bring together a range of agencies – police, health, social care, probation – to put forward a co-ordinated package of care for the courts or Crown Prosecution Service (CPS) to consider. They also co-opt other agencies and organisations, such a third sector organisation, housing services and drug services.

One aspect of existing diversion services is that they are more often than not focused at the court stage. A key innovation of the Bradley report was to suggest a role of liaison and diversion services earlier in the criminal justice system; operating at the police stage to identify offender's mental health problems and learning disability earlier (Bradley, 2009, p.53).

Bradley (2009) saw CJLD teams, or 'Criminal Justice Mental Health Teams' as he called them, playing a vital role in ensuring more joined up health and social care support for offenders throughout the criminal justice pathway. This included contributing to the assessment and identification of problems at the arrest and police custody stage, then ensuring continuity of care throughout the criminal justice pathway and ensuring effective joint-working and information sharing. They would also provide a vital contact for criminal justice staff with mental health queries, and offer multi-agency training opportunities (Bradley, 2009, p.140).

This vision for liaison and diversion has been hugely influential in the current policy context. It has seen liaison and diversion services move to centre stage in offender health policy, and form part of the current government's 'rehabilitation revolution', outlined in the *Breaking the Cycle* green paper. It is now government policy to pilot and roll-out liaison and diversion services nationally by 2014 (Ministry of Justice, 2010, p.36).

As part of this, a national, point of arrest pathfinder scheme has been launched to develop evidence of good practice, inform national guidance and develop a business case for the continued roll-out of liaison and diversion in England and Wales. Continued support for this approach was confirmed with the announcement by health minister Paul Burstow that the initial £5 million of funding released for 2011-2012 is to be followed by a further £19.4 million for 2012-2013 (Hansard HC Deb 12 January 2012 C22WS).

Despite this support, it is still unclear the precise form that liaison and diversion schemes would take. The national pathfinder scheme, as well as the Big Diversion project in the North East, aims to develop evidence of good practice and service specifications for services going forward, to contribute to the ongoing development of these services. Previous research into existing services has also suggested a number of characteristics which contribute to good practice:

- There is an emphasis on the need for strong governance arrangement, including a multi-agency steering group and a secure budget (Dyer, 2011, p.3; Winston & Pakes 2010a, p.23 as cited in Dyer, 2011, p.44)
- CJLD teams worked better as a separate team, with a minimum of three practitioners competent in a criminal justice environment (Dyer, 2011, p.3). Larger teams tend to work more effectively than smaller teams (Bradley, 2009, p.85)
- Protocols should be in place for the monitoring and evaluation of outcomes, as well as systems for recording interventions and activities (Dyer, 2011, p.3)
- Teams should engage in extensive liaison across the offender pathway with statutory services and non-statutory/third sector service providers (Dyer, 2011, p.3)

Services must also work to overcome many of the barriers identified as facing existing services in achieving successful outcomes. Barriers raised have included:

- Restricted service provision. 16% of the schemes reviewed in the Bradley report operated three days a week or less, with no out of hours cover (Bradley, 2009, p.81)
- Problems with information exchange (Bradley, 2009, p.85)
- Problems with referral pathways, due to poor multi-agency links (Winstone & Pakes, 2010, p.8 as cited in Dyer, 2011, p7)
- A lack of proactive screening (Winstone & Pakes, 2010, p.8 as cited in Dyer, 2011, p.7).

A recent Offender Health Research Network report, commissioned by the Department of Health as part of the national work into liaison and diversion, identified a range of 'core tasks' undertaken by these services.

These included accepting referrals from other health and criminal justice staff, searching Trusts' electronic databases for information, initial assessment; onward referral to community mental health, social care and/or substance abuse agencies, information sharing with GPs and providing information to court staff in terms of any treatment recommendations formulated following assessment. In addition a minority conducted initial face to face screening of all detainees; short or medium term follow up of clients after the 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 (OHRN, 2011).

The report found that while liaison and diversion services provide an important service for clients that are often poorly served by mainstream health and social services, there are important considerations that need to be given in order to improve this service. In particular there is a need for:

- a standardisation of approach
- a national model of practice
- improved data collection
- more consideration to the conduct of ongoing evaluations into service impact and outcomes.

They also highlighted the lack of a robust evidence base to support the belief that they improve the health, social and criminal outcomes of people who are in contact with them.

5.2 Regional Provision and Practice

There are currently six Criminal Justice Liaison and Diversion (CJLD) services operating in the North East region, with five smaller services in the north of the region provided by Northumbria, Tyne and Wear NHS Foundation Trust (NTW) and one larger newly-combined service in the south of the region provided by Tees, Esk and Wear Valley Foundation Trust (TEWV).

The NTW services are managed by the Clinical Community Manager of Forensic Services and overseen by a Band 7 Forensic Community Psychiatric Nurse from the Forensic Community Mental Health Team.

The TEWV services are currently managed by the Service Manager for Offender Health and the Joint Lead for Offender Health (and overseen by two Band 7 Community Psychiatric Nurses who act in a 'clinical coordination' role). Many of the services have undergone recent changes to their management structure having previously been located within adult mental health services, with the Gateshead and South Tyneside service moving to forensic services as recently as October 2011.

The services all operate on a slightly different model and details about staffing and coverage of each of the services can be found in figure 5.1. All the CJLD services considered here are for those aged 18 and over only, although the Cleveland area also has a youth diversion service that is also a Department of Health Pathfinder project.

There are also advanced plans in place to pilot a model of liaison and diversion provision at Newcastle Crown Court through the secondment of a psychiatrist to the court one day a week.

5.2a Identifying clients

All of the services receive referrals from custody staff working at the police stations and courts covered by their service. These include police officers, probation staff working in courts and detention and healthcare staff provided by private sector providers, notably Reliance (police custody in Cleveland) and GEOamey (custody area of courts). Referrals from other practitioners working in courts or community-based case workers concerned about clients in custody will also be accepted but are far less frequent sources of referrals. Custody staff raise concerns based on their own screening and risk assessment procedures (see police custody section for more details), markers on the Police National Computer (PNC), notes regarding behavioural or mental health issues or risk concerns on the Prisoner Escort Record (PER) and observation of the detainee.

In addition, some of the services adopt a more proactive approach to screening. The Bedlington CJLD service currently receives a list each morning of all those being held in police custody at the Bedlington station which also includes any PNC markers on the arrestee. Similarly, the Gateshead service also has access to the names of all those held in police custody at Gateshead. South Tyneside has requested that a daily list is also provided but as yet this is not in place. This list of names is then checked against Trust records held on their RIO system (to which the worker has access at the station) and then a clinical judgement that takes into account police and custody staff concerns is made as to whether or not a client needs to be seen.

Newcastle, North Tyneside, South Tyneside and Gateshead all undertake a similar proactive screening of court lists from the courts that they respectively serve. However, due to current reductions in staff capacity at the Gateshead service there is not always an opportunity to do this, while Newcastle and North Tyneside focus on those who are being held in custody in the cells.

The newly-combined Cleveland, Durham and Darlington service has recently instigated a duty phone system whereby the two Band 7 nurses serve as coordinators (while still undertaking clinical work). They ring all the police custody suites every weekday morning to request referrals and additionally they receive referrals by phone from police custody suites and courts throughout the day. Referrals are then checked against the Trust database (PARIS) and the other team members are allocated to attend the police stations and courts where they are required (with those clients in police custody prioritised). On some limited occasions, the coordinators were able to undertake proactive screening of those held in police custody suites and a desire was expressed by those interviewed to place a greater focus on this proactive approach.

In addition, the South Tyneside, Gateshead and Cleveland, Durham and Darlington services all receive referrals from probation staff (other than those based in courts). For the probation-based South Tyneside service these referrals make up a significant proportion of the total referrals to and activity of the service. On the other hand, the Cleveland, Durham and Darlington service is currently attempting to realign the way in which the service offered to probation.

5.2b Service activity

The services differ in the range of activities that they undertake (see figure 5.2 for details) however in all services, activity is focused around assessing needs and signposting or referring to community-agencies. Mental health needs were frequently assessed in full where time permitted this with limited assessment of social care needs and limited consideration of indicators of learning disability and other problems such as autism, attention deficit hyperactivity disorder (ADHD) and acquired brain injury (ABI).

For the most part, direct referrals (often electronic) are made for other Trust services such as community treatment teams or learning disability services, while signposting was often used to direct clients to non-Trust services including those in the voluntary sector. Liaison with a wide range of community agencies is also undertaken but there is a particular focus on ensuring that existing care coordinators within the Trust are provided with information about their client's current situation.

A primary focus of the work in all the custody-based services relates to the immediate assessment of risk and ensuring that where risk is identified appropriate action is taken, such as informing custody stuff and prison healthcare departments or mental health " in-reach" teams where the client is remanded, and generating a Mental Health Act Assessment where considered necessary.

None of the services provide active case management, however both the South Tyneside and Gateshead workers offered follow-up appointments to some clients (the North Tyneside worker reported that this had happened on very rare occasions). The South Tyneside worker explained that he might temporarily 'hold' clients until they were accepted by other services but only within strict boundaries and time scales. Both of these services appeared to play a slightly greater role in addressing social care needs for the clients that they saw on a longer-term basis.

The Gateshead, South Tyneside and Cleveland, Durham and Darlington practitioners interviewed also reported attendance at meetings of multi-agency initiatives such as Multi-Agency Public Protection Arrangements (MAPPA), Multi-Agency Risk Assessment Conference (MARAC) and Integrated Offender Management (IOM). They frequently attended on request to give information about clients, although the Cleveland, Durham and Darlington service's involvement with MAPPA had decreased since the Trust's appointment of a single point of contact for MAPPA. Information on clients was fed back to the single point of contact, but practitioners still attended where considered necessary. Up until recently, the South Tyneside worker had chaired the liaison meeting between local mental health services and the police, however since meetings frequently focused around 'housekeeping' issues regarding the local inpatient unit, he had withdrawn from this role.

In addition, the Gateshead and South Tyneside workers also reported rare occasions where they had been involved in facilitating access to beds for someone who was going to receive a hospital disposal from the Court (under section 37 of the MHA). Both of these CJLD services had previously been managed by the crisis team and their involvement in these activities appeared to be related to this link (since the crisis team determine access to inpatient beds).

5.2c Areas of the region not currently receiving a service

There is currently no CJLD service at all operating in the Sunderland area either in the police custody suites (Gillbridge, Washington and Southwick) or in Sunderland Magistrates' Court. A business case has been successfully submitted to the Department of Health for funding to set up a service in Sunderland and to develop the service in Bedlington (which until now has not had any dedicated funding). Rural areas of Northumberland are also not covered.

Additionally, the Newcastle and North Tyneside services only provide a service to Newcastle Magistrates' Court and North Tyneside Magistrates' Court respectively so that none of the custody suites within those areas receive a service. It appears that none of the three Crown Courts in the region (Newcastle, Durham and Teesside) are provided with a direct service.

For details about those areas which are not covered by CJLD services in the North East Region, please see figure 5.1.

5.3 Key issues for the North East

5.3a Re-focusing the services towards the front-end

There was a general consensus among practitioners, interviewees with a strategic overview and national experts, that the work undertaken by CJLD services should be (re-)focused towards the 'sharp' or front end of the criminal justice system. One national interviewee recounted a quote from a forensic psychiatrist.

> *"You either head them off at the pass, or you head them off at the plains, and the pass is easier because the pass is the magistrates' court and the plains is the wider criminal justice field."*

Many of those interviewed expressed the concern that without such a focus on the front-end of the justice system, that many people were being missed altogether or failing to have their needs identified until key decisions regarding their case had already been made. Particular concerns were raised about failing to identify need in those who were quiet and compliant in police custody or those who appeared at court on bail or on summons.

Although all interviewees agreed that catching people earlier in the justice system was important, there was some disagreement between stakeholders as to whether the court or the police station should be prioritised. The former offered an opportunity to catch the most people at the earliest stage, but the latter perhaps offering the greatest opportunity to impact on the legal decision-making process.

Currently neither the Newcastle nor the North Tyneside service undertake any work in police custody suites at all and consequently GEOamey custody staff in both Magistrates' Courts expressed concern that people were arriving into the custody area at court with significant mental health problems unaddressed. The GEOamey custody manager at North Tyneside Magistrates' Court said that she was aware of three people who had been detained under the Mental Health Act by mental health services directly from the custody cells at the court in the past year.

These concerns were supported by a practitioner from these services who highlighted a recent case of a man on a serious charge who was significantly mentally disturbed but whose vulnerability had not been identified and who, as a consequence, had not been provided with an appropriate adult during police questioning. It was emphasised that this was not just important in terms of ensuring

that the person's rights were maintained and that they had access to appropriate support, but that it was also to ensure that the criminal case is not undermined as correct procedure has not been followed.

Although a service is provided to the South Tyneside police custody suite, the focus of the South Tyneside CJLD had traditionally been probation clients and so the service provided to the custody suite was only minimal. The practitioner there felt that being based in the wrong area was one of the two most significant barriers to his helping offenders with mental health problems and learning disability access appropriate support.

Many interviewees felt that a more comprehensive service should be provided to both police stations and courts at the expense of a reduced service being provided to probation. However, one stakeholder highlighted that the Big Diversion Project should not be about a reduction to existing services and stakeholders from probation emphasised the importance of close interaction between the services, particularly at the pre-sentence report stage.

A shift away from probation has already been undertaken in the Cleveland, Durham and Darlington service. Under a previous model of the service, workers had been based in probation offices and undertaken assessments of probation client's on request or probation clinics. However, CJLD workers have now been moved out of these offices and an attempt has been made to reduce probation dependence on the service by only providing them with a limited liaison service to assist them to get their clients into mainstream mental health services (although it is apparent that some assessments of probation clients are still undertaken). One stakeholder explained the decision to stop accepting probation referrals as a result of only limited staff capacity to work with these groups following a service re-focus on police custody:

> *"We were getting people referred to us, we didn't know how risky they were and they were sat there waiting on our books and probation would think 'oh well, we've referred them to mental health so we don't need to think about that'. Also, just in principle, I didn't like the idea that just because you've got a probation officer, you couldn't access the normal mental health services."*

Nevertheless, there was concern expressed that despite this increased focus on front-end work, there was not a worker permanently based in the police custody suite. It is intended that where possible a worker is in the main custody suite for Cleveland Police, Middlehaven, from 9am-11am at a minimum but it was suggested that having a presence at that suite permanently would be a significant advantage. This echoes calls by national experts to reduce reliance on screening tools, emphasising the importance of the presence of trained professionals.

It was also suggested that the service could add value by providing support to the police even earlier at the point of arrest.

5.3b Improving information sharing with courts and other agencies

Since a primary focus of all the CJLD services was liaison with other agencies this frequently involved the sharing of information regarding clients. Those assessed by all the services were asked to agree to information to be shared with other relevant agencies and gaining consent from those seen was not highlighted as an issue. The general approach towards information sharing was reflected in these statements by practitioners:

"We work on the principle that the information, if it's relevant and appropriate, it should be passed along. I'd rather pass the information on and help somebody than not pass it on and have something go wrong. I can argue that one in court better."

"I've never in 30 years had a problem with anybody saying 'you shouldn't have shared that information'."

Positioned at the interface between health and criminal justice agencies, CJLD services were often ideally placed to facilitate the flow of information between the two agencies. The practitioners at the Gateshead and South Tyneside service both highlighted the need to ensure that community-based health practitioners had sufficient information regarding risk and offending. One practitioner felt that more robust information sharing policies were needed and also suggested that it would be helpful if more offence information could be uploaded on to the Trust database. One practitioner took a pragmatic, hands-on approach, seeking out information on community team clients on request. While PNC data was not directly disclosed, community agencies were encouraged to submit a request for information to the Public Protection Unit where there was a cause for concern. Of course, a balance needs to be struck between maintaining client confidentiality, protecting staff and ensuring positive outcomes for clients.

Despite strong information sharing with a range of agencies, information sharing with courts (as opposed to court custody staff) was underdeveloped. Both national experts and some regional stakeholders expressed concern that unless CJLD services take an active role in the provision of information to courts regarding defendants' health and social care needs, then the court may be making crucial decisions regarding culpability and sentencing without the full facts:

"[Nationally] there are liaison and diversion services who don't think that writing reports for the sentences is part of their job, which I think is odd really. Because I think sentencers need it."

Currently, the Bedlington service is the only service in the North East region where a system is in place to systematically provide information to courts about those seen by the service, although this is also planned for the new Sunderland service. Information is entered on to the 'Bedlington Custody Liaison Information Sharing' form and a copy uploaded onto the Trust's IT system (RIO). Two paper copies then go with the prisoner; one to go with the Prisoner Escort Record so that custody staff members are made aware of relevant needs and risks and one to provide information for the Magistrate and other court staff. This form was developed in conjunction with Magistrates to ensure that it meets their needs. Ensuring that the information provided was tailored to need was a point made by the national experts interviewed.

The other services have no such system. Provision of information to the court itself (as opposed to court custody staff) is not routine and where information is provided to the courts, this is usually verbally and often to court probation staff rather than directly to the Magistrate. One national expert emphasised the importance of providing written reports to courts;

"Too many of [the reports] are verbal, which never get written down. They need the written stuff that goes with the case papers so that it can be followed through, for example if people go to Crown Court."

One practitioner felt that relationships needed to be developed directly with Magistrates, *"so that they are confident enough in who you are and what you do that if they have concerns they'll ask you"*. The Gateshead practitioner reported that in a previous similar role he had provided written reports to court, however he was reluctant to start offering a new service and developing these relationships when he was only expected to remain in the position temporarily.

Court probation staff interviewed informally as part of a site visit to the North Tyneside Magistrates' Court felt that although the CJLD service was very helpful they wanted greater support around the provision of information to courts. Probation officers want to know who they need to contact for follow up when a mental health problem is identified.

They highlighted that the courts are pressed to get people through the system very quickly and so there is no time available to get feedback from community practitioners on clients, notably GPs (who could charge for information). They felt that the burden was on them to provide verified information since solicitors were unqualified to provide information on mental health and could often only provide partial information where it was favourable to their client. They expressed support for the suggestion that a tool, similar to that used in Bedlington be introduced.

Included within the successful bid for the further development of the Bedlington service and the new service at Sunderland is the proposal to run weekly court "clinics" where courts and agencies working within them can seek further advice about particular defendants.

It was also clear from interviews with the Crown Prosecution Service that they would welcome more information around mental health to inform their decisions about whether it was in the public interest to proceed and culpability (*mens rea*). At the moment they were heavily reliant on information from the police and there appeared to be no awareness among these interviewees of CJLD services. They emphasised that concern about a defendant's needs was not within their role, they would welcome greater relevant information at the earliest possible opportunity, i.e. pre-court, to inform their decision on charging and whether or not to proceed with a case. Experts emphasised that providing relevant information to the CPS at the charging stage was an important component of police-stage diversion.

5.3c Low involvement in diversion into alternative disposals

Most of the services referred to themselves as Criminal Justice Liaison services only (omitting the 'Diversion') in recognition of the fact that they played only a very limited role in the diversion of those with mental health conditions or learning disabilities into a range of alternative disposals including alternative sentencing options as well as the arrangement of hospital orders under s.37 of the MHA.

This reflects the national picture:

> *"They don't do diversion, they do screening and assessment, signposting…and the really important thing is diversion."*

In part this low involvement in diversion reflects the rarity of cases where mental health conditions or learning disabilities are severe enough to warrant whole-scale diversion from the justice system into the health system. CJLD practitioners reported involvement in arranging Mental Health Act assessments where required. However, only two of the services reported involvement in arranging beds for a hospital disposal (Gateshead and South Tyneside) and in both cases this appeared to be linked to the situation at the time in which their service was under the management of the crisis team.

None of the services reported involvement in the provision of formal psychiatric reports and only had access to a forensic psychiatrist informally through their links to Forensic Services within the Trust. (See figure 5.2 for further information regarding service activity). One CJLD practitioner reported significant difficulty in accessing the services of a psychiatrist:

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"I have to make phone call after phone call after psychiatrists."

However, the low involvement in diversionary interventions is also a significant reflection of the limited role that many of the services play in the provision of information to courts, discussed above. With the exception of South Tyneside (which is embedded in probation), none of the services have been involved in developing alternative packages of care that support an alternative, non-custodial disposal. Experts highlighted the importance of having a service to divert someone into. This is discussed in greater detail in the courts chapter.

One regional stakeholder also highlighted that diversion teams that were purely police-based could never hope to divert those who have committed medium-severe offences since it was inevitable that these groups would have to go through some form of police and court process. The stakeholder suggested that police-limited diversion teams can only hope to have an impact for minor and petty offences and so much greater work needs to be undertaken at court stage. It is notable that none of the services appears to cover the Crown Courts in the region although a pilot at Newcastle Crown Court is being established in which the court will be provided with support from a psychiatrist seconded from the Trust.

5.3d Maximising coverage

One concern across all of the services working in police custody was how to deal with the fact that *"People don't get arrested at convenient times of the day"*. Police custody suites inevitably held people seven days a week with the weekends being busy times, while all the main Magistrates' Courts operate on a Saturday (except Gateshead which combined with South Tyneside on the day).

The CJLD services all operated for five days a week only and had different operating times (see table 4.1); the Bedlington service starts at 7am but finishes at 12pm whereas workers in the Cleveland, Durham & Darlington patch were unlikely to arrive at custody suites until 9am at the earliest once they had been allocated by the duty phone system but were then available all day.

The Gateshead and South Tyneside services, which were both staffed by a single worker, currently had no arrangements for holiday cover. As the funding for both services originated from South of Tyne and Wear PCT it was suggested that the original intention may have been that the workers provided cover for each other; this was not happening. In addition, the Gateshead service is currently running with only 0.5 full-time equivalent staffing as opposed to a full-time worker. Although they are currently recruiting, a number of stakeholders expressed significant concerns about the damage to the service due to this break in cover, in particular the breaking down of links and a stall in the development of the service. It was also clear that there had been no service at all over the Christmas period.

CJLD practitioners, managers and a wide range of regional stakeholders based in custody areas all expressed a desire for greater coverage by the respective services. A consultation of practitioners organised by Safer Durham Partnership highlighted a strong wish among practitioners in mental health, learning disability and justice, particularly the police, for a single point of contact for mental health and learning disability-related issues in the justice system that was available twenty-four hours a day, seven days a week, with the suggestion being that the CJLD service could occupy this role.

Interviewees from both NTW and TEWV who had oversight of their respective Trust CJLD services suggested that improved joint working with the Trusts' crisis teams (or other community services) could also be utilised to bridge any gaps in service. One interviewee suggested:

"Where we don't hit the mark is that the service isn't big enough. It's not staffed enough. Because what we need to do is we need a 24/7 Criminal Justice Service. And, you could say, yes well, looking at the figures they could be sat twiddling their thumbs all night because nobody might come in. Well, in that case, what they could do is support the Crisis Teams. You know, we're not saying that you have to be bolted into custody."

Conversely, another interviewee suggested that staff based within the Crisis Team might be able to provide cover out of hours which they were currently reluctant to do. One practitioner who had worked in both services emphasised the similarities between his role in the crisis team and in the CJLD service; *"I'm a bit like a crisis worker [in the CJLD team], but a different kind of crisis."*

Plans were also in place in the TEWV service to bolster staff numbers in the liaison teams during the high demand morning period through the introduction of staff sharing arrangements with the TEWV-run prison in-reach services. Prison services would then provide extra capacity to the CJLD service in the morning and CJLD workers would provide extra capacity in the prison services in the afternoon. It was hoped that this would have the joint advantage of increasing the skills and service knowledge of practitioners from both services.

In addition, it was clear from the site visits and discussion with those working in custody areas that there were a range of other services that already went into custody that might be utilised better, as discussed previously in the police custody chapter. In order to utilise these resources however it was necessary to improve screening processes within these suites and have a clear system in place regarding when an assessment by a mental health practitioner was then required.

Other related issues include how to maximise both geographical coverage of the services and coverage across the justice pathway. Whilst plans are afoot to develop a CJLD service in Sunderland, the police custody suites in Newcastle and North Tyneside are not provided with a service.

In the Cleveland, Durham and Darlington area, there has already been a significant revision of their service model in order to maximise geographical coverage. The service in Durham and Darlington has been combined with the service in Cleveland so that the staff is pooled between the two services (with the exception of the Approved Mental Health Professional who is restricted to the Cleveland area). In addition, a duty phone system has been introduced so that staff members are allocated on a daily basis to the police custody suites and courts where they are required (with police custody suites prioritised). While this has increased the capacity of the service to cover all of the courts and custody suites within its catchment area, there have been concerns raised about a resulting reduction in proactive screening of those held in police custody.

It was clear that a different model for CJLD provision would have to be considered for very rural areas, in particular rural Northumberland which is currently not covered (although in many cases arrestees are brought to the Bedlington custody suite that does receive a service). Suggestions from stakeholders again concentrated on how you might using existing health services within these areas (such as crisis teams) to provide a minimal service. CJLD practitioners could then provide liaison support on the phone or attend rural locations only when it was considered necessary by a mental health professional.

> **Good Practice Example:**
>
> **Sussex Police** work with the **Sussex Court Liaison Team**, which is run by the local NHS Foundation Trust. The scheme prioritises overnight arrests, which usually involve a higher rate of offenders with mental health problems. The police email the CJLD service the arrest records at 4am in the morning. At 8am that team start working and immediately cross-reference the automated arrest sheet that has been emailed with the Trust computer system. They prioritise who they should then see that day (at court where they are based).
>
> One national expert who identified the scheme as good practice highlighted the matrix used by the team to determine which detainees are seen by the service:
>
> > *"They also have a good prioritisation system, a scoring system, which I think is really an excellent model."*
>
> In this system, detainees are given a score of between 0-9 based on the type of offence, a range of police markers and historical contact with services (three sections with up to three points available). Those with a sufficiently high score will definitely be seen. The interviewee suggested that this matrix had been validated against other scales;
>
> > *"The scoring system has proven to be quite reliable and those with the higher score tend to score high on various measures of severity the service uses. The scoring system seems to be quite robust."*
>
> One local practitioner praised the proactive approach of the scheme:
>
> > *"In the past we had to rely on phone calls with busy custody officers to see if they were worried about any particular offenders. Now our system of proactive screening means we can assess the raw arrest data ourselves, taking the onus off the police and enabling us to provide a rapid response, making the whole arrest and sentencing process operate more smoothly" (Mind, 2010, p.14-15).*

5.3e Improving relationships with other health and criminal justice services

Relationships between CJLD services and services with which worked they worked closely on a daily basis were generally strong with a few service-specific exceptions. However, it was worrying to note low awareness of these services or low clarity about the services being offered by a range of agencies.

Our survey of probation staff suggested extremely low awareness of the CJLD services among probation officers from both Probation Trusts within the region. 42% of respondents said that they were not aware of a CJLD service operating in their area (excluding those respondents who responded to say that they were based in an office in the Sunderland area). In addition, interviewees from other agencies such as the Crown Prosecution Service or court staff (including Magistrates and Judicial Clerks) were unaware of these services or unclear what they offered. Particular confusion surrounded the Cleveland, Durham and Darlington service following the substantial service restructuring. This is despite training conducted by the CJLD service to over 30 magistrates and clerks to the justices.

However, there was also a need in some areas (and across both Mental Health Trusts) to improve relationships between CJLD teams and mainstream mental health services. This includes

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relationships with community treatment teams, crisis teams and primary care, in particular Improving Access to Psychological Therapies (IAPT) services.

Commonly identified problems included a poor awareness among community staff of the CJLD teams, their coverage, their role and the assistance that they may be able to provide. For example, the Newcastle service reported that the service does not receive any referrals from other agencies who are concerned that their client is going to court. Practitioners in both Trusts suggested that so far there had been a failure to adequately promote what they do. A stakeholder in the Cleveland, Durham and Darlington service suggested that the TEWV intranet system, 'InTouch', might have been better used to promote the service internally, particularly around the time of significant service change. It is our understanding that changes to the CJLD service are still at an interim stage and that further work to publicise the changes is yet to be undertaken.

In the recently established Bedlington service, considerable effort had been taken to address this issue and engage other services through a 'road show' to local community treatment teams and other services which outlined what the service could provide and what the CJLD service expected in return.

Significant problems also existed around facilitating access to community services for clients with some of the CJLD services reporting difficulties getting their referrals accepted by other services within their own Trust. For example, the Newcastle service provided by the NTW Forensic Community Mental Health team reported that where a practitioner identified that a client was in immediate need of an inpatient bed, the crisis service that determined access to beds still insisted on reassessing clients, often with the result that a bed was denied. However another senior stakeholder from the Trust emphasised that while it was important that assessments were streamlined, crisis services needed to retain this gate-keeping role.

One regional stakeholder highlighted that problems accessing services could be reputationally damaging for CJLD services given that external services struggle to understand how these blockages could occur within the same organisation:

> *"I'll be quite honest with you, it is sometimes quite embarrassing…if you've seen them at a police station and [you're] talking about trying to get someone into a mental health service and it's part of our own organisation. Because the police just look at it and say well, they're the same staff, aren't they?"*

This was not just a regional problem as one national expert explained;

> *"Regardless of whether one part of a mental health trust provides diversion and liaison or prison in reach or does the bit of helping people leave the prison – regardless of any of that, that doesn't seem to provide a gateway into mental health services."*

A number of regional stakeholders, as well as national experts, highlighted that there often remained a certain stigma of 'offenders' in community services. A resulting fear of working with offenders led staff to demand excessive information around offences committed and risk or to suggest that the client needed a forensic service despite a relatively minor offending history:

> *"I think when you're looking at saying the word offender…it's less than it used to be. But you know, certain people have certain ideas even within mental health services."*

For the Cleveland, Durham and Darlington team this appeared to have been a particular problem in terms of accessing IAPT services although the situation here had improved significantly and the IAPT

scheme in the Durham and Darlington area was commencing a number of positive initiatives in working with offenders.

There was however a number of CJLD services that reported extremely good relationships with crisis services and/or community treatment teams. These were the NTW-provided services in Gateshead, South Tyneside and Bedlington. All of these services had currently or historically had close staffing or management links with the crisis teams. Both the Bedlington service and the Gateshead service had at least one worker who also had a permanent role within the crisis team. Additionally, CJLD workers in both the Gateshead and the South Tyneside services had been managed by the crisis team up until October 2011, when management of the services passed over to the NTW Forensic Community Team as part of preparations for the national Pathfinder Programme.

Both the CJLD workers in Gateshead and South Tyneside said that their assessments had credibility and legitimacy with these teams and relationships with these teams clearly did not present a barrier to helping those with mental health problems or learning disability access appropriate support. This allows the worker to consider a range of options for the client and has the advantage for the service user that they are not subject to repeat assessments:

> *"So in practice it works and certainly within the known circles they accept my referral as is…So hopefully if I've done my job properly, I've given a good risk assessment, given a good assessment and a clear direction of what I think is the plan at the end. There are a number of things that I could put in place, like requesting a medication review from the consultant psychiatrist, I could ask for care coordination, I could ask for psychology, being quite specific about why I am making that referral. As long as they can read that and understand that it tends to be accepted."*

The importance of having existing relationships with other workers in these teams ('being known' to other services) was repeatedly stressed with practitioners highlighting previous employment histories within other Trust services as providing valuable links.

The importance of personal links for the CJLD work was reiterated throughout the interviews with one practitioner suggesting:

> *"Having that personal link, I think that's really key in what I do. Being able to pick the phone up and say, hello, remember me, I've got someone that I think might be appropriate for you."*

Concern was expressed about how these relationships might develop in the future due to the changes in the Trust management structure, with consequent loss of links and access to community services. One CJLD practitioner explained; *"that could make my life very difficult if I didn't have that cooperation."* A senior representative from TEWV also acknowledged that there may be difficulties retaining strong links with CJLD services following the change in management structure there.

Operational practice and service structures that facilitate the development of strong professional relationships between staff within CJLD services and those within community teams have to be considered. Both Trusts have taken the decision to situate Criminal Justice Liaison and Diversion services within forensic services. While this provides an advantage in terms of familiarity with the justice system, there is a corresponding disadvantage in terms of 'distance' from mainstream community services.

However, the management structure of the CJLD services is just one factor that could be considered when attempting to promote better relationships between staff in the two sets of services. Joint-working initiatives such as providing inter-service staff cover is another option. It was also suggested that CJLD workers for the TEWV service, which covers a wide geographical area,

should utilise the numerous 'hot desks' available in a range of Trust services, which are listed on the TEWV InTouch system. Stakeholders emphasised the importance of informal working relationships.

5.3f Developing care pathways into the voluntary sector to meet a wider range of needs

Support was focused around addressing immediate risk and facilitating access to mental health support for those with higher level needs. For the most part referral pathways appeared to be into health services including those provided by the Trust, those in primary care and private provision with police stations (FMEs). However, it was clear that although some of the clients seen by the services have severe and enduring mental health problems, the majority suffer from common mental health problems such as anxiety and depression or personality disorders interwoven with a range of other health and social problems including substance misuse.

All of the CJLD services offered some basic support around meeting social problems, for example homelessness and lack of benefits, however frequently this was limited to signposting clients to services and the range of services signposted to was often limited. Although the region has a significant number of voluntary-run services providing support for a range of needs, few of the CJLD services appeared to have developed strong links and resulting care pathways into the voluntary sector. The exception was drug and alcohol services where links were stronger, particularly to those providing arrest referral services, although these could still benefit from strengthening in some areas.

Housing and homelessness was cited as a frequent and significant problem by a number of practitioners as well as the Band 7 nurses managing both the TEWV and NTW run CJLD services. However, intervention was usually limited to signposting the client to the local authority housing options or homelessness teams. Concerns were expressed that the time involved in offering increased support for housing issues was unmanageable:

> *"Obviously if you became an agency for housing you'd be flooded. And you give the best advice you can without getting too involved in the housing issue because it would actually take up all your time."*

Those practitioners who had been engaged full-time in CJLD work for a significant period or who engaged in follow-up work with clients perhaps had slightly better links with services. However, for the most part the impression gathered from site visits and interviews was that this work was de-prioritised and that these links were underdeveloped. However, plans were in place for the new WOW! service being established to support women in Sunderland to receive the majority of its referrals from the new CJLD team being established in the area.

A number of practitioners highlighted the fact that it could be difficult to keep up-to-date due to the regular changes in the service landscape. In particular, the practitioner from the Cleveland, Durham and Darlington service was concerned that the geographical expansion of the work meant that knowledge of and links to other services might be lost or diluted. One suggested that a regular group or forum for sharing information about services would provide an invaluable interface.

5.3g Overcoming information technology barriers

Frequently issues were raised regarding access to information held about clients on Trust records or those of other services. Most of the services, with the exception of North Tyneside and Newcastle, have remote access to their respective Trust databases (RIO and PARIS) on site via a laptop. This was seen as invaluable since it allowed records on clients to be reviewed, amended and created without having to return to one of the main Trust offices. However, in the South Tyneside project

remote access was highly problematic and frequently the connection and consequently data had been lost while in the process of inputting this. This had caused significant frustration to the worker who had ceased using this system as a result, therefore having to go to a local hospital several miles away each day to access the Trust database there. This was identified as one of the two most significant barriers to helping offenders with a mental health problem and learning disability to access appropriate support. There were also problems with the remote connection in Gateshead however while frustrating it did not appear to provide a significant barrier to working in this case.

In both North Tyneside and Newcastle there is no remote access to the NTW database (RIO). Instead, the CJLD practitioner attending the court would ring the office of the Forensic Community Mental Health Team and ask the team's secretary to check the names against the Trust records. Information is then fed back by phone to the CJLD practitioner. It was highlighted that this system was highly problematic since it involved a non-qualified member of staff making a clinical judgement about which information was relevant to share. There were also pragmatic issues in that there was often some inconsistency between those anticipated to be in the cells under the court and those who were actually in these cells when the practitioner arrived, frequently resulting in a second phone-call back to the office.

A practitioner from the Cleveland, Durham and Darlington service emphasised just how helpful the provision of remote access to the PARIS database had been for the team and facilitating this access remotely will clearly be an important development step for the services without this provision. However, for the current Newcastle service, the provision of remote access is likely to be significantly hampered by environmental considerations in the court including the lack of a desk and the scarcity of space in the cells underneath the court.

Even those services with good access to their respective Trust databases faced the much more impenetrable problem that there is no one universal health database so that information is held across a range of different systems. The NTW services use the RIO database while the TEWV services use PARIS. In addition, other databases such as CareFirst or SWIFT are used by local authority social care teams and in the past by Community Mental Health Teams. Remote access to SWIFT is simply not available at all (although the North Tyneside service provided by a social worker reported easier access to this system). The possibility of obtaining remote access to the CareFirst system is currently being explored for the NTW-run services. Currently information can only be obtained verbally from the duty officer within the social care team and can involve considerable negotiation time. This was suggested as a particular barrier for obtaining information regarding clients with a learning disability.

5.3h Monitoring activity and outcomes

Although information regarding all referrals to the services were entered onto the respective Trust databases, there appeared to be only very limited monitoring of activity and no monitoring of outcomes at all undertaken by any of the services. This inhibited the ability to take an evidence-based approach to service-development.

CJLD services are for the most part commissioned by local Primary care Trusts. The exceptions are the North Tyneside service which is commissioned by the local authority and the Bedlington service which has, until recently, not had any dedicated funding. The Bedlington service and a new service at Sunderland have now received funding directly from the Department of Health. Details of commissioning arrangements for the respective services are given in figure 5.1. We were informed

that these services are commissioned as a small part of broader contracts and consequently there is only limited focus on the performance of these services.

Barriers to outcome monitoring by managers and commissioners centred around the use of these standardised Trust systems which are also used by a wide range of other services and their inappropriateness for criminal justice liaison and diversion work. In particular they failed to capture much of the criminal justice information and also did not allow for liaison activity to be captured adequately:

> *"If you go on to RIO at the moment, as far as the criminal justice system is concerned, you can't audit outcomes. It is extremely difficult, because it's such a generic tool. The crisis team use it, the wards use it."*

> *"The problem is that criminal justice liaison work is not just about the numbers of people that you see. It is also about the relationships that you have with people in the criminal justice system, and that they know you are there when they need you."*

Another central problem was a lack of staff capacity among any of the teams to undertake any proactive follow-up work of clients to determine whether a referral was successful and whether a client's mental health or re-offending rate improved. It was also suggested that the services needed to be monitoring other relevant outcomes such as the number of suicides in custody among clients seen by the service and the number of readmissions to inpatient units.

Currently, without any follow-up data, it is impossible to draw any evidence-based conclusions on the effectiveness of these services.

> *"The priority [traditionally] has been what's the risk, where do we pass these people on to, and we discharge. We're not staying involved with them. Which I'm not suggesting we should stay involved with, but what we need to do is to start building in the ability to start chasing up some of this more assertively…we don't necessarily know when we've referred people on…if they've been seen, but if they have been seen, has that been effective and was that more useful, or are they then referred onto someone else after that, and are we just part of a chain of referring people on."*

This comment from a regional stakeholder from CJLD services echoes concerns from national experts regarding a lack of data on CJLD services nationally: *"We just don't have the body of evidence because we don't keep onto people – we couldn't even do an audit, we don't track people."* This lack of robust data nationally is behind the drive by the Department of Health to collect appropriate data to evidence the financial, health and reoffending impact of liaison and diversion services as part of the national roll-out of liaison and diversion services.

Managers of all the services (both the senior managers and the Band 7 nurses) recognised that the current situation regarding monitoring of activity and outcomes was inadequate and some work was underway or anticipated in both areas to rectify this. For the newly established Bedlington service record is kept of how many people have come through the custody suite in 24 hours, how many of these have been screened, how many have been processed without being seen and for those seen, where they have been signposted to. Additionally, follow up information is recorded where it is known, however record-keeping remains largely referral and activity focused. It is hoped that similar improvements in data collection might be extended to the other NTW-provided CJLD services.

Meetings between the Band 7 nurses at the TEWV-provided Cleveland, Durham and Darlington service and their admin worker to consider data collection and outcome monitoring are also anticipated. Significant work had been undertaken in the TEWV-run prison-based services (the prison Inreach teams) to create a spreadsheet that monitored appropriate outcomes and this was

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seen to have been a positive development (although required significant staff resources to input data) that could be replicated for the CJLD services. In fact, a previous iteration of the Cleveland service (pre-2000) had had a specially designed database for recording activities, designed by Wendy Dyer. This system (which was Microsoft Access-based), had been designed for the CJLD service and so made it very easy to find out detailed information about the people who had been referred to the service. Unfortunately because of concerns that it did not conform to the Trust data security standards (as it was a stand-alone system), it had been scrapped.

There was also significant anticipation that the national roll-out of CJLD services, of which all the CJLD services in the region form a part, would provide a standardised data set for diversion services nationally that the Trusts would then be compelled to use although representatives from the Department of Health suggested that this would be the minimum set required to evidence the business case.

5.3i Improving the service for those with a learning disability

For the most part, neither the CJLD services provided by TEWV nor those provided by NTW had any input from a learning disability practitioner at all; the Newcastle service is provided by the Forensic Community Mental Health Team which has access to a learning disability practitioner. Consequently there was no capacity to undertake a full learning disability assessment which there was for mental health and no standardised screening tool validated for a custodial population was used. CJLD practitioners relied on a number of questions in the generic mental health assessments on RIO or PARIS that might identify learning disability such as attendance at a special school, poor literacy and being known to learning disability services.

Practitioners within the services varied as to whether or not they considered current practices adequate in identifying and meeting the needs of learning disabled offenders. Some felt that they had sufficient knowledge to identify those likely to have a learning disability and refer on while others suggested they lacked the expertise to support this group:

> *"I don't always and can't always communicate with somebody with learning disability."*

However, a senior representative from Forensic Learning Disability Services in TEWV expressed considerable concern at the very low number of referrals to their community service received from the Cleveland, Durham and Darlington CJLD service. It was reported that when the CJLD service had first been established a forensic learning disability nurse had spent some time within the team to increase awareness of learning disability and the available care pathways. The Forensic Learning Disability Service had at one time also provided an on-call pager service to the CJLD team offering immediate support around learning disability assessments for those in the justice system (this service is no longer provided). Initially numbers of referrals to the Forensic team had been considerably higher and have dwindled significantly over time. This was not felt to be a reflection of a decrease in a number of people with learning disability going through the custody suite.

The need for learning disability input to the TEWV-provided CJLD service was recognised by those overseeing Offender Health provision in the Trust as an important area for development:

> *"I think the biggest thing is that learning disabilities aren't picked up. That's the biggest area. And that's been noted, certainly within the Criminal Justice Liaison Service that we don't have a dedicated LD worker within that team. There was a time when somebody was attached to it in Cleveland and the recognition went up. That person since left the team and now, I could say hand on heart, probably two or three have been recognised as having a learning disability."*

In addition there were a number of other conditions such as autism, ADHD and ABI where a lack of expertise, validated screening tools and knowledge of care pathways, meant that these were likely to go unnoticed by CJLD services.

Figure 5.1		Funding	Staffing	Operating hours	Desk / main place of work	Coverage	Not covered by the service
NTW	Bedlington	No dedicated funding	0.5 FTE (currently high intensity psychological therapist & Band 6 CPN job share)	7am-12pm Mon - Fri	Bedlington police station	• Bedlington custody suite • South East Northumberland (Bedlington) Magistrates' Court	• Hexham (part-time rural) custody suite • Alnwick (part-time rural) custody suite • Berwick (part-time rural) custody suite *Those with MH issues in these suites are supposed to be brought to Bedlington* • Berwick Magistrates' Court • Probation offices in area
	Newcastle	Newcastle PCT	0.5FTE Band 7 CPN, covered by staff from Forensic CMHT		Forensic CMHT offices	• Newcastle Magistrates' Court	• Etal Lane custody suite • Clifford Street (Byker) custody suite • Probation offices in area
	North Tyneside	North Tyneside LA	0.5FTE social worker (cover provided by Forensic CMHT)			• North Tyneside Magistrates' Court	• Wallsend custody suite • North Shields (part-time resilience) • Probation offices in area
	South Tyneside	South of Tyne and Wear PCT	1FTE Band 6 CPN	8am-4pm Mon - Fri	South Shields probation office	• South Shields police custody suite • South Tyneside Magistrates' Court • South Shields offices of Northumbria Probation • Support on request to probation offices at Jarrow & Cornwallis Street	
	Gateshead	South of Tyne and Wear PCT	1FTE Band 6 CPN (currently only staffed 0.5FTE – recruiting)	8am-4pm Mon – Fri (currently Mon, Weds, half-day Thurs)	Gateshead police station	• Gateshead police custody suite • Gateshead Magistrates' Court • Gateshead offices of Northumbria Probation	• Whickham (part-time resilience) custody suite
TEWV	Cleveland, Durham & Darlington	Durham & Darlington PCT; Middlesbrough PCT	2FTE Band 7 CPNs (funded by Durham & Darlington PCT); 3FTE Band 6 CPNs & 1FTE AMHP (funded by Middlesbrough PCT)	8am-4pm Mon – Fri		• Middlehaven police custody suite • Hartlepool police custody suite • Redcar police custody suite • Darlington police custody suite • Durham police custody suite • Bishop Auckland police custody suite • Peterlee police custody suite • Teesside Magistrates' Court • Durham Magistrates' Court • Darlington Magistrates' Court • Chester-le-Street • Consett Magistrates' Court • Newton Aycliffe Magistrates' Court • Peterlee Magistrates' Court	• Probation offices in area provided with limited liaison service only

Figure 5.2		Assessment of risk	Mental health assessment	Learning disability assessment	Assessment of social care needs	Provide support for meeting social care needs	Signposting/ referral to prison agencies	Signposting/ referral to community agencies	Liaison	Active case management	Provision of formal psychiatric reports	Provision of information to courts	Assistance in the organisation of a MHTR	Assistance in organisation of bed for hospital disposal	Training to Stakeholder Agencies	Involvement in MAPPA; MARAC; IOM
NTW	Bedlington	Y	R	L	Y	Y	L*	Y	Y	N	N	Y	N	N	Y	
	Newcastle	Y	R	L	L	L	L*	Y	Y	N	N	L (verbally)	N	N	N	N
	North Tyneside	Y	R	L	L	L	L*	Y	Y	N	N	L (usually verbally)	N	N	L	N
	South Tyneside	Y	Y	L	Y	Y	L*	Y	Y	L (holds clients on short-term basis)	N	L (usually verbally)	Has not yet had to do this	Y	Y	Y
	Gateshead	Y	Y	L	Y	Y	L*	Y	Y	L (some follow-up work)	N	L (verbally)	N	Y	Y	Y
TEWV	Cleveland, Durham & Darlington	Y	Y	L	Y	L	L*	Y	Y	N	N	L (usually verbally)	N	N	Y	Y

Y = Yes; N=No; L=Limited; R=Reduced version   ***Prison healthcare or inreach teams only**

6
Courts

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KEY ISSUES:

- **Strengthening sources of information to courts**
- **Identifying need in defendants on bail or on summons**
- **Reducing delays without reducing fairness of outcomes**
- **Improving current processes for obtaining formal psychiatric reports**
- **Increasing engagement with the court process**
- **Increasing awareness of impact and alternative options for sentencing**
- **Clarifying processes around Mental Health Treatment Requirements**
- **Developing a range of alternatives to custody**

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6.1 National Picture

As well as the roll-out of liaison and diversion services nationally, proposals in the *Breaking the Cycle* green paper (Ministry of Justice, 2010) included reduced use of custodial remand for offenders unlikely to be sentenced to custody as well as substantial reforms to sentencing. This included a renewed emphasis on using "robust community sentencing" to effectively tackle reoffending, as well as changes to the benefits received by the defendant who offers an early 'guilty' plea (MOJ, 2010, p.63). After a political backlash, a tougher approach is represented in the Legal Aid, Sentencing and Punishment of Offenders (LASPO) bill. In particular, changes to community sentencing are focused more on improving control of offenders, making the requirements tougher and enforcing compliance, while changes to the benefits received for a guilty plea have been dropped altogether. This raises some concern over where the £130 million these sentencing reforms were proposed to save will now be cut from (Clinks, 2011a, p.11).

There is also a strong policy emphasis currently on speedier, more efficient justice (Ministry of Justice, 2010, p.78-79). This emphasis encourages earlier resolution of cases and fewer delays and adjournments, which must include getting psychiatric advice to court staff earlier to avoid the substantial delays this can involve.

6.1a Diversion of offenders at court: findings from the literature

Fitness to Plead

The defence, prosecution and judges require information about any identified mental health needs in order to determine the defendant's ability to stand trial.

At Crown Court a judge may decide that a defendant is unfit to plead. The main criteria when considering fitness to plead are: (Jacobsen and Talbot, 2009, p.2)

- Capacity to plead with understanding
- Ability to follow proceedings
- Knowing that a juror can be challenged
- Ability to question the evidence
- Ability to instruct counsel.

These considerations are vital to ensuring a fair trial, and reliable testimony. Many vulnerable defendants, especially those with a learning disability, find the court process challenging to understand, and may struggle to participate in a meaningful way (Jacobsen and Talbot, 2009, p.1; p.6-7).

While the decision to declare a defendant unfit to plead is only open to the Crown Court, there are other diversion options open to both Crown and Magistrates' courts where concerns are raised. The defendant can be remanded to hospital for a report on their medical condition under section 35 of the Mental Health Act (MHA), or alternatively remanded for treatment under section 36 while awaiting trial, providing a possibility for assessment in a psychiatric setting (Bradley, 2009, p.60).

Where a defendant is deemed unfit to plead at Crown Court, it must be noted that there are important differences between dealing with mental illness and learning disability. After diversion and treatment a defendant with a mental health problem might become fit to plead, whereas a defendant with learning disability will have a more constant level of comprehension (Jacobsen and Talbot, 2009, p.9).

Support in court

Vulnerable defendants do not always need to be diverted out of the criminal justice process altogether, and this is not always appropriate. As the Prison Reforms Trust's *No One Knows* programme has been keen to point out, many vulnerable defendants may be able to participate effectively in criminal proceedings as long as they are provided with appropriate support. Indeed, as regards learning disability, HMCTS has a duty under the Disability Discrimination Act 1995 (amended 2005) to eliminate unlawful discrimination on the basis of disability and to promote equality. It has been argued that this implies that defendants with learning disabilities should be provided with the practical assistance they require to participate fully in court proceedings, where appropriate (Jacobsen and Talbot, 2009, p.2).

Despite this, actual provision of assistance is limited. One problem nationally is that vulnerable defendants as a whole do not have the same statutory rights as vulnerable witnesses when it comes to help and support in court (Jacobsen and Talbot, 2009, p.15). Thus, where a vulnerable witness can provide evidence by video link, the public gallery can be cleared so that evidence is given in private, and an interpreter can be made available to aid communication, only a few of these provision are available to vulnerable defendants. In particular, there is no statutory access to an interpreter to aid with communication (Jacobsen and Talbot, 2009, p.15).

Seeing as relatively few people are declared unfit for trial, improving access to support to enable vulnerable defendants to participate fully in their trial is hugely important. Recommendations from the *No One Knows* programme include:

- Every court should have access to a Criminal Justice Liaison and Diversion Team (Jacobsen and Talbot, 2009, p.3)

- "HM Courts Service [now HMCTS] should ensure that all its provision complies with the Disability Discrimination Act, such that courts are fully accessible to vulnerable defendants (as well as to all other court users who are vulnerable), and these defendants receive the practical support and assistance they require in order to participate effectively in proceedings" (Jacobsen and Talbot, 2009, p.4)
- "Judges and magistrates should receive training on the range of impairments (including learning disabilities) that defendants can display, the implications of these impairments for the criminal justice process, and methods by which vulnerable defendants' participation in court proceedings can be enhanced" (Jacobsen and Talbot, 2009, p.3)
- There should be equal access to statutory support for vulnerable witnesses and vulnerable defendants (Jacobsen and Talbot, 2009, p.3).

Remand Decisions

Information about a defendant's mental health needs or learning disability should also shape remand decisions. Magistrates and Judges have a number of options:

- Remand on bail
- Remand to custody
- Remand to hospital (using section 35 or 36 of the MHA as described above).

Bail can be refused, and the defendant remanded in custody, where there are substantial grounds for believing that the defendant, if released on bail, would fail to surrender to custody, commit an offence, interfere with witnesses, or otherwise obstruct the course of justice. Further considerations are also made where the defendant is identified as vulnerable. Here, remand in custody is permissible for the defendants own protection and to reduce the risk of self-harm. Other factors, such as a defendant's housing situation, may also be considered as part of the 'risk' factors around granting bail (Jacobsen and Talbot, 2009, p.23).

There is an even higher prevalence of mental illness among the population on remand compared with sentenced prisoners, reflecting the stressful situation and difficulty prison health teams have in engaging remand prisoners in their short periods in custody (Bradley, 2009, p.64). People remanded in custody can also be subject to a long wait, particularly where the court is waiting for a psychiatric report.

Where appropriate, alternatives to remand in custody should clearly be preferred when dealing with vulnerable defendants. If there is an active CJLD service at the court, defendants may be signposted and referred to community services before they go out on bail, which may reduce risk. They can also be bailed on condition that they reside at 'approved premises' (Jacobsen and Talbot, 2009, p.24). These enable the probation service to manage risk while avoiding remand in prison. Residents at approved premises can also be helped to access health and social care services.

This option remains problematic, however. As Bradley (2009) has pointed out, mental health services in approved premises are often not highly developed enough to cater for the high levels of need that they experience (Bradley, 2009, p.65). On top of this, there are limited spaces at approved premises nationally. As such, approved premises do not always provide a realistic alternative to custody. There is a concern that vulnerable defendants are still too often remanded to prison due to a lack of alternatives (Jacobsen and Talbot, 2009, p.24).

Recommendations to address these problems nationally include:

- Community healthcare and other support services for defendants on bail, and provision for hospital remands, should be extended in order to minimise the use of custodial remand for vulnerable defendants (Jacobsen and Talbot, 2009, p.29).
- "An audit should be undertaken to the mental health needs of individuals in approved premises, and of the capacity of local services to deal with the identified level of need" (Bradley, 2009, p.67).
- "Primary care trusts should identify and address the health needs of residents in approved premises when planning local services as part of their commissioning plans" (Bradley, 2009, p.67).
- "The national approved premises training package addressing suicide and self-harm should be reviewed and updated to include mental health awareness training" (Bradley, 2009, p.67).

Provision of psychiatric reports

Psychiatric court reports are an important source of information for court staff on the mental health needs of defendants. Indeed, where a court lacks support from a CJLD team, and where information from police custody is poor, they can be one of the few avenues for magistrates and judges to obtain reliable mental health information.

Nevertheless, there are widespread problems in the process of getting a psychiatric court report that occur nationwide. One of the major issues is that there is no constant service provision for this. The final report on the South West Courts Mental health advice and assessment pilot sums up some of the problems:

> *"The NHS is not under any responsibility to provide information to the courts and the majority of psychiatrists who undertake the preparation of a report do so in a private capacity. This results in courts having to find a psychiatrist willing to carry out an assessment and prepare a report for the fees payable. For many courts this has proved difficult with defendants often spending long periods in custody waiting for a report to be prepared or numerous adjournments waiting for the case to be dealt with"* (HMCS and NHS SWO, 2009, p.16).

These problems appear to be widespread, as Lord Bradley found:

> *"My review received significant input from stakeholders on this particular issue, with an overwhelming view that there is inconsistent service provision which can contribute to unnecessary delays and costs to the criminal justice system"* (Bradley, 2009, p.71).

In 2006, the Department of Health (DH) and Her Majesties Court Service (HMCS) developed a framework to tackle this using local Service Level Agreements (HMCS and NHS SWO, 2009, p.15). This approach was piloted in the South West, with their service level agreement setting a target time of 14 days. This approach had great success not only in improving provision around psychiatric reports but also in reducing the number of psychiatric reports requested through an active liaison and diversion service (see good practice box on page 129).

This approach informed Bradley's recommendations to improve provision of court reports (Bradley, 2009, p.73):

- "Courts, health services, the Probation Service and the Crown Prosecution Service should work together to agree a local service level agreement for the provision of psychiatric reports and advice to the courts"

- "All criminal courts should carry out a six-month baseline study recording psychiatrists' and psychologists' reports commissioned by the court and the cost of those reports, in order to inform the development of the service level agreement."

Sentencing advice – Probation and Pre-Sentence Reports

Once a defendant has been found guilty, and the decision made to proceed with a criminal justice sanction rather than divert out of the criminal just system, a key agency providing advice to the court is the Probation service. Probation officers can provide a pre-sentence report (PSR), describing sentencing options to the magistrates or judge. The PSR must consider the circumstances of the crime, the health factors involved and the risk the offender poses to the public. For defendants with an identified mental disorder, the PSR should also address (Bradley, 2009, p.68):

- Culpability
- Risk of further reoffending
- Risk posed to self and others
- Feasibility of compliance with any suggested sentence
- Any supervision that may be required by the probation service or other services as part of any suggested community sentence.

There are different types of PSR according to the speed with which they are required and the level of detail. A Fast Delivery PSR is usually completed within a day or by the next day, and a more detailed Standard Delivery PSR completed on adjournment (Bradley, 2009, p.68). Both are based on the OASys risk assessment tool. However, this tool records limited mental health information and is not considered "fit for purpose" by many mental health professionals (Bradley, 2009, p.137).

Further concerns may be raised as, under pressure to streamline their processes, courts are increasingly favouring less detailed reports. Table 1 shows that there has been a notable decline in Standard Delivery PSRs and an increase in Fast Delivery PSRs, especially those delivered orally rather than written. This is a concern, as information given orally is less likely to follow the offender further down the criminal justice pathway.

Figure 6.1: PSRs completed at Magistrates & Crown courts	Apr-Jun 2010	Jul-Sep 2010	Oct-Dec 2010	Jan-Mar 2011	Apr-Jun 2011	% change April 2010 – June 2011
Standard PSR	23,256	23,488	21,824	22,001	19,278	-17%
Fast Delivery PSR written	18,969	20,377	19,571	20,611	19,395	2%
Fast Delivery PSR oral	9,599	10,338	10,014	10,679	11,139	16%

A further issue is that the PSRs rely heavily on the mental health knowledge of the probation worker conducting the report. It is for this reason that Bradley recommends that:

> *"All probation staff (including those based within courts and approved premises) should receive mental health and learning disability awareness training"* (Bradley, 2009, p.69).

Bradley identified CJLD teams as an important element in providing this training, as well as providing health information to Probation staff producing a PSR.

Sentencing options: Community Orders and the Mental Health Treatment Requirement

As has been noted previously, for many offenders with mental health problems or learning disability, it may be appropriate to continue with a criminal justice sanction, ensuring appropriate access to healthcare services rather than diverting out of the criminal justice system entirely. For some individuals, a custodial sentence will be necessary. However, research and policy suggests the utility of community sentences in dealing with vulnerable offenders. As the Bradley report states:

> "Where used appropriately, community sentences can provide safe and positive opportunities for offenders with mental health problems or learning disability to progress with their lives, as well as receiving a proportionate sanction from the court" (Bradley, 2009, p.91).

Community orders are made up of a combination of 12 requirements that can be mandated by the court. These are listed below in figure 6.2, and include a number that are designed to tackle the root cause of an individual's offending, such as the Drug Reduction Requirement or the Alcohol Treatment Requirement. There is also a Mental Health Treatment Requirement (MHTR) that can be applied, subject to a full psychiatric report and the consent of the offender. However, as figure 6.2 shows, this is rarely used.

Figure 6.2 – Requirements used as part of a community order	Apr-Jun 2010	Jul-Sep 2010	Oct-Dec 2010	Jan-Mar 2011	Apr-Jun 2011	% of overall requirements commenced, Apr-Jun 2011
Community Orders – total	54, 954	57,540	53,858	54,330	51,143	100%
Supervision	18,135	18,795	17,538	17,400	16,194	32%
Unpaid work	18,349	19,078	17,287	18,236	17,151	34%
Accredited Programme	5,084	5,285	4,782	4,612	3,946	8%
Drug Treatment	2,981	3,138	2,876	2,481	2,270	4%
Curfew	4,223	4,372	4,532	4,508	4,172	8%
Specified Activity	3,401	3,918	4,075	4,414	4,675	9%
Alcohol treatment	1,460	1,588	1,409	1,408	1,448	3%
Residential	248	263	288	225	204	0%
Mental Health	**186**	**178**	**188**	**140**	**175**	**0%**
Exclusion	265	272	266	275	259	1%
Prohibited Activity	392	387	358	307	325	1%
Attendance Centre	230	266	259	324	324	1%

A number of barriers to the use of MHTR are identified in the literature. The Sainsbury Centre for Mental Health Report highlight the following difficulties:

- Confusion among practitioners over when a MHTR could be applied, and even the process for applying one (Khanom et al, 2009, p.5).
- Confusion as to who the target group for mental health treatments are, when the most serious cases are diverted under the MHA and thresholds remain high (Khanom et al, 2009, p.5).
- Poor communication between courts, probation and health services around the MHTR, with CJLD staff showing little knowledge of the requirement (Khanom et al, 2009, p.30).
- Difficulty getting psychiatric reports required (Khanom et al, 2009, p.19).
- Concerns over breach, whereby if the offender breaches the order they will be subject to harsher punishment (Khanom et al, 2009, p.5; p.26).

- Concerns over compulsion as an ineffective way for people to engage with mental health services (Khanom et al, 2009, p.18).

This has led to questions whether MHTRs are even the right approach to this client group. Even supporters of the requirement admit that it requires substantial changes and the government's *Breaking the Cycle* green paper suggested:

> *"In some cases, particularly for offenders with multiple problems, a more generic health treatment requirement may be a better way to engage them with all the treatment they need"* (Ministry of Justice, 2010, p.60).

The Offender Health Research Network published a report in 2011 exploring how the government's aim of promoting robust alternatives to custody where suitable would impact on criminal justice services' responses to people with mental health problems. They reported underuse of the MHTR but rather than abandoning the MHTR, they argue that "it is time to proactively manage the process from early identification of potential suitable recipients through to successful completion of mandated engagement with mental health treatment services" (OHRN, 2011, p.33). They suggest that Liaison and Diversion services should play an important role in this process, proactively identifying suitable clients for MHTRs.

This is now subject to review.

6.2 Regional Provision and Practice

6.2a Overview of courts and recent closures

The court system is undergoing substantial changes nationally under reforms pursued by the coalition government. Her Majesties Courts and Tribunals Service (HMCTS) was formed in April 2011, bringing together Her Majesties Court Service and the Tribunals Service. This change is representative of a wider rationalisation of the court estate under the Court Estate Reform Programme, which will see 93 Magistrates' Courts and 49 County Courts closed nationally by July 2012 (Ministry of Justice, 2012a).

Many of these closures have already taken place, including all of those affecting criminal courts in the North East. The Magistrates' courts closed as of 1 April 2011 are listed below, with the court their business has transferred to in brackets:

- Guisborough Magistrates' Court (Teesside Magistrates' Court)
- Houghton le Spring Magistrates' Court (Sunderland Magistrates' Court)
- Tyndale Magistrates' Court (South East Northumberland Magistrates' Court)
- Blaydon Magistrates' Court (Gateshead Magistrate's Court)
- Bishop Auckland Magistrates' Court (Newton Aycliffe Magistrates for admin and hearings to be held at Darlington Magistrates' Court and Newton Aycliffe Magistrates' Court)
- Alnwick Magistrates' Court (Newcastle upon Tyne Magistrates' Court and Newcastle Combined Court)
- Gosforth Magistrates' Court (Newcastle upon Tyne Magistrates' Court)

The remaining Magistrates' courts are:

- Berwick upon Tweed Magistrates' Court
- Gateshead Magistrates' Court
- Chester-le-Street Magistrates' Court
- Consett Magistrates' Court

- Newcastle Upon Tyne Magistrates' Court
- North Tyneside Magistrates' Court
- South East Northumberland Magistrates' Court (Bedlington)
- South Tyneside Magistrates' Court
- Sunderland Magistrates' Court

- Darlington Magistrates' Court
- Durham Magistrates' Court
- Hartlepool Magistrates' Court
- Newton Aycliffe Magistrates' Court
- Peterlee Magistrates' Court
- Teesside Magistrates' Court

Figure 6.3 shows the number of people sentenced by Magistrates' courts in the North East in 2010, as well as showing the CJLD coverage at each court.

Figure 6.3 - Sentencing Figures for Magistrates' Courts, 2010			
Police force area	Magistrates' Court*	Total sentenced***	CJLD coverage
Cleveland	Hartlepool	3492	Cleveland, Durham & Darlington (TEWV)
	Teeside	11792	
	Guisebrough [Teeside]	1339	
Durham	North Durham courts	5523	
	South Durham Courts	6447	
Northumbria	Berwick	355	Bedlington
	South East Northumberland	3840	
	Tynedale [Berwick & South East Northumberland]	2126	Court Closed
	Newcastle	12601	Newcastle
	Alnwick [Newcastle]	475	Court Closed
	Gateshead	7264	Gateshead
	North Tyneside	5014	North Tyneside
	South Tyneside	4174	South Tyneside
	Sunderland	7100	No service
	Houghton-le-spring [Sunderland Mag Court]	340	Court Closed

* Courts that have closed since the statistics were released show the court to which their business has been transferred in brackets.

** MOJ sentencing statistics provide a combined total for North Durham and South Durham Magistrates' courts

*** Based on MOJ statistics released 2010. Source: http://open.justice.gov.uk/sentencing/, accessed 15.02.12

The Big Diversion Project focuses around the Magistrates' Courts in the region. However, there are also three Crown Courts in the North East which deal with more serious offences that have been referred on by Magistrates' courts:

- Durham Crown Court
- Newcastle Upon Tyne Crown Court (at Newcastle-upon-Tyne Combined Court Centre)
- Teesside Crown Court (at Teesside Combined Court Centre)

A specialist Drugs Court has also been set up in Newcastle to sentence criminals convicted of drug related offences. The court deals with defendants who commit low level, non-violent, drug related crime. Specially trained magistrates and/or a district judge sit every week to deal with the sentencing of these cases. They also review cases where a community order or suspended sentence supervision

order has been made with a Drugs Rehabilitation Requirement (DRR). Reviews are held every six weeks until the end of the order.[10]

There are also a number of Specialist Domestic Violence Courts in the North East. The Specialist Domestic Violence Court (SDVC) programme has been running nationally since 2005 and there are now 127 courts, across the country. Since April 2010, Local Criminal Justice Boards (LCJBs) have responsibility for the governance and performance management aspects of SDVCs in their area.

- Teeside SDVC
- Durham SDVC
- Gateshead SDVC
- Sunderland SDVC
- Newcastle upon Tyne SDVC
- North Tyneside SDVC

6.2b Overview of agencies operating within courts and role in diversion

Her Majesty's Courts and Tribunals Service (HMCTS)

Her Majesty's Courts and Tribunals Service (HMCTS) was formed in April 2011 after the merger of the existing Court Service and the Tribunals Service. HMCTS is made up of seven regions nationally. The North East region covers the force areas of Northumbria, Durham and Cleveland, as well as Yorkshire which is not included in this project.

A staff lawyer working for the service has been identified to provide specialist mental health support to the courts in the region; who as well as undertaking work nationally with the Department of Health takes on complex mental health cases in the region and acts as an ambassador to the rest of the courts.

Crown Prosecution Service (CPS)

The Crown Prosecution Service was set up in 1986 to prosecute criminal cases investigated by the police in England and Wales. CPS North East is headed by Chief Crown Prosecutor (CCP) Wendy Williams, and covers all three police forces in the North East region.

In fulfilling its role, CPS (2012) North East:

- Advises police forces in Northumbria, Durham and Cleveland on cases for possible prosecution
- Reviews cases submitted by the police for prosecution
- Determines the charge in all serious cases
- Prepares cases for court
- Presents those cases at court.

The CPS also works closely with witness and victim support agencies, the police, courts, probation services and youth offending teams.

Probation

The North East region is covered by two probation trusts. Northumbria Probation Trust is coterminous with Northumbria police and NTW mental health trust, and Durham Tees Valley Probation Trust covers Durham and Cleveland police forces and much of the TEWV area (excluding North Yorkshire).

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[10] http://www.northumbrialcjb.org.uk/your-area/newcastle, accessed 06.03.12

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Both probation trusts provide advice around sentencing in court, including producing the pre-sentence report or verbally reporting to court. They also provide advice around suitable bail arrangements for those remanded on bail (including approved premises) and act as the prosecutor when an offender returns to court for breach of an order.

GEOamey

GEOamey are an independent provider who currently provide the custody staff for the cell areas beneath the courts, as well as movements around the custodial and court estate.

6.3 Key issues for the North East

6.3a Strengthening sources of information to the courts

Information on an individual's health and social care needs is vital to appropriate decisions being made in court. Identification of mental illness or learning disability in an offender raises issues around the fitness of the individual to plead and stand trial. This information is also important to remand decisions and sentencing options.

The court and professionals operating within the court were reliant on a limited number of sources of information regarding the defendant's health and social care needs. As discussed in Chapter 5, many of the courts in the region are not covered by CJLD teams and even where they are services usually focused on managing immediate risk within the court cells rather than on providing information to the courts. Details of CJLD coverage across the Magistrates' courts in the region can be found in figures 5.1 and 6.3.

Consequently, much of the pre-sentence information provided to the court came from either the prosecution (who usually received their information from the police) or the defence (who usually received their information from the defendant). For those defendants who had been held in the cells below the court (often called 'the Bridewell') information could also occasionally be provided by GEOamey custody staff who may have received information from the CJLD service (where available) or from the Prisoner Escort Record (PER) that provides risk information from the police or any prison that they may have been held in.

Post-sentence information is provided to the court by probation who might provide a verbal, Fast Delivery or in some cases full (Standard Delivery) pre-sentence report. However it was emphasised that this information was arriving very late in the court process when thinking about opportunities for diversion; "*Oh you would hope that we were aware of it [mental health problem / learning disability] before you got to the sentencing phase.*"

There were concerns that the sources of information that did exist were indirect and often incomplete. It was suggested that defendants could withhold information due to concerns regarding stigma or negatively impacting the outcome of the case. Similarly, although the defence were frequently perceived as a good source of information by probation staff, legal advisors and prosecutors alike, many of those interviewed cited concern that this information was often biased in that information was only passed on when it was preferable to the defence. In particular there were concerns that psychiatric reports commissioned by the defence were only made available if they supported the defence.

> *"Another source of information is defence solicitors who if they had a background to a particular offender, they are a really good source of information. If it's helpful to the defendant, they will tell us,*

Probation often receive information from a much wider range of sources than other professionals operating in the court but only if there is an adjournment for a full (Standard Delivery) pre-sentence report and such reports might not be requested by Magistrates. For example, the report writer may seek information from any medical professional involved in an offender's case. However, our survey indicates that the most commonly reported sources of information regarding mental health needs and learning disabilities remain the offender themselves, previous OASys and pre-sentence reports and their own observations, although the offender's support worker in the community was also reported as a source of information by 58.3% of respondents (49 of 84 who responded to the question, excluding those who responded to say that they did not write these reports). One Deputy

Figure- 6.4

When writing pre-sentence and fast delivery reports, where do you find out information about an offender's mental health problems and/or learning disability? (you may select more than one option)
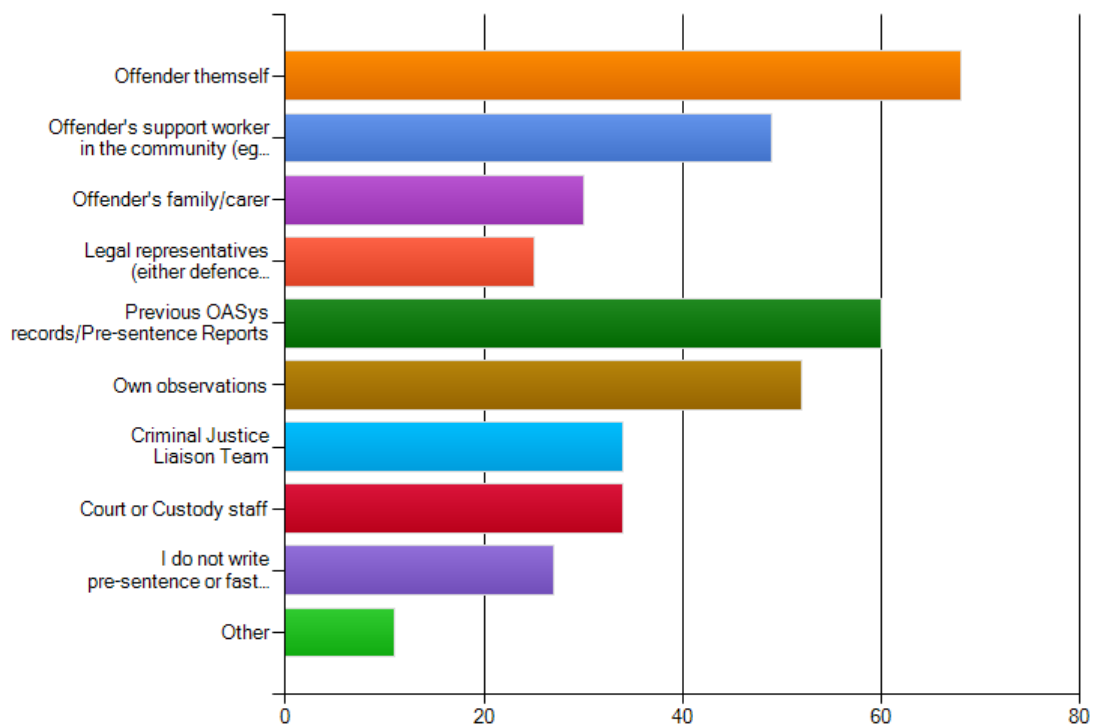
Justice Clerk surveyed also questioned whether it was appropriate that they were reliant on professionals untrained in mental health to provide the courts with health information.

It was suggested that the lack of immediate verified health information in courts resulted in adjournments for what were ultimately unnecessary psychiatric reports:

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Deputy Judicial Clerks surveyed expressed a near-unanimous desire for the presence of a mental health professional in court who could identify mental health issues and provide immediate advice and support to the court. In addition, a number of those interviewed requested written nursing reports that were made available to all parties in the process. Although it was understood that these reports could not make a decision regarding issues such as fitness to plead, it was felt that they could provide an indicator as to whether or not a full report was necessary.

"I mean there will be a cost benefit generally because for every psychiatric report that the diversion officer saves, I mean that's about a grand in time, I think, that we pay for psychiatric reports. So not only are we potentially saving money, but we are getting people on orders more quickly, and that's better for reducing re-offending and protecting victims."

One national expert reported that in London, mental health practitioners based at courts triaged all requests for psychiatric reports to advise the court as to whether such a report would be necessary. It was suggested that this had yielded a reduction in psychiatric report requests of between one third and two thirds.

It was acknowledged that having a mental health professional based in a court full time was very difficult, particularly in very rural areas. However, it was suggested that having a phone number to call for advice and, if necessary, a professional call-out would be helpful. It should be noted that such a number does already exist in the South Durham area (for the Cleveland, Durham & Darlington CJLD service) but there appeared to be confusion among some court staff surveyed about this provision and what they could expect from this service. Certainly the management of this team have specified that clients held in police custody will be prioritised. It was reported that a number of court staff across the region expressed their concern about coming second to police stations in terms of CJLD coverage. It was highlighted that police stations already had on-call access to Forensic Medical Examiners as well as custody nurses in some areas. In contrast courts had no provision and yet were making critical decisions about someone's liberty.

6.3b Identifying need in defendants on bail or on summons

A number of the Deputy Justice Clerk's surveyed in the region highlighted that there was absolutely no provision for identifying and informing the court of the mental health needs or learning disability of a defendant who appears in court on a summons or on bail. This is because the focus of all the CJLD provision in the region is on those clients who are being held in police custody or in the cells attached to the court. However, many defendants were not held in either of these places or if they were might only be held for a short period, at a time when there was no CJLD service in operation.

Highly infrequently information was provided to the court from a source such as the defendant's carer or support worker if the client had asked them to attend with them. However from responses to a survey of (Deputy) Justice Clerks this appeared to be rare.

One senior stakeholder highlighted that severe mental illness or learning disability was not confined to those who had committed serious offences and might be held in custody. The stakeholder reported one incident where a man who was experiencing severe psychotic symptoms appeared at court to respond to a speeding charge. In the relatively informal environment in which such cases are held he was in close quarters with a range of court staff to which he in fact presented quite a high risk.

6.3c Reducing delays without reducing fairness of outcomes

A significant concern for courts is processing cases as quickly as possible. Nationally there has been a drive to increase the speed with which justice is done without reducing the fairness of the outcomes, notably through the Simple, Speedy, Summary Justice (SSSJ) initiative introduced under the previous government which among other proposals included changes to deal with appropriate (low-level) offences in the Magistrates' Court in the immediate aftermath of the commission of the offence. This emphasis has continued under the current government, with a focus on earlier resolution of cases and fewer delays and adjournments in the green paper *Breaking the Cycle.*

In some ways this has advantages for both victims and offenders. However, one national expert highlighted that the speed of the process could be a barrier to appropriately identifying to and responding to needs;

> *"There's a sort of barrier, and it's one about speed. I'm talking about the speed of the process. Point of arrest through to magistrate's courts is very fast….in the courts, things can get rushed through. People's symptoms aren't always obvious, so the speed at which the process moves can be a problem."*

One service user described the experience of the Magistrates' Court:

> *"Court you just get rushed through. The idea is to get you in and out of the door…you just get rushed out and into prison"*

Where possible, courts wish to avoid any delays to the court process, including adjournments for reports, whether they are from medical professionals or probation. In the case of probation reports to inform sentencing, there has been a move towards Fast Delivery Reports which can be turned around for the court on that day, rather than for full (Standard Delivery) pre-sentence reports that take fifteen days and which may allow discussion with other professionals involved in an offender's care. Durham and Tees Valley Probation Trust reportedly underwent a large review of all probation court services and is now working to ensure an appropriate balance between intensive reports and short reports on the day.

However, while it is clearly desirable for the purposes of 'speedy justice', an inevitable consequence of this shift towards Fast Delivery Reports is that there is a reduced opportunity to identify need and the court is provided with less detailed information from a more limited range of sources:

> *"[For] a full pre-sentence report or standard delivery report a court will adjourn, for 2-3 weeks for that to happen. But given the nature of most women's offending, it's not classed as serious, they tend to operate a fast-delivery report, which doesn't even begin to scrape the surface as to why somebody's re-offending, or the risk to themselves, or the risk to anybody else."*

> *"It's not easy for staff at court [to identify mental health and learning disabilities]. They've got to work to very quick timescales, increasingly so as across the criminal justice system we try and move to faster, on the day reports."*

Even where CJLD services were present in court there was only limited opportunity within these tight timeframes to talk to one another;

> *"Health have people into courts, we [probation] have people in courts – they don't get time to talk to each other."*

A senior stakeholder interviewed as part of the analysis suggested that in the Northumbria area 70% of court reports are undertaken on the day or within five days (this figure has not been independently verified). The stakeholder highlighted that there was already a lot to do within this time period already and that this needs to be kept in mind when considering adding validated screen for either mental health problems or learning disabilities into this process.

A basic screening is undertaken to determine whether or not a full report is necessary. This includes some basic questions around mental health and where significant issues were detected then it was suggested that an adjournment was likely to be sought since frequently it proved impossible to get immediate responses to requests for information from healthcare professionals:

> *"Well they will interview the individual, if the individual tells them, you know, I'm in touch with so-and-so doctor or this psychiatrist, then they may well pick up the telephone and try to seek further information. I guess they will come up against barriers of patient confidentiality then because the speed at which they will need that information in court, they probably won't have time to send a written request. Well, we'll get the offender to sign something to say yes they agree to us asking for information, but whether that can all happen quickly enough on the day at court is another matter."*

Adjournments for further information or for full psychiatric reports (which were reported to involve multiple adjournments) could add lengthy delays into the process that were not welcomed by the courts or any victims involved in the case. It was highlighted by one interviewee that current systems work best for those who are already known to services for who information regarding need already exists as well as potentially an existing package of care:

> *"Perversely [it works best] in some senses, where the client is known to the Youth Offending Service or the probation service, where police – you might have somebody who's at risk and has not offended – but they're known to services and services are able to pull in some expert advice and comment. When they suddenly pop up in court and everybody thinks they have a mental health problem or a learning disability, that's where it works worst."*

For individuals who are unknown to services, stakeholders wanted access to assessment that is quick enough to fit the court process. This was identified as a particular challenge for learning disabilities where the process of identification is a lengthy one and there appears to be no easy-to-use screening tool that has been universally accepted.

6.3d Improving current processes for obtaining formal psychiatric reports

The results of the surveys of probation staff and Deputy Judicial Clerks as well as the interviews with senior stakeholders, all identified clear discontent with current practice around the provision of formal psychiatric reports to the courts. One senior stakeholder went as far as saying that *"provision of specialist reports to court is the biggest area that needs addressing"* across the criminal justice pathway.

Concerns focused around a number of key areas: finding a psychiatrist willing to produce the report within the statutory cost restrictions; the time taken to complete these reports; the communication between probation and court authors regarding the content of the report and potential sentencing implications; and the quality and relevance of these reports.

Available funding

Funding for psychiatric court reports is provided from central court funds or alternatively through the Legal Services Commission when requested by the defence and some respondents suggested that wrangling between the two agencies regarding who was to provide the funds was a problem. A more significant problem appeared to be that the funding that is available for the purchase of psychiatric reports for the courts is determined by the Cost in Criminal Cases (General Regulations) 1986. Considerable difficulties finding a psychiatrist willing to do this within the costs allowed was identified by the majority of the Judicial Clerks and Deputy Judicial Clerks surveyed as part of this analysis. Refusals by psychiatrists to take up this work delayed the process and increased the workload for those involved in the commissioning of the report.

It was suggested that a list of those willing to produce a report within the cost restrictions was required, possibly one managed by a rota psychiatrist for ease of process. One stakeholder also suggested that some areas were paying more for this service than allowed under the statutory directions and suggested that this was an area for further exploration.

Timing concerns

Interviewees from a range of agencies expressed their concerns regarding delays, psychiatrists' failure to meet imposed deadlines and resulting adjournments to the case. As one senior stakeholder from the Crown Prosecution Service reports;

> *"We sometimes have cases that can be adjourned week after week after week after week after week after week after week trying to get the psychiatric reports through. And then once they are served on the prosecution, the prosecution then need to, in most circumstances, to then serve them on their own psychiatric expert. So it can take a long time to get a final stage in relation to psychiatric evidence."*

During adjournments, defendants could be remanded in prison, to hospital or released on bail. Concerns were expressed by national and regional experts that during the wait for the psychiatric report to be completed a vulnerable person was being held in custody or alternatively a hospital space was being occupied inappropriately.

Except for one area (Sunderland) where it was reported that psychiatric court reports were simply not being requested, all of the Deputy Judicial Clerks and Judicial Clerks surveyed across the region responded to say that they were either dissatisfied or very dissatisfied with the time that it takes for the delivery of a formal psychiatric report to the court. Similarly, of the 131 probation staff across the two Probation Trusts who responded to our probation survey (excluding the 64 who responded to say that the question was not applicable to them and the 20 who did not answer the question), 55% (72) reported that they were either fairly or very unsatisfied with the time taken between the commissioning of a psychiatric court report and its return to them, with only 15% (19) reporting that they were either fairly or very satisfied.

Figure- 6.5

How satisfied are you with the time taken between the commissioning of a psychiatric court report and it's return to you?
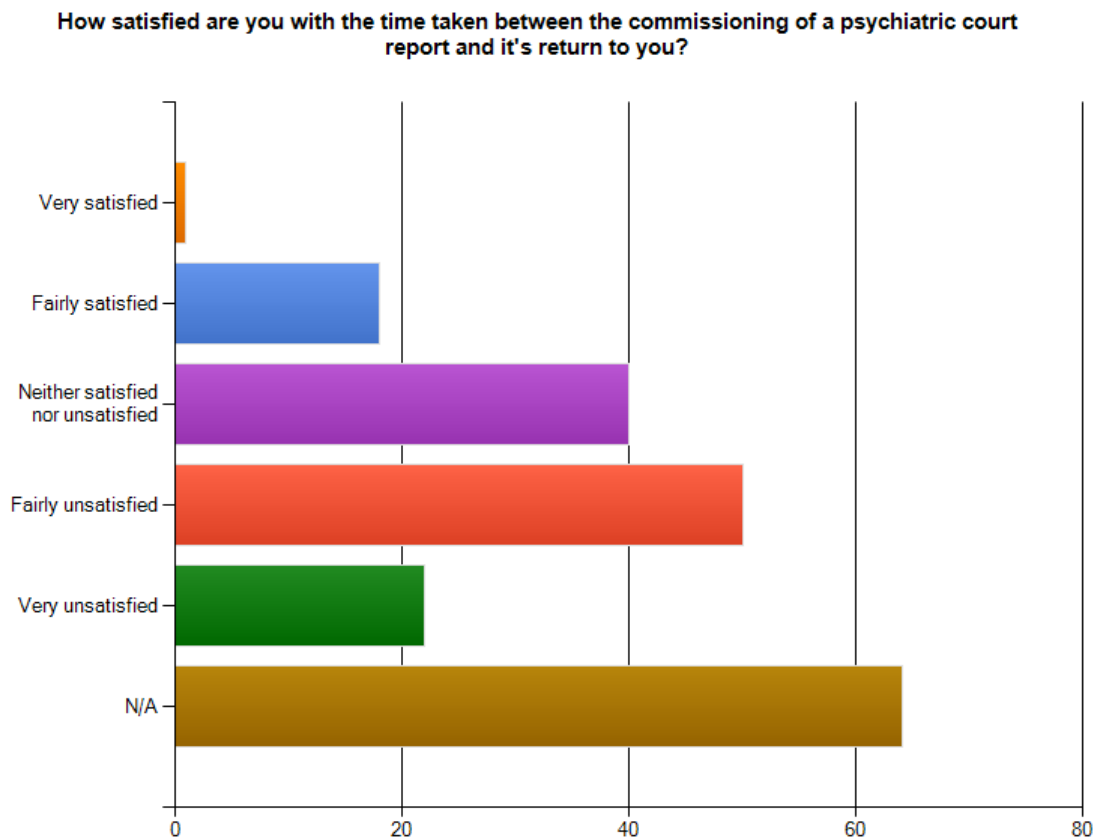
Of 82 open responses to a request for comments regarding current processed, half expressed concerns regarding timing issues. It was suggested that a dedicated team of psychiatrists was required who could manage and internally allocate requests for reports so that they were completed within the required timescales.

As well as general concerns regarding delays and adjournments, free-flow survey responses highlighted that a central concern for probation staff was around the mismatch between the deadline for the completion of the pre-sentence report and the deadline for the psychiatric report. A common complaint was that pre-sentence reports were simply unavailable to probation at the time of writing their reports unless (and sometimes even if) probation officers repeatedly chased psychiatrists.

One interviewee, a senior stakeholder from probation, echoed these complaints that were repeatedly expressed in survey responses (mentioned in 25 responses):

"I mean our timescales don't correspond. We're asked to advise the court on sentencing and often alongside that the psychiatrist is asked…to do a report. I don't think there are any clear guidelines for psychiatric reports in terms of timescales. So they are not working to consistent timescales as we are. Sometimes that means then we've got 15 days or a set period to write our report in and the psychiatric report isn't ready so, therefore, we haven't got any knowledge to inform our [sentencing] proposal, we don't know if the person has got an assessed need or not. So, yeah, I think there's not a consistent timeframe, that's a barrier."

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Suggestions for improvement focused around setting firm deadlines for the return of reports which still enabled time for probation to consider the report prior to suggesting sentencing options to the court. Another suggestion included having a named psychiatrist to contact but survey respondents generally felt that probation should be sent these reports by psychiatrists as a matter of course.

Communication

The view was expressed in the survey and interviews that concerns over timing could be ameliorated if communication and information sharing was improved between the probation staff member and the psychiatrist undertaking the reports.

> *"In a sense, the probation officer needs to have some communication with the author of the psychiatric assessment to be able to put their proposal to the court. So there are difficulties around that in terms of information sharing. They're not consistently aligned…and there are no clear rules, guidelines…as far as I know – that a psychiatrist has to follow to say, yes actually, you need to inform the probation officer of this."* **(Interviewee)**

> *"Discussion with a psychiatrist after assessment completed in relation to his/her recommendation could speed up process without needing to view full report before sentence."* **(Survey respondent)**

This appears to be a particular concern where the psychiatrist has been commissioned by the defence with reports that psychiatrists were then unwilling to engage in discussion and the defence sometimes unwilling to share (unfavourable) reports.

> *"Solicitors are not always willing to share a report that they commissioned with Probation and this hinders our understanding of the needs of the individual."* **(Survey respondent)**

A number of interviewees and survey respondents suggested that the defence should be mandated to share their psychiatric reports once these have been commissioned, no matter what the findings. This is a national concern but touches on a range of important issues around someone's right to a defence and right not to incriminate oneself.

Given the status quo that defence solicitors can withhold unfavourable psychiatric reports, it is therefore understandable that psychiatrists for the defence may be unwilling to communicate with probation staff in this circumstance. One interviewee suggested that a clearer understanding of each other's roles in the court process on both sides would improve practice around information sharing.

Report quality

A number of the concerns outlined in free-flow responses to the survey (16/82) focused on the quality of the report received and the usefulness of these reports to the court process. The quality of the reports was frequently perceived as variable, with a number of responses highlighting a tendency to repeat the offender's version of events or their personal history that was already available to the court.

> *"Reports take too long to be prepared and are often lengthy, focusing on overall personal history as opposed to points that are/may be pertinent to their mental health."* **(Survey respondent)**

> *"The psychiatric reports themselves need consistency in terms of the depth of analysis – some are quire poor and base most of their assessment on the offender's version of events or the pre-sentence report (if already written)."* **(Survey respondent)**

Another repeated complaint was that these reports failed to consider potential options for moving forward including sentencing and treatment options, although one response disagreed, stating that although the quality was variable these were generally useful for determining treatment options.

> *"Often the conclusions are very "woolly" and do not assist in the sentencing process, i.e. what exactly the person can do or not or what needs to happen next."* **(Survey respondent)**

Alternatively, there was concern that psychiatrists' knowledge of the criminal justice system was in some cases limited or outdated and that psychiatrists might be recommending treatment options that they did not understand. In turn it was suggested that the court was being overly guided by these recommendations:

> *"I think there are some awareness issues that psychiatrists have, for example, they tend to do, I've seen some reports recently, where they use old terminology. So they will refer to a probation order, well we don't use that terminology anymore. So what that suggests to me is that psychiatrists who are writing these reports, how much awareness have they got of the role and what is going to happen next with a community order. So there's a bit of lack of awareness there."* **(Interviewee)**

> *"Report quality varies a great deal. Some are very good. Others merely a transcription of what the offender has said. Psychiatrists should not recommend sentences without fully understanding them."* **(Survey respondent)**

It was suggested that training for psychiatrists on the criminal justice system and risk management might be useful. Several respondents and interviewees wanted clear protocols for report requests which outlined both timeframes and what information was expected to be included within psychiatric reports. Other suggestions for improvement included a list of psychiatrists which included their relevant areas of expertise and a system of recording satisfaction with reports to inform future commissioning decisions. One respondent repeated a view expressed in a number of the interviews, that;

> *"A short assessment by a forensic CPN [is] more helpful than [a] 6 week adjournment for psychiatric report which often just repeats the history you already have."* **(Survey respondent)**

Work is underway currently to ameliorate some of these problems. The Staff Lawyer within the region with special responsibilities around mental health for HMCTS, has developed a draft Service Level Agreement (SLA) regarding the commissioning of psychiatric reports. Discussion is currently underway with the Judicial Clerks around the region regarding the implementation of this SLA in order to identify potential issues, raise awareness and encourage compliance with the SLA following its approval. There are also plans to develop a pro forma letter for the requesting of psychiatric reports so that there is clarity about what is expected. It was suggested that following the Big Diversion Project, consideration could also be given to a similar system for requesting nursing reports from CJLD services, possibly adopting a 'tick-box' approach.

A number of national experts suggested that there need to be a move towards bringing CJLD services and psychiatric services together utilising joint-commissioning so that CJLD services provided both nursing and formal psychiatric reports where required.

Good Practice Example: South West Mental Health Assessment and Advice Pilot

In 2006, the Home Office and HMCS developed a framework encouraging service level agreements (SLAs) to solve problems with psychiatric reports. The South West's bid to pilot the approach was accepted, and Bristol, Portsmouth, Southampton and Winchester Crown Courts, and Bath, Bristol, Fareham, New Forest and Southampton Magistrate's Courts chosen (HMCS and NHS SWOH, 2009, p.8).

The pilot was overseen by a steering group made up of key HMCS and health service officials within the South West. The steering group agreed that the way forward was not only to work on a SLA to give courts access to psychiatrists who would complete reports to agreed timescales, but to consider a whole service to the courts (HMCS and NHS SWOH, 2009, p.21).

As such, the SLA negotiated included an enhanced mental health liaison service that provided a written screening report for all defendants assessed. This broke existing statutory guidance which states that the courts may only pay for written reports by medical practitioners. However, it was agreed the service would be funded by HMCS Courts Innovation Branch central funding (HMCS and NHS SWOH, 2009, p.26).

The mental health professionals' screening report is shared with the court, Crown Prosecution Service, Defence and Probation. Where required, a more detailed report can be requested, including:

- a Health and Social Circumstances report, written by a mental health professional
- a full psychiatric report prepared by a general adult psychiatrist,

It was agreed that a full forensic psychiatric report was reserved for those at Crown Court, charged with more serious offences (HMCS and NHS SWOH, 2009, p.31). Where a full psychiatric report was required, mental health professionals at court would facilitate the report and it would be delivered within 12 weeks (HMCS and NHS SWOH, 2009, p.24).

Under the agreement, the courts commissioned the two mental health service providers in the region to provide a number of court reports. It was then the duty of mental health service provider to find and pay a psychiatrist to produce the reports within agreed timescales (HMCS and NHS SWOH, 2009, p.68).

The pilot achieved:

- A reduction by 55% in the number of psychiatric reports
- An increase in the identification of the number of defendants with mental health issues
- A reduction in the amount of time courts and defendants wait for mental health advice – the median number of days to disposal has reduced from 54 to 15.

Although this pilot offered a good model for improving processes around psychiatric reports, stakeholders in the North East highlighted difficulties associated with the transference of this model including existing statute, the need for NHS Trusts to renegotiate contracts of employment with psychiatrists, sensitivities around the perceived reduction of private work for psychiatrists and concerns around objectivity. Work is being undertaken nationally to see how the work from this pilot might be mainstreamed nationally.

6.3e Increasing engagement with the court process

A number of interviewees at both a national and a local level identified the need to recognise how conditions such as mental health problems and learning disabilities might impact upon the defendant's engagement with the court process and to support defendant's to maximise this engagement. National experts reported that conditions such as a learning disability can mean that the defendant has little understanding of the court process and might result in the defendant incriminating themselves (even where they may not have committed the offence).

One regional stakeholder echoed national experts in highlighting that adaptations to the process were perfectly possible as long as courts were made aware of what the problems were and equipped with the knowledge and tools to make the necessary adaptations;

> *"Even if it's as basic as – you might need to approach this differently; you might need to speak to the defendant differently; you might need to explain bail differently…If you got some information [that] he's got learning disabilities, perfectly understands that what he did is wrong, there's no reason why he shouldn't come through the courts, but you're going to have to take a bit more time, or, you know, it's not rocket science."*

A couple of interviewees suggested that a tailored approach was already being taken but only where there was a severe learning disability that is easy for a lay person to identify, and only using common sense (rather than expert-informed) adaptations.

One stakeholder proposed starting an Easy Read pilot for bail forms to assist those with learning disabilities and difficulties who are at a significant disadvantage going through the justice system:

> *"[A bail form] will give a lot of conditions and people can't read it. I mean you can't read the form anyway, but also it might say you're not coming to this court you're going to another court, there again I don't know where that is and I can't read a bus timetable. And also you've got to stay in the house between 10 o'clock and 8 o'clock, but I can't tell the time. And also, you've got to be within this postal area, and that's really quite a complicated thing. Also you've got to have a curfew and a tag, I've got to wait for someone to come in, I don't know the time, I don't know when they are coming. I mean, we're putting all of these on but if you breach that bail and you're brought back before the cells and you're no longer entitled to bail legally, so you're more likely to be remanded into custody."*

It was highlighted by one interviewee that even if they have reasonable literacy and numeracy, someone who is new to the court process and the criminal justice system more generally might struggle with the range of new language that accompanies this process. There are therefore strong arguments for such a pilot to be considered moving forward.

Another concern when thinking about how to maximise engagement with the court process is that, while the Police and Criminal Evidence (PACE) Act 1984 includes a statutory obligation for vulnerable adults to be supported through the police custody and interview process by an appropriate adult, there is no corresponding requirement to provide support for vulnerable adults once they are in court. One national expert explained;

> *"At the moment, [vulnerable defendants] don't have access to registered intermediaries, which witnesses and victims do…they have no right to any support during the process. And therefore, they may or may not have their vulnerability identified in terms of difficulty with communication and understanding and so on. But even if they do, there is nobody necessarily available to support*

them…it's a real, real gap…they may well not be supported through a trial, and the outcome would be different if they were provided with a support."

Without such a support, or without a CJLD practitioner with a strong understanding of conditions such as learning disabilities and autism, as well as mental health, it was felt that the defence case could be damaged:

"It's all of the defences…to do with autism that are not coming through. Especially when they don't appear mentally ill or learning disabled. They can be very able, you know, nobody would guess that they've got a problem. So [they are asked]…Did you have those drugs in your pocket? Yeah I did. But [what they don't say is that] someone else actually put them in there, so it's things like that. So I think autism is one of the big issues."

One example of regional good practice is in place in Middlesbrough where the appropriate adult service in the police station provided by volunteers with Middlesbrough and Stockton Mind has been expanded to include a court support element at Teesside Magistrates' Court. As with the appropriate adult service, Department of Health funding has also been secured so that volunteers are also able to provide follow-up support and signposting to services as well as simply help on the day.

It was also suggested that Magistrates needed awareness training regarding mental health and learning disabilities so that they were not to misinterpret behaviour as disrespectful or even as contempt. It was reported that Magistrates had requested such training but that this had been considered to be a low priority funding-wise.

However, there appeared to be a number of opportunities to provide this training for no cost other than travel, subsistence and making Magistrates available to undertake the training. The HMCTS' Staff Lawyer with a special interest in mental health might be able to provide the training. Additionally one Magistrate had previously utilised existing professional contacts to arrange training for Magistrates in North Tyneside around mental ill-health and learning disabilities to be provided on a voluntary basis. Unfortunately this never took place as another training need which was perceived to be more urgent had taken precedence. While it was acknowledged that it may be appropriate that other training takes priority, it was a matter of concern that no training on mental health/learning disabilities had yet taken place.

As well as training for all Magistrates, a number of interviewees suggested the training of a specialist bench for those with mental health problems, as for youth in North Tyneside. Although this is one option for development there is a concern about de-skilling other members of the Magistracy.

As with Magistrates, it was clear that their legal advisors would also benefit from training around mental health awareness. This had previously been provided to those at Gateshead and Bedlington following a request; however frequent team changes meant that it was unclear how many of those with expertise remained within those courts. There had however been the introduction of the post of a specialist legal advisor to undertake all complex mental health cases in the Magistrates' Court and to be a source of expertise for the other advisors to turn to. This was seen as a positive development, although judicial clerks surveyed highlighted that mental health awareness training was still needed to respond to first appearances before complex problems became apparent.

6.3f Increasing awareness of impact and alternative options for sentencing

Even where mental health problems and learning disabilities were identified, interviewees from both community and prison-based services repeatedly expressed their concern about people being sentenced to imprisonment due to a lack of understanding about community alternatives. One Magistrate who worked across both the youth and adult benches outlined these concerns;

> "I know for example as a Magistrate we could sentence someone [with a drug problem] to an auxiliary order and send them for a drug treatment order. I have to admit, maybe I'm just guilty, of not knowing what I could do [for a mental health problem] – I guess I could detain somebody under the Mental Health Act but I've never, ever done that in 19 years and I'm not too sure what below that [level of intervention] I could do."

Frequently interviewees highlighted a misplaced belief among Magistrates that a period of imprisonment would enable them to get support without consideration being given to the damaging impact of imprisonment on mental health conditions;

> "I would like to see people not going to prison by default. There are still people going there because on the day it seems safest place for them."

> "It just annoys me the way that sometimes prison seems a good protective place for women to go to sort out their problems. But being in prison is just a damaging experience for people; whatever positives can be gleaned are good, but it's not a positive experience."

The view was expressed by a number interviewees that it was important to make Magistrates aware of the impact of imprisonment as well as the lack of support available in prison to those serving short-term prison sentences. However, a risk of further up-tariffing was highlighted if Magistrates increase sentence lengths so that some rehabilitative work can be undertaken.

Considered often equally damaging was the problem of Magistrates inappropriately down-tariffing sentences so that informal diversion was put in place without sufficient consideration of the likelihood of re-offending and changing behaviour. Those with expertise in learning disabilities throughout our consultation highlighted the dangers of not challenging inappropriate behaviour by these groups and their concerns were borne out by one interviewee discussing a recent case:

> "The last time I saw someone with a straightforward adult learning disability. And what do we do? I remember, we take sympathy and gave them an absolute discharge, pat them on the head and send them off. That's not exactly going to help them."

Alternatively, where Magistrates sought more constructive solutions such as community orders, interviewees expressed concerns that orders were being put in place with which people were incapable of complying with precisely because of their condition, thus setting them up to fail. Again the Magistrate outlines the difficulty of such a situation;

> "Another classic is you get told – you want to send someone to a community sentence and you're thinking 'unpaid work, that's what that individual needs to do' – and then somebody pops their hand up in the back of the court and says, 'Sorry Sir he can't do unpaid work because he's suffering from depression.' So what do we do? Do we send him to prison because he can't do the unpaid work? Or do we just let him off with a straightforward community order, no requirements. It's a mess."

There were also concerns that some requirements of community orders, such as a curfew, might also have negative implications on mental health conditions. It was felt that Magistrates needed to have sufficient understanding of the impact of how health conditions, offending and sentencing

options were likely to interplay so that they could sentence appropriately. A strong argument was made by experts for CJLD-led training for Magistrates on mental health awareness; this had proved highly successful with a supportive reaction from Magistrates where it had been introduced elsewhere.

Considerable work had been undertaken by the WOW! project in Newcastle to raise awareness among sentencers of these issues and to encourage the use of community alternatives for women, for whom particular concerns were expressed regarding up-tariffing. However, this work by WOW! has so far been limited to Newcastle and is women-specific as opposed to focusing more broadly on offenders with mental health problems and/or learning disabilities.

6.3g Clarifying processes around Mental Health Treatment Requirements

One of the potential community alternatives for an offender with a mental health problem or a learning disability is a community order with a Mental Health Treatment Requirement attached. Low use of the requirements nationally is mirrored locally, particularly in Durham and Tees Valley Probation Trust's area which at a snapshot had only 11 offenders subject to such requirements on its books, compared to 67 in Northumbria (data provided by interviewees). (Deputy) Judicial Clerks surveyed reported both low awareness and infrequent use of these orders.

Magistrates and legal advisors are frequently guided by probation recommendations but our survey of probation staff across the two Probation Trusts in the region found that for the majority of probation staff making recommendations to court, these were not routinely considered when weighing up potential sentencing options for offenders with a mental health problem.

Of the probation staff who responded to the survey undertaken for this analysis (excluding those who skipped the question (24) or responded to say that they did not have responsibility for making recommendations to court (64)), 72% (91/127) said that they would infrequently or never consider recommending a Mental Health Treatment Requirement to the courts for defendants with a mental health problem or learning disability.

Figure- 6.6

For defendants with a mental health problem or learning disability, how often do you consider recommending a Mental Health Treatment Requirement to the courts?
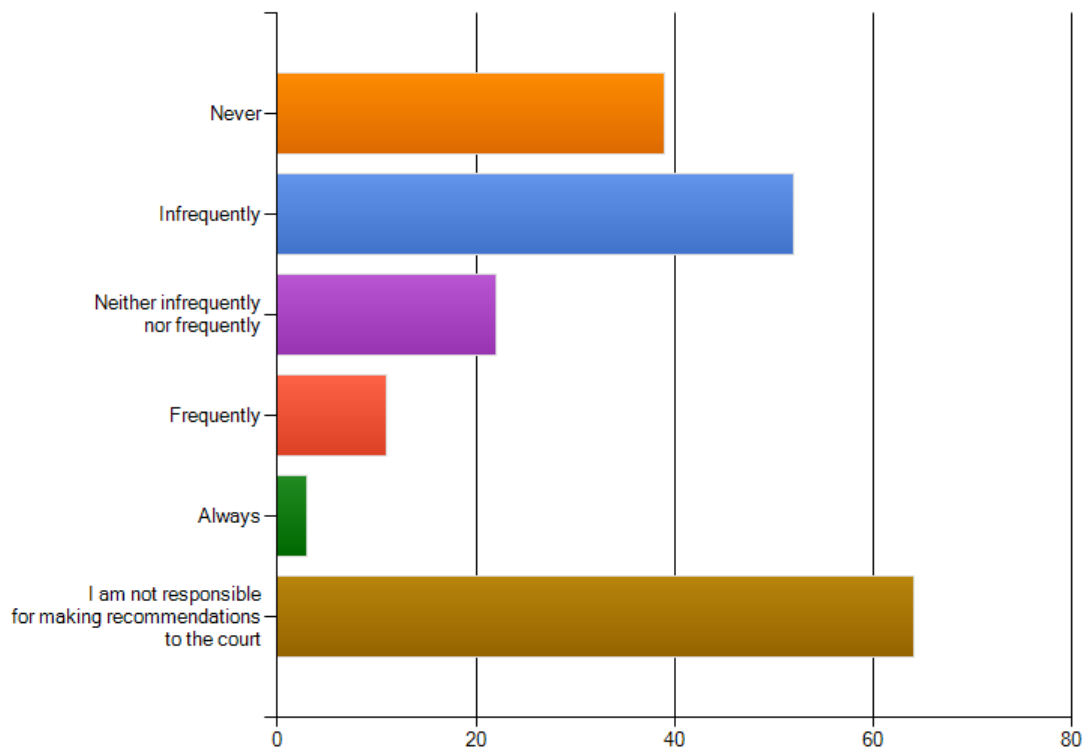
A range of barriers to the recommendation of such orders were reported by the probation staff surveyed. The most commonly reported barriers were uncertainty over which mental health conditions it may be appropriate for (73); followed by difficulties associated with obtaining psychiatric reports (65); followed by unfamiliarity of procedures associated with Mental Health Treatment Requirements in general (63).

Figure- 6.7

What do you feel is the greatest barrier(s) to you recommending Mental Health Treatment Requirements more frequently? (you may select more than one answer)
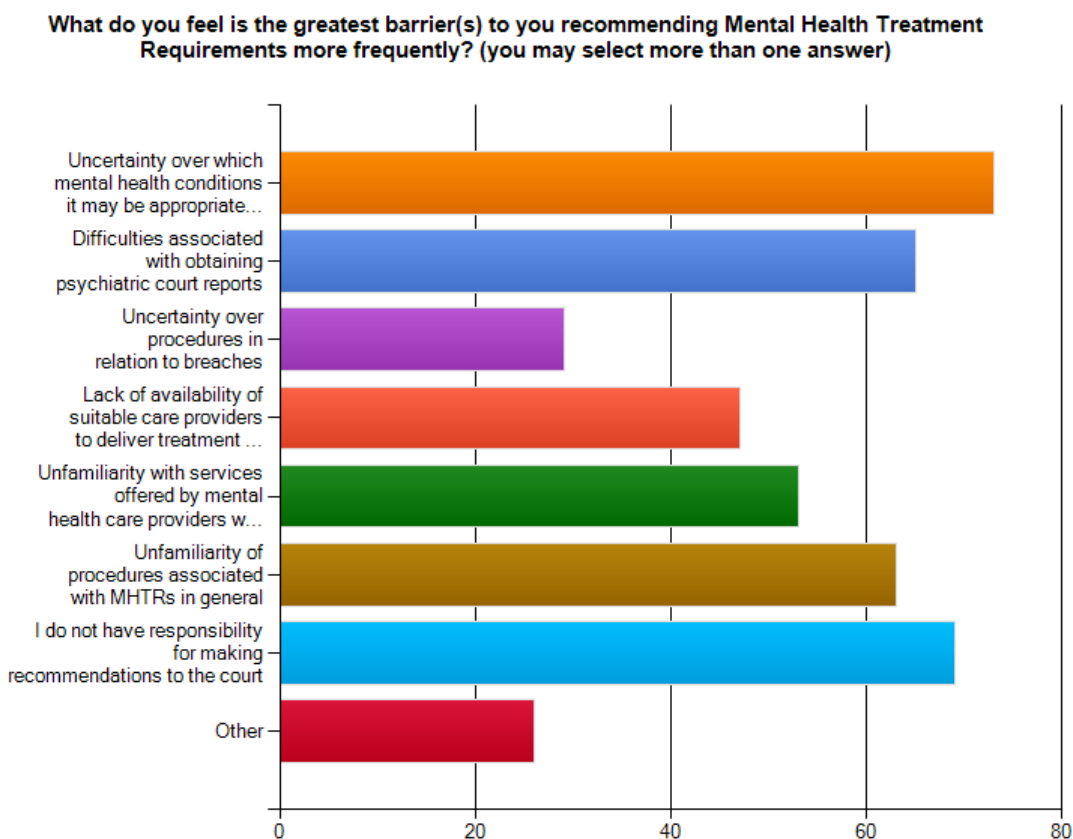
In addition to those barriers specifically asked about in the survey, a small number of respondents identified barriers around the difficulties getting treatment into place in time, including obtaining the consent of a named mental health professional to accept responsibility for the treatment. One senior stakeholder interviewed for this analysis also expressed concerned regarding the length of time taken for treatment to be organised and commenced;

> *"We know getting people into treatment quickly is a priority…I'm aware there are some gaps between at point of sentence and the first appointment with the psychiatrist. A case I looked at this morning, for example, that was [three months] before the first appointment had been made. I mean that is somebody who had been through the court process which had obviously taken some time anyway. And then [he] doesn't get to see the psychiatrist as part of the MHTR [for three months] which is by no means ideal when you are working with someone who has got an obviously treatable mental health issue and has consented to having some treatment for it."*

The survey of probation also identified significant lack of knowledge around making, operating and enforcing a Mental Health Treatment Requirement (MHTR) among the probation staff who responded. Of those who responded (excluding those who skipped the question or responded to say that the question was not applicable to them), 51% (91/178) responded that they were fairly or very unknowledgeable in making a MHTR; 56% (100/179) in operating a MHTR; and 63% (113/179) in enforcing a MHTR. The survey results suggest that – while knowledge-levels appear to be low among staff at both Probation Trusts – knowledge levels around MHTRs may be lower among staff

from Durham and Tees Valley Probation Trust than those from Northumbria Probation Trust particularly around their operation and enforcement.[11]

Figure- 6.8

How would you rate your knowledge of Mental Health Treatment Requirements (MHTR), in the following areas?
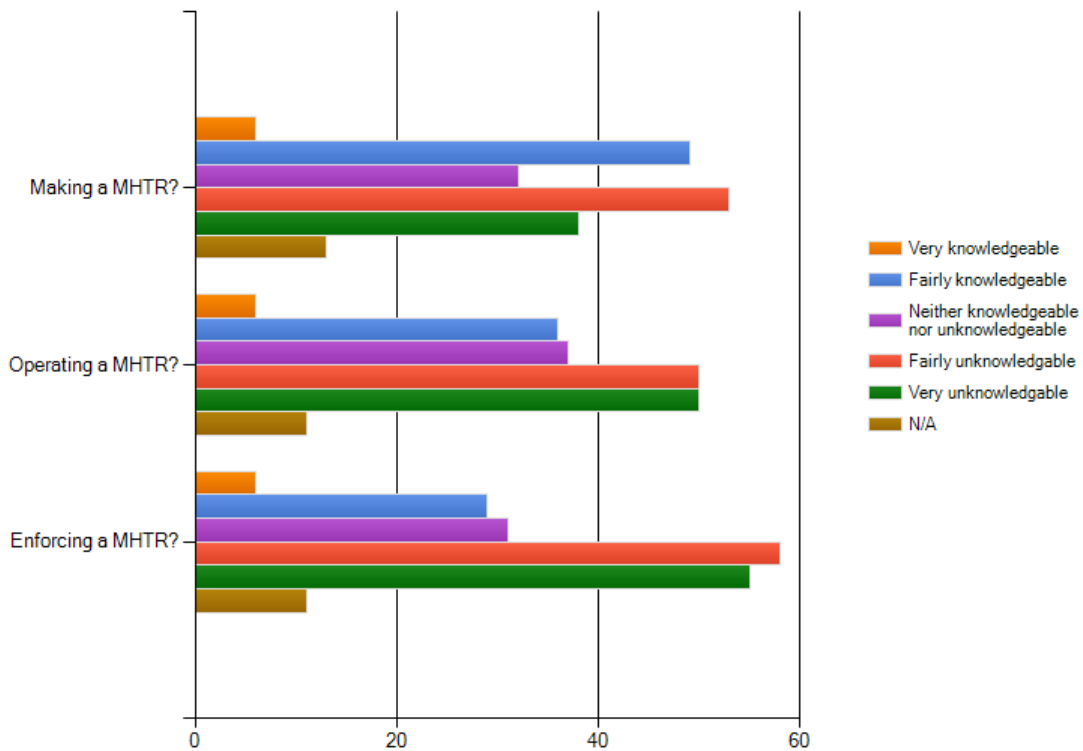
Senior stakeholders interviewed outlined a number of the difficulties around enforcing such a requirement, in particular encouraging psychiatrists to engage in the breach process:

"I guess, from a psychiatrist's point of view, one of the things they will be concerned about is patient confidentiality and how much they can say to us. But if we manage the community order as we do other orders, you know, part of the sentence plan that the offender buys into at the beginning, or he's involved in drawing up, even if they don't agree to it. What they know is, as part of this community order, you have to comply with the mental health requirement. If you don't comply with it, I have to manage that and I have to potentially take your matter back to court and they will give you a different sentence. So it's actually imperative that psychiatrists pass us information about whether they've maintained contact or they've done, kept the appointments. I guess, what they

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[11] The differences that emerged from the survey may not be representative of actual differences between the two Trusts. However, we received similar numbers of responses from the two Probation Trusts which are roughly the same size. There appears to be a difference in the workforce who responded from the two Trusts, with a more senior section of the workforce responding from Northumbria and far fewer respondents based in prisons (1 in Northumbria, 9 in Durham and Tees Valley). However, the differences remained even when comparing results for staff at a similar level and based within probation offices; although the difference between the two trusts may relate to further differences between the respective samples which we have not been able to identify.

would need to be clear about is what they need to tell us and what they don't need to tell us. And that might make them find it easier to tell us what we do need to know about."

A recent paper written by Ann Attwood, staff lawyer for HMCTS with a special interest in mental health, outlines a number of the legal complexities and challenges around Mental Health Treatment Requirements. It was suggested during our interviews that there may be some work on the horizon nationally to address some of the perceived issues and this should perhaps be borne in mind when any work is being undertaken locally to increase their usage.

6.3h Developing a range of alternatives to custody

Several regional stakeholders questioned whether Mental Health Treatment Requirements were the appropriate response to mental health problems among offenders;

"The decision was made not to have ETE [employment, training and education] requirements because you can't force people to learn. It is ridiculous; Mental Health Treatment Requirements are the same – if they need it they get sectioned in which case they shouldn't be on a community order in the first place; the act is potentially flawed in practice."

"People just don't think of making them. And I wonder if that is something to do with having to get a forensic psychiatrist in to say, yeah it's fine…personally I think if you just had a general treatment requirement and said, we'll see what he needs and then we'll liaise with psychiatry when we need to."

These concerns were supported by national experts. There is likely to be some role for these orders in trying to divert mentally ill offenders out of custody, particularly following the planned abolition of the reliance on section 12 approved doctors for the granting of these orders. One national expert highlighted that like other treatment requirements, the MHTR provided a "useful vehicle" for the delivery of a holistic package of care, but that it was the holistic package of care accompanying the requirement which was crucial to its success.

National experts highlighted the potential for the Specified Activity Requirement to be used as an alternative intervention. One national expert, speaking about the Mental Health Court pilot explained that:

"For some of the less complex mental health needs, we were issuing community orders which contained specific activity requirements that supported offenders to address those mental health needs. So I think it's about looking out of the box a little bit and trying not to make it such a complicated process."

As well as being easier to arrange and implement it was emphasised that unlike the MHTR (which is a medium-higher level order) this intervention is suitable for those who might have complex needs but where the seriousness of their offending is at a lower level. It therefore avoids the risk of up-tariffing some offenders.

This approach is being explored in London as part of their liaison and diversion strategy. Mental health practitioners attached to probation offices and the courts are working with probation to design an activity or intervention that would deal specifically with their symptoms and other problems arising from these.

Another potential approach to develop alternatives to custody is to strengthen existing non-custodial disposals through the provision of support from another agency, such as a volunteer-led

project or other specialist provision in the third sector. This has the advantage that it avoids the risk of up-tariffing since the support could be offered to accompany any disposal, including discharges or fines.

In Newcastle, the WOW! Project provides support to women in the criminal justice system. Through offering a comprehensive package of care to accompany non-custodial disposals, it is hoped that sentencers perceive such disposals as viable sentencing options for women, thus reducing the number of women sentenced to custody. Additionally, WOW! might become involved with a woman post-sentence with the aim of increasing compliance with community orders and reducing imprisonment as a result of breach.

WOW! already have a part-time consultant psychotherapist from NTW who provides support to staff to increase their capacity to work with women with a personality disorder, as well as providing a personality disorder group. They have just received Department of Health funding to develop their therapeutic group work, receive input from the local charity Tyneside Women's Health to run programmes on anxiety, depression, healthy eating and confidence building as well as to second a Band 6 mental health nurse (also from NTW) to the project one day a week to undertake assessments and facilitate access into treatment for these clients. The WOW! Project currently serves the Newcastle area but additional funding to extend the project to Sunderland has also been found. There is other women-specific provision for those in the justice system through the SWAN project in Northumberland (a consortium-approach led by ESCAPE) and REACHES in Teesside but many areas of the region still have no such service.

In offering alternatives to custody for women offenders, WOW! workers attend courts where they are able to quickly develop an offer of support to present to a sentencer. Yet again the view was expressed that there needed to be a mental health practitioner in court that alongside probation could quickly develop an alternative sentencing package that was appropriate for the person's needs:

> *"You need a mental health practitioner to be available there on the day when the magistrate's asking the questions. You almost wouldn't need the mental health treatment requirement if you've got that…. It's about having people willing to quickly pull together a package for sentencing. Because they've got to make a decision within a time frame. You can't be remanding someone for several weeks or whatever, it's inefficient."*

Once again it was argued that the process of assessment needs to fit the timeframes required by the court.

Good Practice Example: The Mental Health Court Pilots

"The Mental Health Court (MHC) pilot was established to explore improvements in policy and practice to support offenders with mental health needs. The pilot sites for the MHCs were at Brighton Magistrates' Court and Stratford Magistrates' Court" (Winstone and Pakes, 2010b, p.1).

Across both courts, the pilot aimed to identify defendants with mental health and/or learning disability issues through screening and assessments, provide the court with information on a defendant's mental health needs, and offer sentencers credible alternatives to custody, including improved use of the Community Order with a supervision requirement or mental health treatment requirement (Winstone and Pakes, 2010b, p.2).

The core model involved the presence at the court of a Mental Health Court Practitioner (MHCP), who would provide the screening and assessment as part of the Mental Health Court Team (MHCT). At Brighton this service was provided by a registered NHS mental health nurse, and in Stratford by a forensic mental health practitioner employed by the charity *Together* (Winstone and Pakes, 2010b, p.2).

The Mental Health Practitioner at both pilots conducted proactive mental health screening. This took place at the charge stage in Brighton, with good local IT links to Brighton police station to flag up mental health needs. The main target for screening and assessment at Stratford was those in court custody (Winstone and Pakes, 2010b, p 8-9). The MHCPs at both courts worked closely with a probation officer within the MHCT in providing advice around the mental health needs of defendants. They informed pre-sentence reports as well as providing mental health information to the courts to support case management (Winston and Pakes, 2010b, p.8-9).

The teams at both Brighton and Stratford had good links into local community pathways, and referred and signposted people identified into services pre and post-sentence (Winstone and Pakes, 2010b, p.9). It is interesting to note that Brighton had much stronger links with the community sector and a broad range of services, where Stratford tended to refer to statutory services (Winstone and Pakes, 2010b, p.18). Where no mental health problem was identified at assessment, but other health and social care needs were present, the defendant/offender was signposted onto appropriate services.

4,000 individuals were screened across the two pilots, with 547 identified to require mental health assessment (Winstone and Pakes, 2010b, p.10). Of the 547 individuals referred and assessed, 492 did not receive a Community Order with a mental health component (Winstone and Pakes, 2010b, p.13). For those that did, both MHCTs provided regular reviews of orders. In Brighton, the team conducted the first review within ten days, then at monthly intervals, then after a period at regular intervals of not longer than 12 weeks (Winstone and Pakes, 2010b, p.9).

The evaluation of the court pilots found that:

- The MHC pilot yielded innovative multi-agency collaborations that addressed needs which probably would have gone unmet
- The use community sentences and MHTRs increased. 55 offenders were given Community Orders with mental health requirements across both courts in 2009
- The holistic support offered by the MHC team pre- and post- sentencing was appreciated by service users interviewed.

Despite these successes, it was reported that the pilot has now ceased due to difficulties in establishing cost effectiveness and the closure of Stratford Magistrates' court as part of national court restructuring.

7
Probation and community orders

KEY ISSUES:

- **What service should CJLD teams provide to probation?**
- **Engaging offenders in community treatment**
- **Improving confidence and competence in working with these groups**
- **Knowing where to access a comprehensive range of community based support**
- **Balancing need to protect confidentiality and to enable effective working**
- **Strengthening partnerships**

7.1 National Picture

In 2010, the government's justice white paper, *Breaking the Cycle: Effective Punishment, Rehabilitation, and Sentencing of Offenders,* appeared to usher in a renewed emphasis on reducing reoffending. This was described as a "rehabilitation revolution", to be achieved through:

- "Probation, police and other local services taking an integrated approach to managing offenders.
- Getting drug dependent offenders off drugs and into recovery
- Getting offenders into jobs and with somewhere to live so that they can pay their own way
- Tackling mental health problems" (MOJ, 2010, p.24).

This emphasis on rehabilitation has stalled somewhat recently, with a more traditional stance on crime evident in the *Legal Aid, Sentencing and Punishment of Offenders Bill* (Clinks, 2011a). Nevertheless, some key themes from *Breaking the Cycle* (MOJ, 2010) remain, and are shaping the context in which the Probation Service operates.

One of the key themes being taken forward is payment by results. *Breaking the Cycle* stated that:

> *"We will move to a new approach where providers are increasingly paid by their results at reducing reoffending"* (Ministry of Justice, 2010, p.10).

This approach continues to be pursued by government in a number of contexts as a means of improving efficiency, cutting costs and promoting a more outcome focused approach. It will involve a big change in the way that Probation Trusts work with, and pay for, other services targeted at reducing reoffending, including the more health focused services that deal with offenders mental health problems. It is not yet clear how services aimed primarily at delivering health outcomes will be paid by their results at reducing reoffending, or how such outcomes will be reliably measured.

A further developing policy emphasis has been the growth of a more integrated approach to offender management and reducing reoffending. It has been increasingly recognised that there is a need for more agencies to be involved to effectively manage offenders. This has recently led to government support for joint commissioning approaches at a strategic level, using payment by results (Ministry of Justice, 2010, p.24). There has also been the more gradual development of integrated approaches to offender management which have been supported and promoted by central government. This began with MAPPA arrangements in 2001, and has grown to include the government's current support for localised Integrated Offender Management (IOM) approaches (see below).

Good Practice Example: Integrated Offender Management

Integrated Offender Management is an overarching framework that encourages a range of partner agencies to come together locally to ensure that the offenders identified as causing the most damage and harm locally are managed in a coordinated way.

A Ministry of Justice evaluation of five IOM pioneer areas (Avon and Somerset, Lancashire, Nottinghamshire, West Midlands and West Yorkshire) found the following characteristics aided good practice (Senior et al, 2011, p.30):

- Close links between operational and strategic leadership
- Robust governance and delivery structures, including clear definitions of the roles and responsibilities of different agencies and agency staff
- Risk and need driven interventions, particularly for non-statutory adult offenders
- A heightened role for police intelligence in supporting offender management
- Co-location as an effective model of operational delivery, modulated by local needs and relationships
- Effective operational links between prison and community intervention to ensure offenders could be tracked through their custodial experience and linked immediately on release to IOM services where warranted
- Developing local models of offender management consistent with existing national models
- Extending the nature and breadth of police engagement in managing offenders.

The report stressed that it was difficult to assess best practice and build robust evidence for the success of IOM due to wide regional variation and a lack of comparability between schemes. Nevertheless, it concluded that *"IOM goes further than any other scheme to achieve the end to end offender management concept"* (Senior et al, 2011, p.32).

7.1a Prevalence of Mental Health Problems and Learning Disability

There has been little research conducted into the prevalence of mental illness among offenders in the community; indeed there has been little on health and social care needs generally. One recent study attempted to address this, and design a research framework for use going forward (Brooker et al, 2011). After interviewing a random sample of 173 people on the caseload of Lincolnshire Probation Trust, they found that:

- 27.2% of participants had a current mental illness
- 15% of participants had a current mood disorder
- 21.4% of participants had a current anxiety disorder
- 8.1% of participants had a current psychotic disorder
- 2.3% of participants had a current eating disorder
- 47.4% of participants were 'likely cases' of personality disorder[12]
- 38.2% of participants had a past/lifetime mood disorder
- 15.6% of participants had a past/lifetime psychotic disorder.

Substance misuse problems were also identified among the cohort:

- 55.5% of participants were likely cases of hazardous/harmful alcohol consumption[13]
- 12.1% of participants were found to have 'substantial' or 'severe' levels of drug use[14]
- 72.3% of those identified with a current mental illness also had a substance misuse problem.

The study also compared the results of the interviews and assessments with the case files for those identified, to assess the success of Probation staff in identifying or obtaining information on an offender's mental health need. The report found that ¾ of those identified as having a current mood disorder by researchers were also recorded in probation files. However, this reduced to less than ½ for those with a current anxiety disorder, 1/3 of those with a current psychotic disorder, less than a ¼ of those with a personality disorder and none of those with a current eating disorder.

The majority (over ¾) of those with an alcohol problem, and those with a drug problem were identified. This suggests that drug and alcohol problems are more commonly picked up and dealt with by Probation staff than some mental health problems are, with a surprisingly low number of those recognised as having a current psychotic disorder being picked up in probation files.

There is a similar paucity of research around offenders with Learning Disability in the community. One 2002 study screened specifically for intellectual disability (ID) with a cohort of 90 offenders on probation in the South East of England, and found 7% with possible ID.[15] The study concluded that it is likely that the probation service contains a "significant minority" of people with ID, and noted that *"people with ID or borderline ID are likely to have a number of support needs which could affect the success of their time on probation"* (Mason and Murphy, 2002, p.230).

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[12] This was assessed using the Standardised Assessment of Personality Abbreviated Scale.
[13] A score of 8+ on the Alcohol Use Disorders Identification Test identifies a strong likelihood of hazardous/harmful alcohol consumption.
[14] A score of 11+ on Drug Abuse Screening Test indicates 'severe' or 'substantial' levels of drug use.
[15] The study used the Learning Disabilities in the Probation Service screening tool, which is designed for use by probation officers. It incorporates two measures of cognitive functioning, the Quick Test and the Clock Drawing Test. Those falling over 1.6 standard deviations below the mean were considered possible cases of LD.

7.1b National Problems

The Lincolnshire study also conducted semi-structured interviews with service users and probation staff to determine what currently works well in linking offenders with mental health and substance misuse services, what act as barriers to access, and where improvements could be made to facilitate access to services for this group. Major barriers they found included (Brooker et al, 2011, p.98):

- Referral systems
- Lack of flexibility in provision, particularly in relation to people with complex needs
- Poor/one-way communication between services
- Silo working
- Stigma
- The need to travel long distances to access services
- A lack of resources for the treatment of particular issues, such as alcohol misuse
- Mental health professionals appearing to be reluctant to treat complex cases or to accept responsibility for mental health treatment requirements
- Probation staff having insufficient mental health awareness training
- Offenders' inability to engage with services for a variety of reasons.

The gap in provision of alcohol services was a particularly common issue raised in the study (Brooker et al, 2011, p.9).

There is a further gap in services for offenders with learning disability (LD). People with LD are unlikely to benefit from conventional programmes designed to address offending behaviour, and there is a lack of alternative services for offenders with LD to engage with:

> *"Few community-based services for learning disabilities in the UK are set up specifically to address offending, and few programmes for offenders or addiction services have been adapted for people with learning disabilities or learning difficulties"* (Loucks, 2007a, p.5).

There are further problems for those with borderline learning disability. Not only is this less likely to have been picked up by criminal justice agencies, but many community LD services work with strict, IQ based definitions of learning disability in their referral system (Loucks, 2007a, p.5).

7.1c National Best Practice

Positive factors that aided engagement with appropriate services for offenders in the community were also identified in the Lincolnshire study. These included (Brooker et al, 2011, p.8):

- Joint meetings between probation staff, the offender and health service staff
- Services guaranteeing confidentiality
- Co-location of services
- Clear communication within and between agencies
- A good relationship between the offender and probation staff
- Probation staff knowing a worker within the service which they wish to refer to (so they have an identified point of contact)
- Probation staff having sufficient mental health awareness training to identify the signs and symptoms of mental illness and to make referrals to appropriate services.

7.2 Regional Provision and Practice

7.2a Introduction to the Probation Trusts

Northumbria Probation Trust (2012a) covers the north of the region; the geographical area that is co-terminus with that covered by Northumbria Police Force and in which secondary mental health services are provided by Northumberland, Tyne and Wear (NTW) Mental Health Foundation Trust. There are six local delivery units (LDU) which are co-terminus with the six local authorities in the area and the six police Basic Command Units (BCU); Northumberland, Newcastle, North Tyneside, South Tyneside, Gateshead and Sunderland. The Trust supervises an average of 7,000 offenders at any one time and employs approximately 650 staff (Northumbria Probation Trust, 2012a). There are 20 community supervision teams across Northumbria. Northumbria Probation Trust (2012a) is currently appointing someone to the new post of mental health and learning disabilities coordinator.

Durham and Tees Valley Probation Trust covers the south of the region, which is the area covered by Durham Constabulary and Cleveland Police Force and in which secondary mental health services are provided by Tees, Esk and Wear Valley (TEWV) Mental Health Foundation Trust (Ministry of Justice, 2011d). As with Northumbria, there are six LDUs that are co-terminus with the police BCUs; Hartlepool, Stockton, Middlesbrough, Redcar and Cleveland, Durham and Darlington. Each of these Basic Command Units is co-terminus with a local authority, except for the BCUs of Durham and Darlington which together are co-terminus with the boundaries of County Durham local authority. The Trust supervises around 7,700 offenders at any one time of which approximately 1,500 are serving a custodial sentence (Ministry of Justice, 2011d) .

Rates of reoffending are similar for the two Probation Trusts with a 44% reoffending rate for the Northumbria Probation Trust area (3.5 offences per reoffender) and 42% reoffending rate for the Durham and Tees Valley area (3.7 offences per reoffender). This is significantly higher than the average rate of 34% for England and Wales (Open Justice, 2012).

7.2b Role of probation

The Probation service is responsible for overseeing offenders who have been sentenced to a Community Order, a Suspended Sentence Order, or have been released from prison on licence. Probation also provides advice to the courts around sentencing, provides some services in prisons, and runs approved premises.

It is a vital part of Probation's role not only to manage the risk to the public posed by the offender, but also to address the underlying causes of their offending and prevent reoffending. Probation officers can refer offenders to a number of accredited programmes and other services to address behaviour, including those that address health and social care needs (Ministry of Justice, 2012b).

7.2c Strategic and operational partnerships

There are a number of strategic and operational partnerships in place across the North East that relate to the management of offenders and reducing reoffending.

Multi-Agency Public Protection Arrangements (MAPPA)

MAPPA have been in place in every police and Probation Trust since 2001. They provide the framework for the coordinated risk management of potentially dangerous offenders by different

agencies, protecting the public from these offenders once they are given community sentences or are released from prison (Ministry of Justice, 2012c).

The police, probation and prison services together form the Responsible Authority for MAPPA. Other agencies who have a statutory duty to work together through MAPPA include Youth Offending Teams, the Strategic Health Authority and other health service bodies, Social Services, Victim Support, Local Authority Education and Housing, private education and housing providers and electronic monitoring providers (Northumbria Probation Trust, 2012b).

There are three categories of offenders managed under the MAPPA arrangements:

1. Registered Sex Offenders (RSO's)
2. Violent and other sexual offenders
3. Other offenders assessed as posing a risk of serious harm to the public.

There are also three levels of risk applied:

- **Level 1, Ordinary Agency Management** – This is the lowest level of risk. The offender can be managed by the agency responsible for supervision / case management of the offender. This does not mean that other agencies will not be involved.
- **Level 2, Active Multi-Agency Management** – A higher risk level. Offenders are managed by Multi-Agency Risk Management Meetings, drawing staff from across statutory and voluntary sectors.
- **Level 3, Multi-Agency Management at Senior Management Level** – This is the highest level of risk. It is reserved for the critical few who present a risk of serious harm in the community. Comprehensive assessment tools are used to ensure that they are properly identified, monitored and supervised.

Within Durham and Tees Valley Probation Trust, the core mechanism for delivering MAPPA is the joint Police and Probation Public Protection Units that exist within both force areas. In Durham the unit was set up in 1999, while in Cleveland it was set up in 2004 (Ministry of Justice, 2012c).

In Northumbria, MAPPA is centrally coordinated by a Strategic Management Board. The Northumbria MAPPA SMB comprises senior representatives from police, probation, prisons, health and two lay advisers, with support from other agencies when required. At a more local level, there are six MAPPA Strategic Groups across Northumbria, which meet to discuss local issues and procedures (Northumbria Probation Trust, 2012b).

Multi Agency Risk Assessment Conference (MARAC)

MARAC is a forum for sharing information and taking actions to reduce harm to high and very high-risk victims of domestic violence. The police are the lead agency in the project and chair to the meetings, while the Probation Service also has a specialist MARAC Coordinator. As many agencies as possible are represented at the meetings, including health, social services, housing, probation and the domestic violence forum. The process helps to:

- Reduce repeat victimisation
- Improve agency accountability
- Enhance information sharing
- Offer a consistent approach to risk assessment (Ministry of Justice, 2012c).

Integrated Offender Management (IOM)

IOM is an overarching framework that encourages a range of partner agencies to come together locally to ensure that the offenders identified as causing the most damage and harm locally are managed in a coordinated way. The core principles of IOM are:

- All partners tackling offenders together
- Delivering a local response to local problems
- Offenders facing their responsibility or facing the consequences
- Making better use of existing programmes and governance
- All offenders at high risk of causing serious harm and/or re-offending are 'in scope'.

The concept is strongly influenced by the principles of localism, with priorities and the offender cohort focused on decided at a local level. This is reflected in the variety of approaches to IOM taken in the North East, with probation's role varying between different areas.

Each local authority area has developed their own IOM approach, through the vehicle of the community safety partnerships working closely with probation and the police. In some areas such as Gateshead and Northumberland this involves criminal justice and drug services being brought into an IOM strategy, with these agencies now working under the umbrella of IOM. In many local authorities, however, dedicated IOM teams have been set up. These are:

• Newcastle IOM team	• Darlington IOM Unit
• North Tyneside IOM team	• Durham City IOM Unit
• South Tyneside IOM team	• North Durham (Consett) IOM Unit
• Sunderland IOM unit	• Chester-le-Street IOM Unit
• Redcar / South Bank IOM Unit	• Peterlee IOM Unit
• Stockton IOM team	• Bishop Auckland IOM Unit
• Middlesbrough IOM unit	• Newton Aycliffe IOM Unit

The constitution of these multi-agency teams and their offender cohort vary according to local priorities. In Durham, for example, all prolific and priority offenders (PPO) and Drug Rehabilitation Requirement (DRR) have been merged into a single IOM approach, and these form the IOM cohort. In South and North Tyneside the IOM team target the 'top 100' reoffenders, regardless of whether they are under statutory supervision by probation.

Prolific and Priority Offenders (PPO)

Within local integrated offender management arrangements, the prolific and other priority offender (PPO) approach provides a focus on the small group of most persistent offenders. PPO schemes pre-dated the current focus on IOM, and IOM approaches are intended to build on the success of these original schemes. In most areas in the North East, dedicated PPO teams have been disbanded and the cohort has become part of a single IOM approach. A dedicated PPO team is retained in Middlesbrough, however.

Community Safety Partnerships (CSPs)

Community Safety Partnerships (CSPs) are multi-agency groups that aim to tackle crime, drugs, anti-social behaviour and re-offending within a local area. They are funded by the Home Office, and made up of representative from the police, police authorities, local authorities, fire and rescue authorities, primary care trusts and probation. Currently, there is a CSP in each local authority in the North East.

Each CSP creates an agreed annual partnership plan, outlining priorities to be focused on. The priorities differ between areas. CSPs currently have an important role in the development of IOM approaches in the North East, developing strategies in partnership as part of their duty to reduce reoffending.

The position of CSPs is set to change dramatically. The Policing and Social Responsibility Act 2011 removed the statutory duty to form CSPs. They have suffered a 20% budget cut in 2011/12, and face a 40% cut in 2012/13 (Clinks, 2011b, p.2). By 2014, responsibility for community safety will be transferred to the new Police and Crime Commissioners. CSPs have been encouraged to work together to submit proposals to PCCs, with recommendations on their future role and funding (Clinks, 2011b, p.2). They may form clusters reflecting the areas covered by PCCs.

7.3 Key issues for the North East

7.3a What service should CJLD teams provide to probation?

There was a broad consensus among stakeholders that in order to identify and divert people at the earliest possible stage, the work of the CJLD services needs to be focused at the 'front-end' of the system at the police and court stages. However, if CJLD services are to focus their work at the 'front-end' a decision will need to be taken regarding what service CJLDs should provide to probation, given finite resources.

All senior stakeholders interviewed from probation reported either low awareness or mixed experiences of these services and expressed a desire for greater engagement of the services with probation. It was suggested that having staff based in probation offices, as is the case in South Tyneside. As well as assessing those in police custody and providing information to courts, the South Tyneside CJLD practitioner was seen to provide an invaluable point of contact for offender managers with clients with mental health problems. The practitioner was reported to provide a bridge between probation and health services facilitating both access into services and information exchange (the latter being an important concern for probation staff).

> *"It's a point of contact for offender managers who are managing offenders on orders who may not have presented initially with mental health issues, but during the course of the supervision, people begin to divulge more information about their background, etc., and things come to light. So he's very helpful as a point of resource and a point of contact in terms of that."*

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One national expert was adamant that liaison and diversion strategies should not be limited to police stations and courts, but must also include probation. In London, many of the boroughs have a mental health practitioner from a third sector organisation who is based in the courts in the morning and in the probation offices in the afternoon. At probation the mental health practitioner will offer advice, undertake assessments, undertake one-to-one work with clients and provide local training. The scheme is seen as highly beneficial to offender managers who require assistance in accessing support for their clients and is jointly funded by both the local PCT and London Probation Trust. Some similar joint-commissioning arrangements in the North East might provide real benefits for the probation caseload.

A senior stakeholder from health questioned why offenders in the community should access assessment and treatment services differently (i.e. via the CJLD route) to other people in the community, suggesting that this approach can be stigmatising. Nevertheless, this stakeholder reiterated the view that CJLDs do have a role to play in supporting probation to access help from mainstream mental health services through problem-solving when probation come across barriers to referrals.

Crucially, it is also clear that if CJLDs are to provide interventions which divert offenders from custody, close working between the teams and probation at the pre-sentence report stage will be crucial. Once again, the CJLD practitioner in South Tyneside was seen to provide a bridge between psychiatrists writing psychiatric reports and probation ensuring good information flow between the two;

> "Where our CPN who works at the custody diversion is really helpful is talking the same language to the psychiatrist and having some shared value basis or whatever it is that helps that communication take place. So really he's the conduit…to some effective, really effective information exchange, that's really helpful."

In London, many of the community disposals were arranged through utilising other sentencing provisions and the arrangement of a package of care to accompany these, without the need for a psychiatrist to be involved.

7.3b Engaging offenders in community treatment

Although diversion strategies frequently focus on keeping offenders out of custody where possible, there are some problems with attempting to engage this client group in the community;

> "I think people on probation, people on community sentences are still kind of difficult to engage, [it is] difficult to provide services that people will access. Because they are mainstream [services]. They're not in an environment where it's in-house. They've got to go out to it. So I think, I would say the vulnerable groups…in terms of access to services [are] people leaving prison on discharge and people on probation caseloads who are not contained."

> "Because I think one of the problems for people who offend is that perhaps their lives might be quite chaotic and they are traditionally a hard to engage group. So the more barriers there are, the more hurdles they have to jump over to access something, then the less they are probably going to access it. So I think that's an important feature in whatever we do here, we've got to make it quite lean in terms of the process that they have to undergo."

Interviewees emphasised the need for those planning services to be creative when developing strategies to engage this client group in treatment. A promising pilot has recently been launched in the region, linked to the national Improving Access to Psychological Therapies (IAPT) programme.

IAPT aims to increase access to so-called 'talking therapies' – principally those which are based on the principles of Cognitive Behavioural Therapy (CBT) – for those suffering from anxiety and depression[16]. In the Durham and Darlington area, the local IAPT service, 'Talking Changes', identified 'offenders' as one of their specialist areas in their bid for national funds. As part of this work, a pilot has recently been launched in the Darlington area to provide assessments and therapy sessions from dedicated clinicians, within the offices of probation and the Youth Offending Service. The aim of the pilot is to maximise the engagement of clients attending these services. In the case of young people, the sessions are to be held in conjunction with the Children's and Adolescents Mental Health Service (CAMHS) that provides secondary mental health care, to minimise the chances of these young people falling between the gaps in services.

As part of this pilot, training is also being undertaken with case managers from the probation and Youth Offending Services to raise awareness about common mental health problems, the IAPT programme and to highlight the proposed care pathway for this project.

One potential risk with this service model is that it will increase client's dependence on probation as a means of accessing support (although IAPT support is limited to six sessions). Other examples of promising practice nationally include the development of a community-based Mental Health Hub in Brent providing a range of services, including housing, and which offender managers will use as a venue for supervision appointments. Another model that is widely-adopted is the provision of mentors or support workers (frequently from the third sector) who remind clients about and accompany them to appointments, such as the WOW! Project for women in Newcastle.

7.3c Improving confidence and competence in working with these groups

There were concerns from one senior stakeholder from probation that his staff lacked confidence in working with these groups, in particular they lacked confidence in working with offenders with a learning disability.

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[16] Although this is now being extended to other groups: see http://www.iapt.nhs.uk/smi-/

Figure- 7.1

How confident do you feel in identifying the following amongst offenders who you work with?
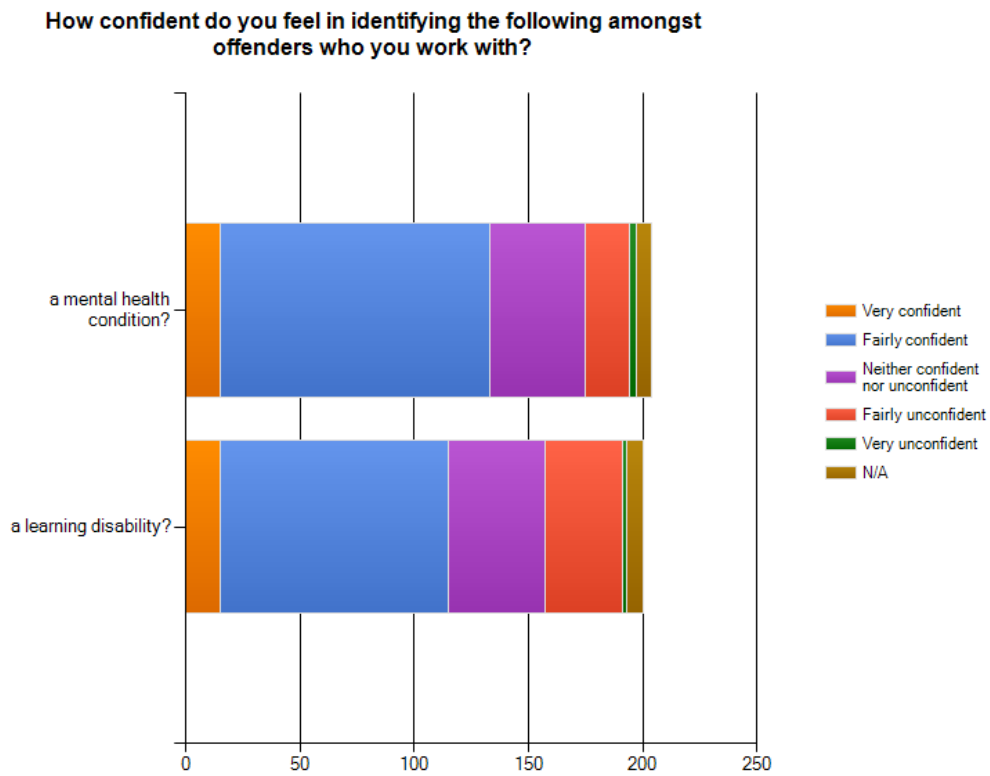
Confidence of survey respondents in identifying a learning disability was indeed lower than confidence around identifying mental health conditions among respondents. Over two-thirds (67.5%) of probation staff who responded to our survey (excluding those who skipped the question [MH: 11; LD: 15] or responded to say that the question was not applicable to them (7)) said that they felt very or fairly confident in identifying a mental health condition among offenders that they worked with, while 11.1% disagreed or strongly disagreed. 59.6% said that they felt very or fairly confident in identifying a learning disability, while 18.7% disagreed or strongly disagreed.

Given that senior probation officers stressed that the OASys assessment tool, used to assess offenders' needs and risk, is only as good as the person operating it, it is positive to see that there were high levels of confidence among respondents regarding identification of problems.

Figure- 7.2

To what extent do you agree with the following statement? I believe I have the knowledge and skills to meet the needs of offenders with:
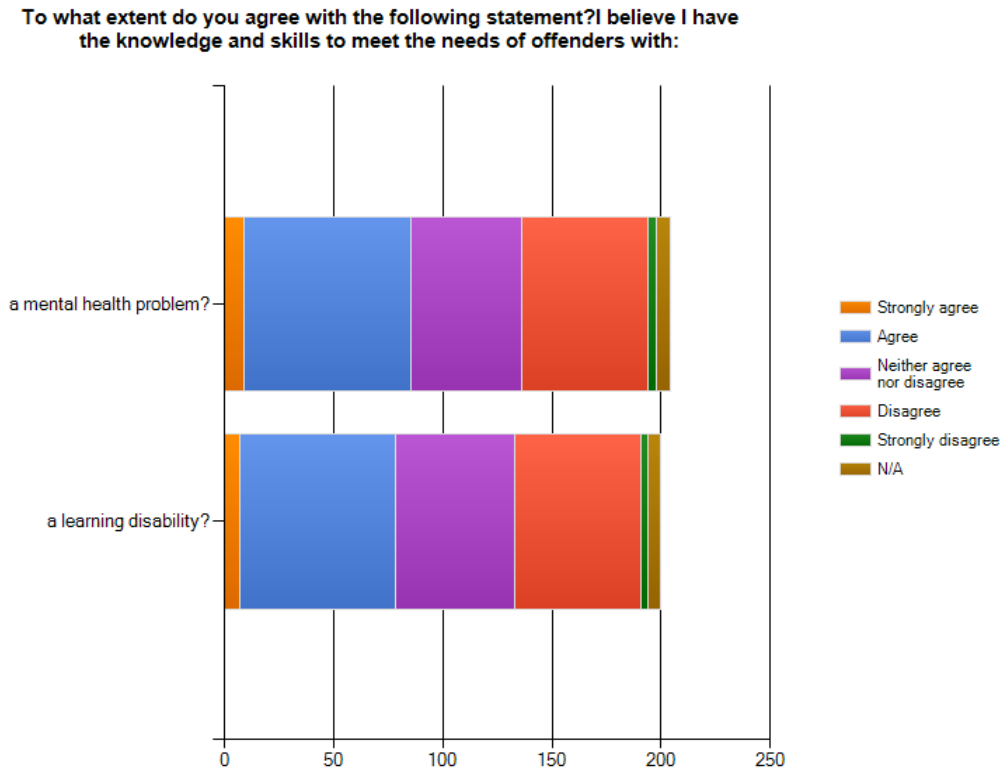
In terms of having the knowledge and skills to meet the needs of offenders with these conditions, 42.9% of respondents agreed or strongly agreed that they had the knowledge and skills in terms of a mental health condition, while 40.2% of respondents agreed or strongly agreed that they had the knowledge and skills in terms of a learning disability (respondents who skipped this question [MH: 11; LD: 15] or answered to say that this was not applicable to them (6) were excluded).

Although the majority of respondents felt that they did have the knowledge and skills, just under a third of respondents disagreed or strongly disagreed in each case. This suggests that there is still work to be done to ensure that the whole workforce who may come into contact with these groups of offenders have the knowledge and skills to work effectively with them.

7.3d Knowing where to access a comprehensive range of community based support

The majority of respondents to our probation survey reported that they knew where to access support to help them in managing an offender with a mental health problem (64.8%) and gave a range of examples of where they would go to for help including CJLD teams, community mental health services, crisis teams, GPs, IAPT and voluntary sector agencies. However, despite this positive response over a quarter of free response suggestions for training (46/158) focused on practical advice regarding service provision locally and referral pathways into these services.

Figure- 7.3

To what extent do you agree with the following statement? I know where to access external help to support me in managing an offender with:

Legend:
- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- I do not have responsibility for managing offenders
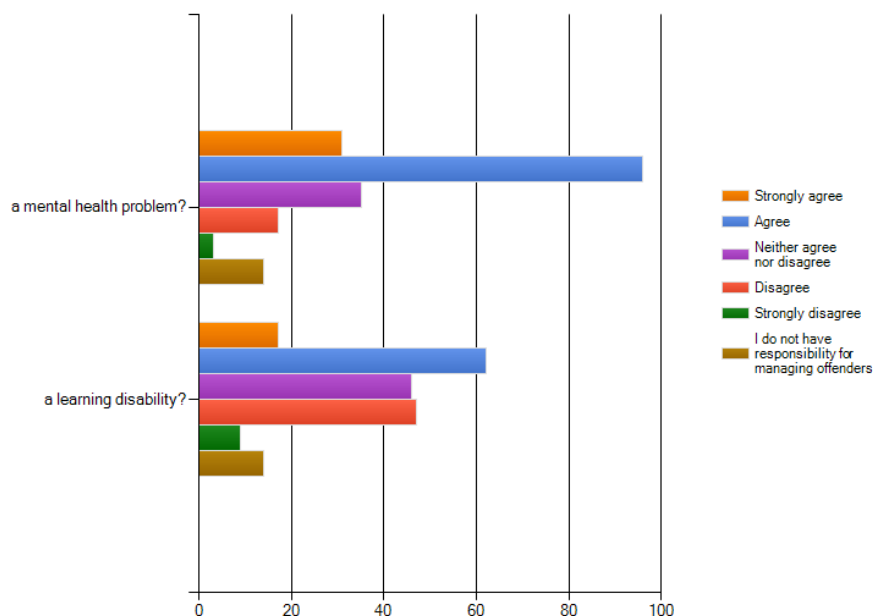
National experts highlighted reciprocal training with health services or a 'Train the Trainer' approach as approaches that were perceived as having been effective elsewhere in developing strong awareness around mental health and care pathways.

Fewer respondents reported that they knew where to access help for offenders with learning disabilities (40.5%) with over a quarter of those surveyed suggesting they would not know where to go for support in managing these offenders. As well as knowledge of referral pathways for social care and other support, survey responses suggested the help that probation staff wanted included support around how to approach offending behaviour work with clients with learning disabilities.

Accessing support was perceived to be far less of a challenge for offenders with significant needs who posed a high risk of harm. Senior stakeholders from both Trusts described strong and productive partnership arrangements for these groups and appeared to feel that this area was one where the Probation Trusts were performing well.

> "[We are responding well to] high end, high risk offenders. It is a slick operation. We have excellent liaison points with all relevant services."

In particular, joint arrangements for supporting sex offenders and stalkers in the Northumbria-NTW area were highlighted by both health and probation as working extremely well. One senior stakeholder did describe some problems accessing support for very high risk offenders with a severe personality disorder once they had reached the end of the criminal justice process (i.e. the end of their licence). However discussing a recent case it was acknowledged that the forensic personality disorder team within the local Mental Health Trust were *"pulling out all the stops"* to find a solution.

Where links were seen to be less successful were for those who posed a low risk to the public and/or who had lower level mental health needs despite the fact that they might pose a high risk of reoffending.

> "We are poor on the bulk [of offenders] in the middle."

> *"The ones that fit in the middle are 'coped with' but because we don't have good lower end mental health services we tend to battle on with them at the coal face."*

Senior stakeholders from probation as well as survey respondents wanted a comprehensive range of health service provision with clear referral pathways, as well as a single point of contact with health to offer advice about appropriate services. CJLD services were felt to be an obvious choice to fulfil this role.

> *"[Probation staff need] named contacts – they need to know who to turn to when they have a problem."*

> *"I guess [what would help staff] would be the information about the network support and the access to support provision and treatment pathways, etc. You know a constant flow of that information…Because what we know in probation is we're not the expert in everything. We need quick routes into the experts in the various fields. And where we manage to achieve that, things are quite successful…single points of contact are very good from that point of view I think. You can have a resource pack, I guess, but having somebody who you can pick up the phone to, or who understands why you're asking it and is able to give you answers is going to unlock a lot of difficulties."*

Where access to services was refused probation staff wanted help identifying an alternative service to support them in managing offenders so that they were not left *"holding the baby"*. There was clearly frustration about clients "*falling through gaps in services*" or failing to meet high thresholds for service provision. It was suggested that funding cuts to services might be raising service thresholds hence exacerbating the problem. However, one national expert described how support solutions could frequently be found simply by raising awareness among probation staff of where to refer to.

> *"We were looking back [on] another era…when thresholds were going up as again they are now. And it was becoming more difficult for probation officers to refer into health services and we were trying to understand that. One of the things that we came up with was, [probation staff members] were very often referring to the wrong level of service. You know, [probation] had kind of developed a relationship with forensic services [and] wanted everything to go to forensics because that was what [they] always did. And of course, very often, they were being rejected."*

A regional stakeholder from health explained;

> *"I certainly think that probation have a big role to play in this – and again, maybe that's just about awareness or just making sure our services are easily accessible to probation in that sense…Of course mental health exists across a huge continuum doesn't it? From mild, low level mental health which may well be picked up through something such as IAPT for instance to mainstream secondary, tertiary services – and perhaps there isn't an understanding of the breadth of service available to the general population if you like."*

Developing clear pathways from probation into IAPT services (as in the Darlington pilot) may improve support for those with less severe mental health problems. Close partnership working at a strategic level was also seen as a way to identify and resolve problems in terms of access to services.

In the North East, offenders with dual diagnosis and/or personality disorder were highlighted as posing particular challenges. Although we have no data locally, research conducted with a representative sample of offenders on probation in Lincolnshire found that 47.4% of 173 offenders were 'likely cases' of personality disorder and 72.3% of those identified with a substance misuse problem also had a mental health problem. Given the high prevalence of these conditions it is perhaps unsurprising that difficulties accessing services for these groups were a source of frustration.

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In the South of Tyne area, NTW had been commissioned to provide a specialist dual diagnosis nurse in each of the three local areas; Sunderland, Gateshead and South Tyneside and the view was expressed that this had improved access to dual diagnosis provision in this part of the region. The South Tyneside nurse in particular was reported to have developed strong links with probation, engaging with the IOM arrangements locally. However there were still a small number of free-flow responses to our probation survey from staff members based in the South of Tyne area who identified dual diagnosis as a problem. This may well be because the appointment of the nurses is a relatively new development, the impact of which is yet to filter through. However, one respondent from the Gateshead area specifically commented that *"there doesn't seem to be much evidence of dual diagnosis workers getting involved in these cases."*

7.3e Balancing need to protect confidentiality and to enable effective working

When considering sensitive information about medical issues or about offence histories, there is a need to find an appropriate balance between protecting confidentiality and enabling effective working (including protecting both the public and the client).

Senior stakeholders from both Trusts reported that steps were taken to ensure client consent before information is shared with other agencies. Where consent to share information is obtained, one senior stakeholder from probation suggested that they attempted to hold *"open conversations"* with other professionals in which information was shared relatively freely. Where consent is refused by the offender, information sharing by probation is often difficult which can inhibit effective work with clients by probation staff and other agencies; although both Trusts had a clear policy of sharing information without client consent when it was a public protection concern.

However, another senior stakeholder raised the question of whether information about mental health problems or learning disabilities is being shared appropriately, i.e. whether information is perhaps being passed too freely. The comparison was made with HIV status and it was highlighted that this information would only be passed on, on a strictly need-to-know basis.

Conversely, when asked about working with other agencies free-flow survey responses highlighted communication problems with health agencies, notably a reluctance by health to share information due to concerns about confidentiality. One senior stakeholder from probation echoed these concerns:

> *"It is fine doing a referral and having an initial conversation with the health professional but then the blinds come down in terms of future liaison because of medical stuff – we then don't get an awful lot back, unless it's MAPPA for example."*

While concerns about protecting confidentiality are legitimate, over-zealous application of confidentiality can be as damaging as a lapse application. One national expert emphasised:

> *"Yes we have to worry about confidentiality and data protection, but there are ways of sharing information that we need to overcome. People use data protection, or their understanding of it, often poor, and use for example, medical confidentiality and their poor understanding of it as a sort of, it's almost like a risk aversion. I won't share anything at all, and of course, as we know, there are very few if any enquiries that worry about the OVER [emphasis] sharing of information and every single enquiry we can think of in the mental health world in the social care world, you could almost write to find that paragraph about information not being shared and it's a common feature."*

Information sharing protocols provide one method of overcoming some of these issues but can be difficult to manage given the wide range of agencies that might be involved with an offender – as one national expert highlighted:

> *"What I did find more of a difficulty is the sort of administration of the information exchange and the kind of governance, you know, having the written agreements…we kept being told you've got to have an information sharing agreement. In a [busy urban local authority], there must be about 60 information sharing [agreements], I mean if every organisation has got an information sharing protocol with everyone else, you know…"*

However, without clear accessible policies, probation staff are reliant on discretion in order to determine what to share. Almost 2/3 of probation staff who responded to our survey (196, excluding those who skipped the question, 19, or responded to say the question was not applicable to them, 15) said that they were not aware of any formal protocols regarding what information is shared about an offender's mental health problems or learning disability.

7.3f Strengthening partnerships

Multi-agency Public Protection Arrangements (MAPPA)

As previously mentioned, interviewees from both Probation Trusts and health expressed the view that services were responding well to those who were considered to present a high risk of harm. Such offenders are normally subject to MAPPA which have local panels which are overseen by a Strategic Management Board (one for Northumbria; one for Durham and Tees Valley).

A number of stakeholders emphasised the importance of having the right people around the table;

> *"One of the things I've struggled with, certainly in managing the Level 3 cases that I've been responsible for, [is] knowing exactly who does what in mental health. It's a bit of mystery…Because one of the things I really grappled with [managing Level 3 MAPPA clients] is getting hold of the right person, the right strategic person who can help commission some resources to the management of the case. That's what MAPPA Level 3 meetings are all about basically. And once you get the right person it's fantastic."*

There is arguably a role for CJLD practitioners who are well-versed on client cases to attend these meetings on request to provide health and risk information about specific clients, as still occurs for the South Tyneside, Gateshead and Cleveland, Durham and Darlington CJLD teams. However, there appears to be past-evidence from the TEWV-area of staff at the wrong level attending MAPPA 3 panels:

> *"One of the issues I have [is] sometimes we get level 3 MAPPAs…where they will then say it's not appropriate for [CJLD] staff to go along because it should be someone who can go along and allocate resources. So purely on the basis of grade, there's times where they suggest that I should go to a MAPPA level 3 meeting. But the issue then is that…if there's a member of staff who knows the person they can go along and provide information about the person, but I can't go along and say, yeah the adult team [will] come and see him twice a week…I could go if there was a need to support a member of staff, or even…potentially [to] sit around and discuss contentious clinical issues, and I could advise on where they should refer to, but I can't allocate the resources of other services in the trust."*

However, the situation seems to be improving. In TEWV a MAPPA Start and Finish Group has been established to address a number of current issues and they have now also appointed a single point of

contact in the Trust for MAPPA. Additionally, NTW have now appointed two people, one in the North of Northumbria (Northumberland, Newcastle and North Tyneside) and one in the South (South Tyneside, Gateshead and Sunderland), who have been specifically allocated to resolve pathway issues for MAPPA clients (particularly those at MAPPA 3 Level). While these contacts may not be familiar with the specific details about a client's contact with mental health services, however they have a senior role in the Trust so that they are able to allocate resources to a client's care. There is however still a role for CJLD practitioners who are well-versed on client cases to attend these meetings on request to provide health and risk information about specific clients, as still occurs for the South Tyneside, Gateshead and Cleveland, Durham and Darlington CJLD teams.

One stakeholder also suggested that the Strategic Management Board for MAPPA in Northumbria had failed to adequately engage with local housing providers and this was an area for future work in the management of these groups. It was suggested that this was likely to be a problem for the management of MARAC as well.

Integrated Offender Management (IOM)

Integrated Offender Management (IOM) has been suggested as a potential mechanism locally with which to improve multi-agency support for repeat offenders with mental health problems or learning disabilities. There is evidence that CJLD workers from the South Tyneside and Cleveland, Durham and Darlington CJLD services have been involved with local IOM arrangements to varying degrees. It was also reported by one stakeholder that links between health and IOM were stronger in Sunderland and Durham. However in other areas of the region there appears to be only limited engagement from health. One stakeholder expressed a desire to improve CJLD engagement with the IOM in North Tyneside where *"the only people missing from the table were health"*.

One good example of health engagement in IOM is in South Tyneside. The Cornwallis Project is a multi-agency one-stop shop that includes probation, police and Turning Point, which is where their award-winning IOM Service is based. Clients of the Cornwallis Project are mainly drug and alcohol-using offenders, often with complex needs. The IOM service uses a matrix (points-system) and groups its clients under amber or red groupings. It was reported that over time the local IOM has become aware that there were a group of people on IOM who were under the non-psychosis team, prolific use of the crisis teams, prolific self-harmers, anti-social behaviour and revolving door offenders. Consequently, the local CJLD practitioner and the local dual diagnosis nurse alternately attend meetings for those who are grouped as 'red' and together provide a complex needs service to the IOM team.

Strategic health partnerships and joint commissioning

Through the analysis phase we have not been made aware of any strategic partnerships in place involving probation that allow joint-commissioning of services to support offenders with mental health problems.

In London, a partnership between the London Probation Trust and local PCTs has enabled the joint-commissioning of mental health practitioners to work in courts and probation offices in a growing number of boroughs. In addition, the partnership provides an opportunity to monitor changes in services and jointly problem-solve barriers that emerge to supporting the clients of the service to access mainstream support. This was seen as the mechanism through which the greatest improvements had been made in London for this group of offenders.

Some involvement in commissioning for Employment, Training and Education programmes that might lead to improved support for people with learning disabilities was reported with programmes co-funded with the European Social Fund.

8
Prison

KEY ISSUES:

- **Missed opportunities earlier in the system**
- **Improving identification of mental health problems and learning disabilities**
- **Disjointed computer systems**
- **Passing information without an identified contact**
- **Improving information sharing within the prison**
- **Opening up direct referral routes into community provision**

- **Engaging community support prior to release**
- **Lack of warning about release dates**
- **Housing**
- **Integrating mental health with other resettlement planning**
- **Specific problems for short-sentence prisoners**

8.1 National Picture

A current emphasis on diversion means that fewer offenders with mental health problems or a learning disability should find themselves facing a prison sentence. Government policy supports alternatives to custody where appropriate, especially for less serious offenders where mental health problems are the cause of their offending (Ministry of Justice, 2010, p.36). Nevertheless, while many alternatives to custody are available, it remains the case that a custodial sentence may be the most appropriate option in the most serious and dangerous cases. As the Bradley Report was keen to make clear:

> *"Even if all the diversion opportunities described in this report were fully utilized, there would still be some individuals with mental health problems for whom prison would be the appropriate disposal"* *(Bradley, 2009, p.98).*

For those people with a mental health need or learning disability for whom prison is deemed the appropriate disposal, it is important that their needs are identified, any treatment continued along the pathway into prison, and that support is continued on release.

Policy surrounding the provision of healthcare in prisons has changed dramatically over the last decade, improving opportunities for continuity of care. The framework was set to a large extent in 1999, when the prison service and NHS executive published a report stating that prisoners should receive healthcare equivalent to that which they would receive in the community. The report stressed that this provision should not be disrupted by coming into prison, moving prisons, or on release (Joint Prison Service and National Health Service Executive Working Group, 1999).

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One of the key recommendations of the report was that the Care Programme Approach (CPA) should be used in prisons. CPA is a system of care planning used for people with severe and enduring mental illness. As part of the previous government's response to this, prison in-reach teams were created in 2001 to liaise with health services outside of prison, and provide the same care and treatment for those with severe mental health problems that they would receive in the community (SCMH, 2008b, p.9).

The report also recommended that further consideration be given to the transfer of all prison healthcare to the NHS. This was achieved in 2006, when responsibility for prison healthcare was transferred to PCTs.

This context, with all healthcare now the responsibility of the NHS, has provided an opportunity for a wider range of health needs to be addressed as they would be in the community. In 2008, the document *Refocusing the Care Programme Approach* (Department of Health, 2008b) moved beyond the previous focus on severe and enduring mental illness to call for the inclusion of less severe mental illness, risk of self-harm, substance misuse, and housing or employment needs within the criteria for a 'new' CPA (SCMH, 2008b, p.9).

Nevertheless, there is still much to achieve nationally to ensure continuity of care and equity of care for those with mental health problems, learning disability, or other health and social care needs who receive a custodial sentence.

8.1a Prevalence

It is widely recognised that there is a higher prevalence of both mental health and substance misuse problems in the prison population compared with the general population. The most comprehensive study to date was by Singleton et al (1998 as cited in SCMH, 2008a, p.14), the results of which are shown in figure 8.1.

Figure 8.1: Rates of mental health and substance misuse problems among prisoners		
Mental Health Problem	**Prevalence prison population**	**Prevalence general population (adults of working age)**
Psychosis	8%	0.5%
Personality Disorder	66%	5.3%
Neurotic Disorder	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

<u>Source</u>: Singleton et al, (1998 as cited in SCMH, 2008a, p.2); Singleton et al, 2001 (as cited in SCMH, 2008a, p.2).

Prevalence rates were invariably found to be higher in the remand population than the general prison population (Anderson, 2011, p.15).

Given a lack of consistency over definitions used in research, it is more difficult to estimate the prevalence of learning disability in the prison system. Research by the Prison Reform Trust (Loucks,

2007b) reviewed research into the prevalence of learning disabilities in the justice system. Research undertaken in three prisons (a local prison, a women's prison and a young offenders institution) found that 6.7% were assessed as learning disabled. Studies undertaken in prisons have indicated a much higher level of 'borderline' learning disabilities; those who have IQ levels over 70 but may struggle with adaptive functioning or may face particular challenges in their passage through the criminal justice system (25.4% in the above study).

It should also be noted that prison is likely to cause people's mental health to deteriorate further (SCMHa, 2008, p.14). Moreover, many prisoners have a wide range of health and social care needs on release. Social Exclusion Unit (2002) research found that:

- One-third of prisoners lose their home while in prison
- Two-thirds lose their job
- Over a fifth face financial problems
- Over two fifths lose contact with their family.

8.1b Prison reception and Screening

While in theory information about an offender's mental health needs should have been identified and follow them down the pathway into prison, this is not always the case. Indeed, some offenders with mental health needs or learning disability will not have received any assessment before they are screened at prison reception (Bradley, 2009, p.101).

All prisoners receive the Grubin healthcare screen on reception. This covers physical health needs, medication, previous diagnoses or treatment for mental health issues, self-harm, and drug and alcohol misuse in the four weeks prior to custody (Anderson, 2011, p.18). On top of this, they are also screened for housing needs by the Housing Needs Initial Assessment form, while nationally, considerable screening and assessment of social care needs already takes place as many prisons have developed their own forms to be completed during Induction (Anderson, 2011, p.5).

If needs are identified through screening or self-referral, agencies working within the prison often undertake detailed assessments covering a range of social needs, including mental health. Nevertheless, a number of problems have been raised around these processes (Anderson, 2011, p.6):

- The mental health element of screening has been criticised as being too brief
- There is no learning disabilities element
- Prisoners can be unwilling to disclose mental health problems and other vulnerabilities in the prison environment
- The process can be rushed, and staff can seem uncaring
- There are poor information sharing processes between agencies within the prison.

There are current projects ongoing that could address some of these problems. NOMS have developed an electronic Basic Custody Screening Tool, which would follow the prisoner as they move between prisons. The Learning Disability Screening Questionnaire (LDSQ) is also being piloted, and represents an easy-to-use tool made up of seven components: Ability to tell the time, read, write, whether the prisoner is living independently, has a job, has had previous contact with learning disability services and/or has had special schooling (Anderson, 2011, p.19).

8.2 Regional Practice and Provision

There are seven prisons within the North East region, details of which are outlined in figures 8.1and 8.2 below.

Figure- 8.1

NOTE: HMP Acklington and HMYOI Castington have now been merged to form HMP Northumberland.

Adapted from Prison Service website (accessed 13.02.12):

http://www.hmprisonservice.gov.uk/assets/documents/10004ADFprisonsonlymap_A3.pdf
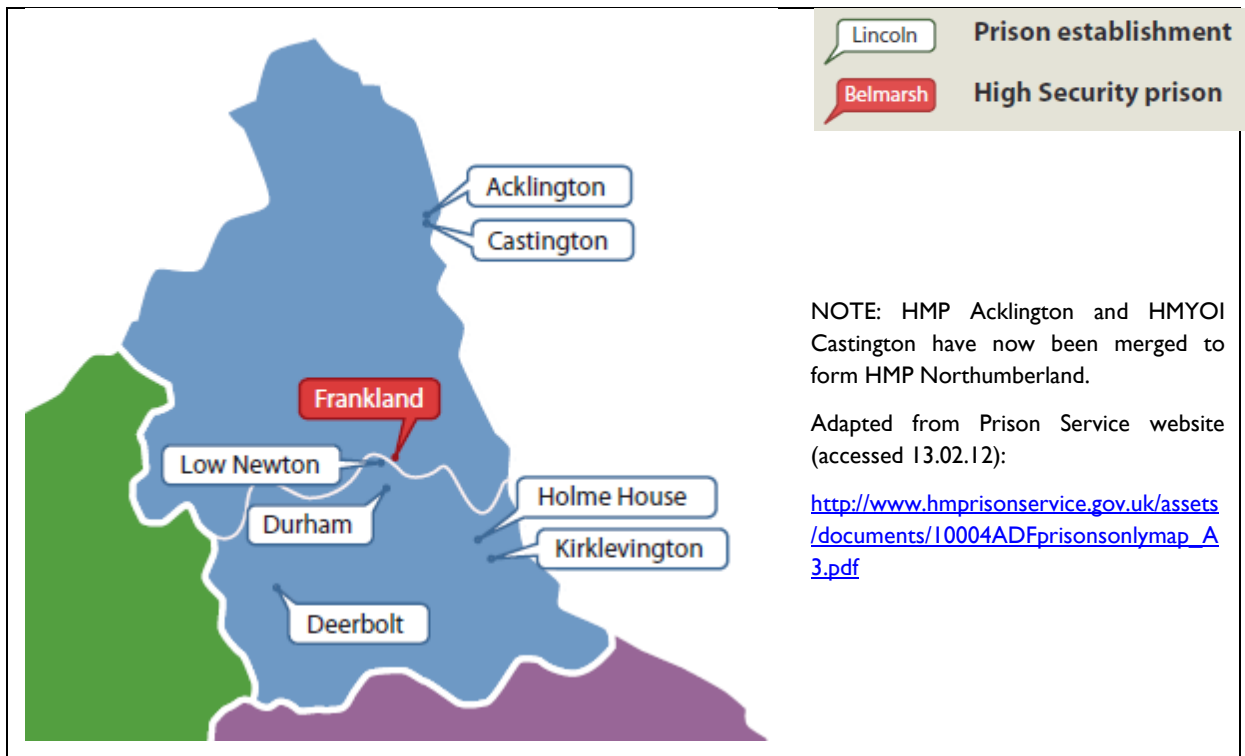
8.3a Commissioning and provision of prison healthcare

Prison healthcare is commissioned by the North East Offender Health Commissioning Unit (NEOHCU). In 2011 the independent provider, Care UK, took over the running of the healthcare contract for all seven of the prisons in the North East region. Prior to this there had been a complicated arrangement of contracts and sub-contracts featuring a range of providers with considerable variation of provision across the North East region's prison estate.

TEWV are sub-contracted by Care UK to provide mental health care services within the seven prisons across the region. These prison teams are managed by this service which is managed by the Service Manager for Offender Health in TEWV. The arrangement for mental health services within HMP Northumberland differs slightly to the other prisons in the region since these are provided by NTW. This service operates as a sub-contract of the mental health contract with TEWV. There is a service manager within NTW's Forensic Services and the Band 7 nurse who oversees the service reports her performance data to TEWV's performance department and attends the prison team manager meetings with the other prison team managers.

The contractually required outcomes for the successful provision of the mental health services are outlined in Schedule 10 of the document ‘*Offender Health Care within Prisons Service Specification Version 1.5*’ (HM Prison Service, NEOHCU and NHS County Durham, 2011).

8.3b Staffing of mental health teams

The prison mental health teams are now coming to the end of a considerable restructuring of staffing arrangements across the seven prisons in the region. Much of this restructuring has been focused on increasing the flexibility of staff to work across the prisons according to varying levels of need and to deal with staff absences. Additionally, provision of mental health care within the prisons has been shifted towards a stepped care approach, with the increase of nurses from lower bands who are able to provide group work and lower-level interventions.

Across the seven prisons there are now four Band 7 nurses who manage the services:

- One Band 7 manages the teams at HMP Holme House and HMYOI Deerbolt, as well as the provision of in-reach support to HMP Kirklevington Grange (which does not have its own team due to low levels of need) from the Holme House team
- One Band 7 manages the teams at HMP Frankland and HMP Low Newton
- One Band 7 manages the team at HMP Durham
- One Band 7 manages the team at HMP Northumberland.

Additionally, there are at least two Band 6 nurses allocated to each prison (with the exception of Kirklevington Grange) as well as a range of Band 5, 4 and 3 nurses. An Occupational Therapist will also provide support to HMPs Frankland, Low Newton and Durham.

A number of other sessions are provided in each of the prisons by staff based within community teams (see figure 8.3 below). In all of the prisons except HMP Northumberland there is a session provided by a Forensic Learning Disability nurse. This is because of a slightly different care pathway for learning disability within NTW, with NTW operating a single referral point for all learning disability support. This arrangement aims to be flexible and responsive to changing levels of need within the prisons. For example, one psychiatry session was moved from HMYOI Deerbolt to HMP Holme House due to reduced demand in the former and long waiting lists in the latter prison.

Figure- 8.3	Forensic CPN sessions (weekly)	Forensic LD nurse sessions (weekly)	Forensic Psychiatry sessions (weekly)
HMP Holme House & HMP Kirklevington Grange	8 across these prisons	1	3
HMYOI Deerbolt			1
HMP Frankland			2
HMP Low Newton			2
HMP Durham			2 (1 from NTW, 1 from TEWV)
HMP Northumberland	1 (from NTW)	0	2 (both from NTW)

As discussed in the Criminal Justice Liaison and Diversion (CJLD) Service chapter, there are also plans to introduce some staff sharing arrangements between the TEWV-run CJLD service in

Cleveland, Durham and Darlington and the prison teams (with the exception again of HMP Northumberland due to the geographical remoteness of this prison). This is being introduced to achieve the multiple aims of increasing the respective team capacities at busy times and during staff absences; increasing staff knowledge of community services and prison systems; and strengthening relationships and joint working between the prison and community teams. The operation policy for the prison teams outlines that the drive for an improved interface with CJLD services is being undertaken with "the aspiration of providing seamless services across offender pathways" (TEWV and NTW, 2011, p.5).

8.3c Service Strategy

The Operational Policy for the prison mental health teams outlines the service aim to provide timely and accessible mental health assessment and treatment to meet the needs of prisoners. The policy outlines a number of key themes that are being adopted in order to efficiently and effectively meet this aim (TEWV & NTW, 2011, p.4). These are:

- Federated model of care integrated with healthcare and prison services
- Mental health service delivery underpinned by a stepped care approach involving three tiers
- Robust triage process
- Comprehensive assessment
- Emphasis on formulation
- Clear pathways of care
- Comprehensive skill mix
- Evidence based practice
- Flexibility in the workforce across the prisons in the region
- Integration into community and other health and criminal justice services."

8.3d Screening and Assessment

On arrival, prisoners receive an initial healthcare screen (Grubin et al, 2002) which covers physical health needs, medication, previous diagnoses or treatment for mental health issues, self-harm, and drug and alcohol misuse in the four weeks prior to custody. This initial screen has a significant focus on immediate risk, but is followed by a more comprehensive healthcare assessment within a week. If either part of this healthcare assessment identifies a mental health need, a referral is made to the mental health team. In addition, referrals can be made following risks identified on the Prisoner Escort Record (that arrives with the prisoner), OASys assessments, observed behaviour that suggests a mental health assessment may be appropriate, or following information supplied by community agencies and family.

Prisoners are also subject to a range of other screening and assessment processes throughout the induction process which can vary according to need and individual prison practices. These include the Drug Interventions Record undertaken by CARATs drug workers and Basic Skills tests undertaken by education which may also indicate need arising from a mental health problem or a learning disability. HMP Durham was also one of the sites for the trial of the Learning Disability Screening Questionnaire (LDSQ) which was undertaken by the education department. The use of this screening tool has not yet been rolled out.

In contrast to community mental health services, no thresholds or exclusion criteria are in place to access a mental health assessment by the prison mental health team. Following referral to the prison

mental health team, an initial assessment of mental health needs is undertaken which includes (TEWV & NTW, 2011):

- Checks whether the person is known to mental health services (if on CPA and if eligible for section 117)
- Presenting problems
- Risk screen
- Care plan (e.g. referral for comprehensive mental health assessment, placement in healthcare centre, recommendation for ACCT)
- Working formulation (synopsis of key issues from background history, presenting complaints and risk concerns).

This initial assessment has a significant focus on risk to self and includes questions from the National Patient Safety Agency Prison Screening Questionnaire with additional follow-up questions, particularly in relation to suicide.

The client's case is then presented to the Referral / Assessment / Pre-release and In-prison Discharges (RAPID) panel for a decision to be made as to the appropriate care pathway. Other functions of the RAPID panel include supervision, continuity of care, patient safeguards, risk management and review of discharge or pre-release plan. Following the outcome of this panel, the prisoner may be discharged to the care of the GP, offered lower tier mental health interventions or given a comprehensive assessment to determine access to higher tier interventions.

8.3e The Stepped-Care Approach

Adopting a stepped care approach is a key theme of the service strategy. The prisons offer a range of interventions across three tiers including health promotion, group work and one-to-one support, full details of which are outlined in the operational policy (TEWV and NTW, 2011). Not all interventions are available in all the prisons in the region and this variability of provision was one concern of stakeholders interviewed.

For the purposes of this review we have focused on processes for the identification of mental health problems and learning disabilities prior to and within prison as well as care pathways and information flow across the prison-community boundary. It was felt that detailed consideration of service provision within the prisons themselves was beyond the scope of this review.

Figure- 8.4

Figure 1: Prison Mental Health Pathway
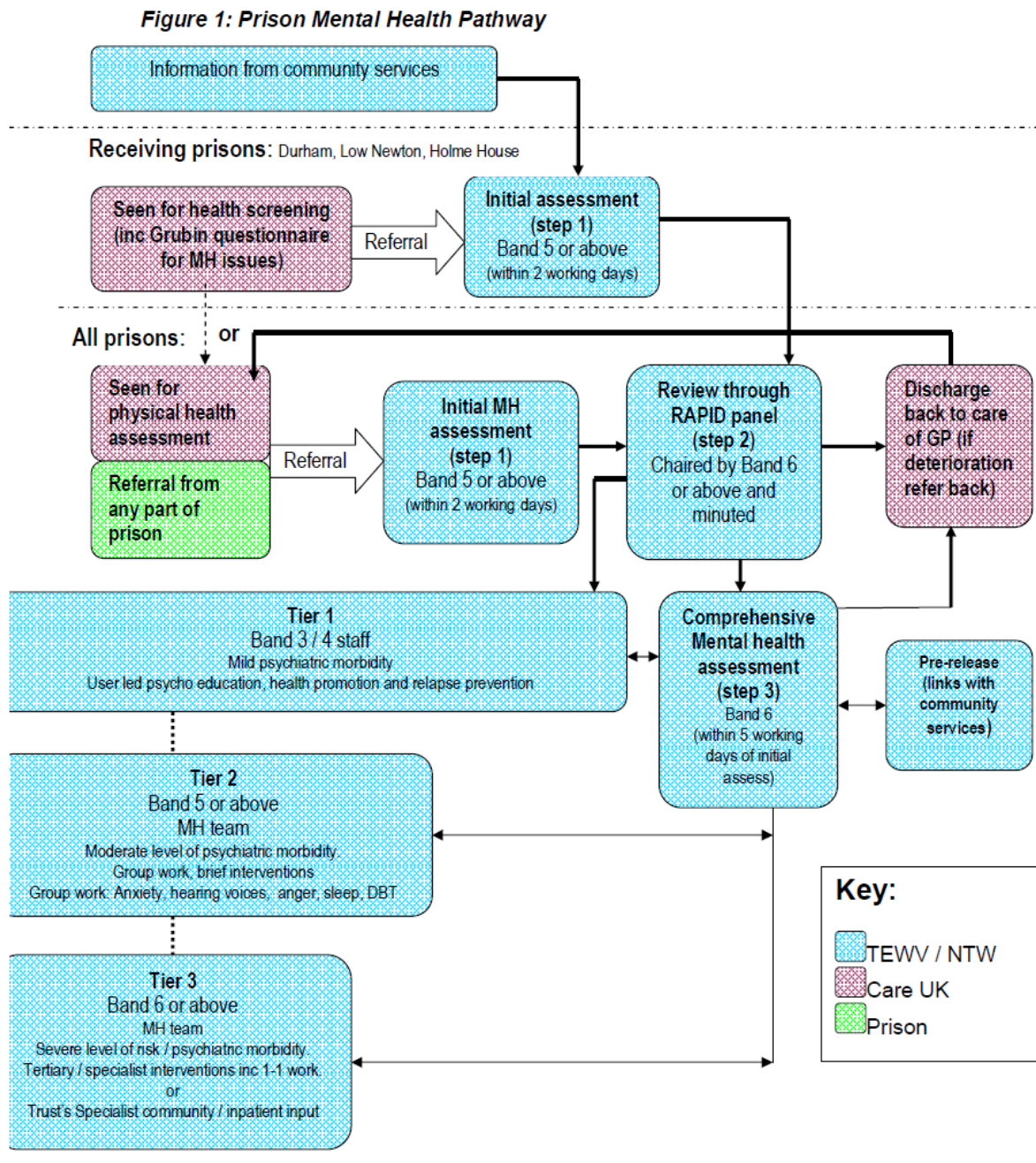
(Diagram reproduced from: TEWV & NTW, 2011)

8.3 Key issues

Identification

8.3a Missed opportunities earlier in the system

All of the prison mental health team managers, but particularly those within the local prisons, expressed concern that a number of people with severe mental illnesses who were inappropriate for detention in prison were still making it through the criminal justice system as far as prison undetected:

> *"We still get patients/prisoners who are in secondary care services who cannot cope, who should be in a hospital and they still are in the prison. It's not the appropriate place to house them. We can't meet their needs, and what eventually happens is we either have to transfer them out or they get released, with very little follow up outside."*

Many reported facing difficulties finding bed spaces to enable prisoners to be transferred out. The view was expressed that judges needed to be provided with sufficient health information at the remand and sentencing stages so that they had other choices but to engage in the fallacy of sending vulnerable people to prison for the purposes of getting their needs identified and met.

> *"I think predominantly what it is, is that [Magistrates] feel that they are sentencing the women for quite laudable reasons to come into prison…Like, well at least they'll get a detox, at least someone will look at what they need, at least someone is going to look at their family issues, at least someone might look at how well they are doing there, their children. So I think they just see it as it's one big, it will do everything. But we don't."*

> *"Even though…they're telling me they are showing signs of mental health symptomatology that's not good. They will still get sentenced into custody for me to address, basically."*

This issue has been considered in detail in the courts chapter with suggestions around the developments for alternatives to custody. However, as one prison mental health team manager highlighted, there will still be some people with significant mental health needs who require a term of imprisonment. Their needs must be managed appropriately if the threshold for transfer to hospital is not met.

8.3b Improving identification of mental health problems and learning disabilities

There were mixed views as to how well processes for identifying mental health need among prisoners were working, although mental health managers were generally positive about current processes.

However, one Head of Resettlement interviewed felt that *"Staff often just see what they are presented with – a lad behaving badly. They often don't understand the behaviour is due to a mental health problem"*. Similarly, managers from prison mental health teams reported concerns that some problematic prisoners were making their way through the prison system without significant and severe mental health problems being identified:

"You get problem prisoners who move around the prison service so much that they've never actually been assessed by a mental health team because they're a problem to the prison. So they just keep moving them and moving them and moving them. And they end up somewhere, you get to

assess them and you think, Good Lord! How has this person ever got to this point without having any contact with services?"

This is reported as a problem nationally (i.e. throughout the prison system).

Conversely, others reported concerns that those who were quiet but in need of mental health support were frequently going unnoticed, echoing concerns at the police stage; *"If they aren't causing a lot of bother, no one is going to take particular attention of them."* It was suggested that prison staff would benefit from continued systematic training – especially on low level mental health issues like depression *"which staff don't always see as a mental health problem".*

As with other stages in the criminal justice system, particular concerns were raised about the identification of those with a learning disability within the prisons. Both prison staff and mental health teams working within the prison felt that this was an area where improvements could be made.

> *"Learning disability: I don't think we're particularly good at identifying that. It only really comes up in terms of an education kind of need, but of course it could be much wider reaching than that. We don't do any reception screening around learning disability."*

> *"The [learning disability prisoners] are unidentified. We don't identify them. It's only if they come across for other reasons."*

Nationally, the absence of a learning disability component in the initial health screen (the 'Grubin' screen) has been identified as a problem. Instead, there was a heavy reliance on the Basic Skills test in education to indicate a learning disability. A regional stakeholder from learning disability services suggested that he was not aware of a tool that had been successfully validated for this group and that this posed a problem when proposing changes to current screening practices in prisons. Once again practice varied across the prisons; when research was conducted in 2010 HMP Durham had included a number of indicative questions on their induction assessment [such as attending a special school] (Anderson, 2011) . HMP Durham was also a site for the Department of Health pilot for the Learning Disability Screening Questionnaire (LDSQ) but this has not been rolled out. One national expert suggested that many of those in prisons found that it took too long to complete and preferred utilising a number of locally chosen questions from the LDSQ.

As well as the absence of an appropriate screening tool, there was also a shortage of learning disability trained staff within prisons. As one prison mental health manager explained:

> *"Learning disability is quite a difficult one because…it's not what the majority of us are trained for."*

This did appear to be changing. HMP Northumberland had recently recruited a learning disability nurse to the team on a temporary basis and while there were concerns raised about the differences in training with nurses with a mental health background, this was generally seen as a positive development. The other prisons had weekly Forensic Learning Disability sessions and it was hoped that this session would be used for consultation, referral but also training of staff.

In HMP Kirklevington Grange there had been a significant increase in the number of learning disability referrals following the initiation of sessions by a mental health worker in the prison. It was felt to be too early to draw any conclusions as to whether this was a temporary fluctuation in numbers or an indication of previously unidentified need. However, it suggests the value of having a worker with significant experience in the field of mental health going into a prison, even without specific learning disability training.

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While concerns predominantly focused on issues with identification, there were also a number of concerns raised regarding care pathways for this group. For example, there was concern about screening individuals without following this up with action to meet need:

> *"I think I can see things like LDSQ, it's a great idea in principal, but the thing I was baffled by was what they were going to do with the findings. If they were going to roll this out, who are they going to refer these people to? And who was going to do all of these assessments? I think, my personal view as well, is to very much look at it on needs basis as well. Because we've had some cases where we got caught up in whether someone should be referred to learning disability or mental health services, and it's meaningless in a lot of cases."*

Several stakeholders supported this view that a needs-based approach rather than diagnosis-based approach could ameliorate some of the problems with care pathways for this group. At our stakeholder engagement events held in Middlesbrough and Newcastle, a number of attendees also highlighted the lack of access to suitable offender behaviour programmes as a problem for those with a learning disability.

Information sharing on reception and release

8.3c Disjointed computer systems

A significant barrier to obtaining and providing health and risk information about prisoners across the prison-community boundary is lack of access to the computer systems on which this information is held. Prison mental health teams are contractually obliged to enter data into SystmOne, the system that is used for prison healthcare. Few of the teams had access to either the PARIS system (used by TEWV services in the community) or RIO (used by NTW services in the community) and were therefore reliant on phoning local teams to get notes on clients faxed over which was time-consuming.

Perhaps an even more important barrier is that this information is spread over a range of different computer systems held by different areas and agencies. The mental health team at HMP Northumberland, who had access to the NTW system, RIO, found that frequently this was not helpful as the clients' details were on PARIS instead. This problem, which was also highlighted as a barrier for the CJLD teams, is particularly pronounced in prisons, since prisoners are often located some considerable distance from their home area, are transferred around the country and who have usually had contact with a wide range of different agencies.

> *"In an ideal world you would have a health system and if I walked into a hospital in Dorset, that I could walk in and they could pull up my medical record. It's talked about and it's never happened. But then we've got the added mental health, primary care, GP services, hospitals, prison service, probation service. You've got all the extra bits in as well. And there is no way those computers will talk to each other."*

In some cases, teams resorted to printing reams of information off different systems and trying to collate this information. Access to some of these systems could be limited by a number of factors. So, for example although many of the teams had access to the prisons C-NOMIS system this was not always the case (e.g. HMP Frankland) or was impractical due to lack of access to computers (e.g. HMP Northumberland). There are also restrictions placed on printing information off the C-NOMIS system.

Concerns about confidentiality and which agency needs to know what, particularly at the interface between health and criminal justice, present another significant barrier to increasing access to the range of these systems. So for example, although healthcare teams across the prison system use SystmOne, access to this data is restricted to those working within prisons.

However, despite the difficulties outlined, managers felt that access to the PARIS or RIO systems might be useful for the local prisons, in particular HMP Holme House which had a large proportion of clients from the TEWV area. Work was in progress to increase access to PARIS in the prisons. RAZ laptops have been secured for the teams (or to be shared between teams) but there have been some difficulties with these laptops periodically locking out of the system for security reasons and then having to be taken out and back in via prison security which is not a simple process. In HMP Durham practical difficulties meant that the system of phoning services to obtain medical records remained the most successful method that had yet been found.

8.3d Passing information without an identified contact

As well as the barriers presented by disjointed computer systems, processes for passing health and risk information to community agencies on release were frequently impeded by the lack of an identified service or individual for this information to be passed on to. Prison mental health team managers stressed the difficulties if the prisoner was not registered with a general practitioner in the community or if they were not leaving under the care of a community mental health service.

In these cases, prison mental health workers felt that they were left with little option but to provide a letter for the prisoner to take on their person on release and pass on to any health agency / general practitioner with whom they subsequently made contact. Given the acknowledged chaotic nature of many of these prisoners and their poor engagement with services, this is clearly a flawed system. As one CJLD practitioner highlighted, in some cases the person would still have this release letter on their person when they are re-arrested and appear back in police custody.

Similarly, heads of resettlement highlighted difficulties for prisoners sentenced to less than 12 months imprisonment who did not have a probation officer: *"for short-term prisoners there is usually no one to pass information on to."*

8.3e Improving information sharing within the prison

There were some indications of problems around the sharing of information within prisons themselves. Two of the three Heads of Resettlement interviewed raised this is an issue:

> *"For longer sentences information would be share with probation – however not health information – healthcare are very reluctant to share any health information at all so this sits outside the process."*

> *"We don't sometimes feel confident that we know exactly what's going on when someone has been referred to a mental health worker in the prison, and then…what that might mean in terms of the pre-release plan and how that is then shared for those that go on license with Offender Managers in the community…they share, but it's very, very basic."*

It was suggested that much of the problem revolved around concerns regarding confidentiality and different views of what it was appropriate to share:

"I think we do come across some issues around confidentiality and different, slightly different bars, as in the standard about when things are being shared, and it doesn't always feel like it joins up."

Offender Management were understandably concerned with assessing and managing risk and the view was expressed that mental health workers must have access to a range of information that could aid with these activities. Work had being undertaken at HMP Low Newton to increase the cohesiveness of joint working between the Offender Management and healthcare teams but it was felt that some problems remained. Inter-departmental risk management meetings were highlighted by two stakeholders as a good opportunity for sharing this information and health engagement here was welcomed.

From a health perspective, mental health managers expressed frustration that they had not been made aware of psychiatric reports commissioned for court purposes. Since these were commissioned independently they remained separate from the health system and so relied on other agencies to make them aware of their existence. Prison mental health workers reported that they often only became aware of these when a prisoner was approaching release when probation staff or parole boards wanted to know why the needs identified within these reports had not been addressed.

Findings here should be taken with caution since only three Heads of Resettlement out of the seven prisons were interviewed for this analysis and poor information sharing with prison mental health teams was not raised as an issue by any of the eleven probation staff working within prisons who responded to our survey of probation.

Resettlement

8.3f Opening up direct referral routes into community provision

Just as Criminal Justice Liaison and Diversion teams sometimes struggled to get clients accepted by Mental Health Trust services, so too did prison mental health teams. Reporting on the situation across all the prisons in the region, one stakeholder said:

"We've had massive problems with some services taking people coming out of prison…we've had some people where it's gone right to the last minute before they've actually accepted referrals."

Lack of access to Trust IT systems in order to make electronic referrals was also highlighted as a potential barrier to accessing services. In addition, problems were exacerbated by wide catchment areas for prisons so that most of the prison teams were frequently required to work across different teams and different mental health trusts. These Trusts varied as to their models of community provision, their threshold for access to a service and their route into services. A wide catchment area also inhibited the development of relationships with relevant professionals in community teams.

Managers commonly reported the problem of being bounced around between the access and crisis teams:

"Six weeks prior to a patient going…we knew we needed to get him in a community service. He wasn't a well man, but he wasn't sectionable. So a member of the mental health team rang the crisis team. You don't want crisis, you want access. So they rang the access team. You don't want access, you want crisis…That went on with various members of staff, backwards and forwards, between access and crisis. At one point they actually said, 'no, no you need to ring forensics'. And it

was my phone call at that point. So I said, believe you me, I don't know whether I want access or crisis, but I DEFINITELY know I don't need forensics."

It was felt that since the teams were NHS providers of secondary mental health care, they should be able to bypass the access function into Trust services and be able to refer into the community teams directly. This had been flagged up as a problem at a high level within TEWV and as a result it was suggested that it was now easier to bypass the access function into TEWV's community services at least.

8.3g Engaging community support prior to release

It was felt that when release planning went well, it was often when professionals from community agencies were encouraged to come into the prison and develop a professional relationship with the client prior to release or maintain an existing relationship while their client was in custody. In this way, they were able to meet with the prison mental health worker prior to the client's release and start preparations in the community where that client was being released to with a smooth handover of care.

> *"Historically what used to happen was quite often they would just be discharged off CPA [the Care Programme Approach by community teams]. We've managed in cases to get the CPA coordinator to continue being the care coordinator and then the prison staff will almost act as kind of a co-worker and work on supporting the person while they are in prison. I wouldn't say they have true CPA meetings, because you don't have family care input, you might not always get the prison to be able to take a fully active part, but they still have some coordination meetings. And then when it comes to discharge, the CPA community coordinator can be planning for the discharge. And that's quite a big step for that."*

However, even within TEWV it was reported that some community teams could be more reluctant than others to coming into the prison. It was reported that the older adult teams and the early intervention in psychosis teams had both previously demonstrated willingness to come into the prison but that securing engagement with other teams such as the affective teams had proved more of a challenge. It was suggested that heavy demand on affective teams might be one reason for this.

The prison mental health team managers also reported that all too often the practice of discharging a patient from the Care Programme Approach continued.

> *"What actually happens with CPA: 'Oh they're going into prison, let's discharge them. Nowt to do with us now.' And when they are up for release, they don't want them back. Happens all the time."*

Distance remained one significant barrier to encouraging community mental health staff and indeed other professionals, such as Offender Managers, to come into the prison and undertake face-to-face release planning. Additionally, a number of the prison mental health team managers highlighted the problem that prison security rules dictated that a professional could only come into the main body of the prison on three occasions before they had to go through the lengthy and off-putting prison security clearance procedures or attend via the main (or possibly the legal) visits system. The view was expressed that it was difficult to cajole community workers into coming into the prison if this route for continuing care was then going to be subsequently removed in effect. The damaging impact on prisoners of removing this direct access to their community worker was also highlighted.

One suggestion was that prisons needed to think about developing a half-way house visits hall; somewhere that was not part of the main visits hall but was not within the body of the prison either

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where care coordination meetings could be undertaken attended by the prisoner, relevant professionals from both the community and the prison (not simply limited to health), and potentially also the prisoner's family.

Mental health team managers reported only very limited family work with their clients, despite acknowledging that this family provided significant support role for their clients in the community on release:

> "We know there is a massive sub-carers input from family and stuff like that. And the majority of my contact with family members is over the telephone. I'd say that's the same for the majority of our staff as well to be honest with you. Whereas there has never been much work [around]… inviting family members in, doing work with the families prior to release, resettlement. But it's a massive issue."

In one prison it was reported that such a meeting involving both the prisoner and their family had been facilitated by the mental health team, but this was an isolated case and had taken place in the prison's board room.

8.3h Lack of warning about release dates

A significant and commonly reported barrier to resettlement planning was the lack of warning about release dates. This could arise when clients were released unexpectedly from court, as charges were dropped or as clients were released on licence at short notice to increase capacity within the prisons.

> "Sometimes you're quite restricted in what you can do. Especially…if you get one of those phone calls on a Friday – because they always happen on a Friday, don't they? – Joe Bloggs is on an open ACCT [Assessment, Care in Custody and Teamwork document for those at risk of harm to themselves], he's open to mental health and he's being released from court now."

> "For the local establishments, we can get people who are acutely ill, still sent into custody…And then all of a sudden we get a telephone call from the CPS on a Friday afternoon, saying that you must release this prisoner. Consequently we have to get in contact with the approved social workers and crisis teams to come into the prison."

Conversely, a senior stakeholder with responsibility for some of crisis teams within the region expressed the frustration felt by these teams that they would receive such phone-calls warning of a high need, high risk client being released from custody imminently with no planning for release having been undertaken.

Mental health team managers reported that it was common that they were not even aware that someone was being released until after they had already gone and the mental health worker attempted to visit them. This was a particular concern for managers because in this instance not even the minimal release preparation of informing and linking with the local crisis team could be undertaken. One prison mental health team manager had unsuccessfully tried to find a solution locally with their custody manager to see if an alert could be placed on the prison's C-NOMIS system for the mental health team to be notified if a client was about to be released.

It was suggested by one stakeholder that for those clients going to court it might be possible to use the Prisoner Escort Record (PER) to request notification by court custody staff if a client is released from court since limited information regarding mental health need is already recorded on this form.

This is one option for further exploration. Alternatively, there appears to be a role here for joint-working with CJLD services based within courts.

8.3i Housing

The recent HMIP inspection into HMP Kirklevington Grange reported that *"It was rare for a man to leave the prison without somewhere suitable to live"* (HM Chief Inspector of Prisons, 2011a, p.6). However, this appeared to be the exception to the norm. Lack of planned housing for prisoners on release was identified as a common problem for prisoners almost unanimously by prison mental health managers as well as by other stakeholders.

Managers reported that prisoners were frequently released without housing altogether. Alternatively, where housing was found for clients, arrangements were not put in place until the very last minute, up to the day before or even the day of release itself. Even with high risk MAPPA clients where there was at least some reassurance that accommodation would be found, prison mental health team managers reported that a place at an approved premise was frequently not identified until the day prior to release.

As well as being a serious problem in itself, a lack of planned housing was also identified as a significant barrier to the provision of continuity of mental health care. Without an identified area to which the prisoner was being released, it was impossible to refer a prisoner to a community team, pass on health information about the client or undertake any positive pre-release work around engaging community teams.

It was also recognised by both national experts and regional stakeholders that without housing you had little chance of maintaining engagement with clients even if they remained within the community team's catchment area;

> *"The post-prison leaving – that's where it is the most crucial – if someone's leaving prison, worrying about whether they're registered with a GP and have they got an appointment with a community psychiatric nurse are icing on the cake. I would worry – even giving them the right meds, if they haven't got a cabinet to put that medicine in and a house around that cabinet, it's pretty worrying. If they haven't got their benefits sorted then…so on and so forth – they're immediately in difficulty."* *(National expert)*

> *"And housing is a massive [barrier] for Holme House and Durham because we get a lot of people there where they are on for short sentences. I've always felt that if you can tackle the housing problem, then you've got half a chance of engaging them in the future. But if they are sofa surfing…you're never going to catch them to be able to engage with them."* *(Regional stakeholder)*

Both HMP Durham and HMP Low Newton are understood to have a Shelter-run housing service. However, the most recent prison inspectorate report for HMP Northumberland (from 2009 as HMP Acklington) reported that there was no housing advice service (HM Chief Inspector of Prisons, 2009), while the report for HMP Holme House reported that "accommodation services…were in disarray" (HM Chief Inspector of Prisons, 2011b, p.5).

Prison mental health team managers expressed their frustration that other agencies within the prison, who they perceived as having responsibility for addressing this problem, did not understand the implications in terms of the prisoner's health care:

> *"And you can supply that information to housing within the prison, to probation staff, but they still say, no there is nothing we can do at this time, that offender will have to just report to the local*

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Echoing comments expressed by the CJLD practitioners, prison mental health team managers said that prison mental health teams simply did not have the capacity to address these issues themselves, however detrimental the impact of not addressing these issues. They urged commissioners to consider the issue of housing provision for these groups.

One stakeholder described relationships between mental health and Stockton housing as extremely good. There is also a programme in Stockton where the top ten most prolific offenders coming out of prison are targeted, and provided with high level accommodation. This ensures that they are provided with good quality housing, with a high level of support. They operate a passport system, whereby if the flat and tenancy are maintained for a period of time, the passport is stamped. This is accepted by a number of private landlords, which helps the individual to move on to other private accommodation. This system has proved to be very effective.

8.3j Integrating mental health with other resettlement planning

In addition to mental health care and the Offender Management Unit, there are a number of other services within the prison which support prisoners in their preparation for release. Provision varies significantly across the prisons as do processes for release planning. In HMP Frankland there is little release planning due to population characteristics since very few prisoners are released directly into the community from high security conditions.

One example of good practice was at HMP Durham where all offenders are put on pre-release discharge board where resettlement needs are identified. For short term prisoners this is normally a 'virtual' process whereas for longer sentences or those who pose a high risk this would involve a multi-agency meeting to look at full range of resettlement needs and to develop a resettlement plan. This works particularly well for Integrated Offender Management (IOM) prisoners who receive a strengthened version of this panel with involvement from outside agencies.

Given the limited time available for this analysis it has not been possible to map resettlement provision across all seven prisons in the region. However, interviews with the heads of Resettlement at HMP Durham and HMP Low Newton identified a range of agencies with involvement in resettlement planning including Offender Management, Integrated Drug Treatment Services (IDTS), housing, education and Job Centre Plus. HMP Low Newton also had a large number of community-based services, include the local women's centres (Women Outside Walls and REACHES) that went into the prison to help link women with support on release. The recent prison inspectorate report for HMP Kirklevington Grange also reports "impressive community links" (HM Chief Inspector of Prisons, 2011a, p.5).

However, in many cases, resettlement planning by mental health services appeared to be removed from any resettlement planning being undertaken by other agencies within the prison.

In both HMP Low Newton and HMP Durham improved integration between healthcare and Offender Management was desired, in particular with regards to the aforementioned problems around information sharing. Additionally, the 2009 prison inspectorate report from HMP Acklington (now HMP Northumberland) reports that "*More work was needed to align healthcare with resettlement services*" (HM Chief Inspector of Prisons, 2009, p.16), although significant changes to that prison have

taken place since this inspection took place. Concerns about housing across most of the prisons also suggest that further joint working between mental health teams and these agencies is desirable.

It was acknowledged by stakeholders from the mental health teams that addressing social care needs is not seen as a priority. Instead, the focus is on facilitating access to secondary mental health support and managing risk. For the most part prison mental health team managers reported that it was very rare for them to link their clients with voluntary-sector agencies, despite a wide range of such services in the region. (The exception here was HMP Low Newton where links with agencies such as Over the Gate were reported.)

In some cases managers reported previous poor experience with these services such as a failure to respond to requests for information or difficulties in the referral process. Another prison-based stakeholder also expressed significant concern about the insecure funding of many of these services which resulted in services closing just as staff were getting used to accessing these. A number of stakeholders pointed to the new Mind mentoring service for prison-leavers with mental health problems might offer a good new referral pathway for some prisoners. However, there appeared to have been some teething problems which had yet to be ironed out, such as a failure to engage mental health team managers at the outset.

8.3k Specific problems for short sentence prisoners

Short term prisoners were identified by the commissioners (NEOHCU, 2011) as one of a number of priority groups for this project. The high levels of need and difficulties in ensuring access to support for this group of prisoners are clearly identified by the literature (Anderson, 2011) and this was reinforced throughout our interviews with prison mental health team managers, all Heads of Resettlement and other stakeholders who suggested that this group frequently *"fall through the net"*.

> *"Many short term prisoners spend most of their time in here on remand so when they are actually sentenced they don't have long left to serve. While on remand they don't have to engage with anything at all."*

One stakeholder emphasised the need for work to be undertaken with Magistrates to increase their understanding of the very limited work than can be undertaken with short sentence prisoners:

> *"I think the very real challenge for us is actually about liaising with our colleagues in probation to liaise with the magistrates' courts locally about how they are sentencing – what do they actually think happens when they sentence somebody to short sentence? And, I think [they need] a bit of a reality check, really, on just what the impact actually is, because we really struggle with the short term population in terms of any kind of proper integrated assessment with a view to any kind of comprehensive release plan. And as I say then, we're 'surprised' when they come back."*

Once again, the importance of having sufficient information and influence at the sentencing stage was highlighted as crucial for improving reoffending and health outcomes.

9
Priority Groups

Given the limited resources that accompany the Big Diversion Project (BDP), consideration was given as to specific groups who might merit a particular focus in any work going forward. As well as groups identified by the BDP Commissioners, interviewees were asked for their views on other groups who were poorly served by services or otherwise deserved prioritisation as part of the BDP.

9.1 Priority groups identified by the BDP Commissioners

9.1a Minority groups

Minority groups were identified by the Commissioners as a priority group for the BDP. Although the BDP service specification (NEOHCU, 2011) does not explicitly identify which minority groups are to be considered, the policy context outlined in the specification highlights national work around improving responses to both Black, Asian and other minority ethnic (BAME) groups and women (considered as a minority group in this context due to the very low numbers of women within the criminal justice system) (NEOHCU, 2011, p.3). Where time permitted, regional stakeholders were asked whether these groups required priority status for the BDP in terms of their need for a specific response, particular challenges that these groups posed or specific work that was already underway to better meet the needs of these groups.

Black, Asian and other minority ethnic (BAME) groups

Nationally some BAME groups tend to be over-represented within the criminal justice system (with some specific exceptions) with evidence of more punitive sentencing of these groups (Anderson, 2011). This has led to significant concerns about discriminatory and extra-punitive responses to BAME groups, although it is acknowledged that this over-representation may, in part, be linked to some BAME groups being disproportionately responsible for some types of offences, probably as a result of the increased social exclusion of these groups (Phillips and Bowling, 2007, as cited in Jacobson, Phillips and Edgar, 2010). Concerns have also been raised regarding the over-representation of BAME groups in mental health and learning disability inpatient care and the routes by which those from BAME communities access mental health services, in particular the higher proportion of those accessing such health services via the criminal justice system (Jacobson, Phillips and Edgar, 2010).

Consequently, a number of national campaigns have focused on these issues including the Clinks 'Tackling Race Inequality Initiative' funded by the Department for Communities and Local Government (2010, p.31) and current work by the organisation Race on the Agenda (ROTA) (2011), which is focusing on the intersection between criminal justice and mental health. Ensuring appropriate responses and diversionary interventions for these groups will be an important part of the work of CJLD services.

However, although language barriers were acknowledged as an issue, responses from regional stakeholders suggested that BAME groups were not considered a key priority for local agencies or

for their vision of the BDP. Responses from regional stakeholders frequently fell into two types. The first type of responses expressed some concern regarding the current response to BAME groups locally, acknowledging their particular cultural, religious and language-based needs that require a tailored response. However, these respondents frequently pointed to the low prevalence of BAME groups in the North East Region (see Figure 9.1).

> "If I'm being honest... we don't see significant numbers. If we were other areas in the country, you know, London, [there would be higher numbers]. But we wouldn't be particularly well geared up to necessarily meet...[any] specific needs of BAME communities in the criminal justice system. So absolutely [they are] a priority, but it's not something that we see significant numbers in. It's a population based thing isn't it? Based in demographics."

> "I would say that black and minority ethnic groups within Cleveland are minimal coming into custody. That said there are a number of Eastern Europeans who would still come under minority group. But I don't think that's a target area that we're particularly looking at."

> "It's not a massive issue but [the services I manage] probably lack a lot of knowledge around cultural issues...[BAME referrals] are just not a common everyday thing. You would hope that [when there are BAME referrals], staff were conscious of [their lack of awareness] as it is not an everyday thing."

In contrast, the second group of respondents did not feel that these groups required particular attention.

> "Politically yes but experience suggests that they're not a problem."

> "No – they are not more disadvantaged than any others in terms of mental health and police response."

> "They get the equivalent service to everybody else."

Unfortunately it has not been possible to obtain data regarding the ethnicity of section 136 detainees and arrestees within the time frame.

Frequently, respondents who fell into this second group were concerned about singling BAME groups out as 'different', emphasising that everybody was treated the same. In particular, those CJLD practitioners who expressed this view highlighted the 'holistic' nature of their assessments, which aimed to identify the full range of support needs of that individual. However, a best practice guide to liaison and diversion for BAME service users by NACRO highlights the danger of this approach.

> "While many schemes claim they operate a 'colour-blind' approach or assert that 'everyone is treated the same', such a stance can disguise the fact that the specific needs of BME service users have either not been thought about or have been ignored...An assessment of a person cannot be carried out properly unless a person is seen in context, and this context includes culture, race and faith. Therefore, unless schemes proactively consider how they might meet the specific needs of BME service users, the result is likely to be both an under-development of policies and the absence of a systematic approach to meeting needs, as well as the fostering of stereotypes and racist attitudes to BME communities. What is needed is an approach that 'moves away from the notion of "an average citizen" to an acknowledgement of the diversity of need and required services'. It is imperative therefore that schemes ensure equal access to diverse services, equitable treatment and equitable outcomes." (NACRO, 2009, p.8)

One interviewee reiterated this concern, emphasising that the low prevalence of BAME communities in the area meant that the danger was in fact even greater:

"Durham and Darlington are a large area of the Northeast that have quite a low ethnic minority population in comparison to other areas in the country. The risk of that perhaps means that services don't ensure accessibility and don't pay particular attention, and I think you need to do the opposite when you have a lower number."

The NACRO (2009) good practice guide presents a range of recommendations for those involved in the development and delivery of CJLD services to support the development of more inclusive and responsive services to BAME communities. In many cases these recommendations are resource-neutral and therefore while BAME communities may not be taken forward as a priority group for the BDP many of these recommendations can yet be implemented.

Recommendations include monitoring service access and outcomes for BAME groups, diversity practice in planning and delivery, proactively identifying and addressing cultural and religious needs, liaising with BAME service providers (including those in the voluntary sector and those which are women-specific), ensuring development and service delivery reflects agency's race equality scheme and diversity agenda, ensuring operational protocols and policies include statements on equality and diversity, staff that reflect diversity of the local community or joint-working arrangements with more diverse teams and cultural awareness training programmes for staff.

In particular, the guide promotes partnership working with local BAME organisations. There was some evidence of promising links being developed such as work to increase awareness of mental health provision through the Asian Families and Carers Network in Stockton, or work being undertaken to establish relevant links by probation in South Tyneside. However, largely the evidence from the analysis phase suggests that links between CJLD schemes and other relevant services (eg. inreach teams) and BAME community-groups are poorly developed. Representatives consulted from BAME community organisations in the North East suggested that improved links would be welcomed and highlighted the importance of looking at how BAME organisations might be better supported to work with this cohort (mentally ill offenders).

Figure 9.1	Ethnic breakdown by local authority area											
	England	Newcastle	Sunderland	Gateshead	North Tyneside	South Tyneside	Northumberland	County Durham	Darlington	Hartlepool	Middlesbrough	Redcar & Cleveland	Stockton
White, British	82.79	83.609	93.113	92.925	92.748	92.388	95.403	94.806	93.277	95.27	88.114	94.764	92.412
White, Irish	Not published	0.668	0.355	0.367	0.406	0.328	0.386	0.316	0.498	0.33	0.498	0.436	0.419
White, other	Not published	3.482	2.272	1.939	2.079	1.312	1.318	1.303	1.892	1.21	1.495	1.164	1.988
Mixed	1.85	1.618	0.816	0.943	0.963	0.919	0.707	0.731	0.896	0.77	1.352	0.655	1.047
Asian or Asian British	6.11	7.035	2.059	1.939	1.876	3.937	1.157	1.501	1.793	1.54	5.907	1.6	2.773
Black or Black British	2.94	1.477	0.71	0.891	0.71	0.656	0.482	0.494	0.697	0.33	1.21	0.727	0.733
Chinese	0.85	0.879	0.284	0.419	0.558	0.197	0.225	0.375	0.498	0.22	0.925	0.364	0.314
Other	Not published	1.196	0.426	0.524	0.609	0.262	0.289	0.415	0.299	0.22	0.427	0.218	0.366
Source	http://www.guardian.co.uk/news/datablog/interactive/2011/may/19/ethnic-breakdown-england-wales who obtained data from the ONS											

Women

Despite roughly equivalent proportions of men and women in the general population, women form only a minority of those passing through the criminal justice system. Ministry of Justice figures from 2009 suggest that women made up less than a quarter (22.7%; 370,520/1,635,664) of all defendants proceeded against at Magistrates' Courts (Ministry of Justice, 2009, p.10).

In 2007, Baroness Corston's review of women with particular vulnerabilities in the criminal justice system was published. In her report, Corston (2007, p.3) emphasised that *"treating men and women the same results in inequality of outcome... Equality must embrace not just fairness but also inclusivity. This will result in some different services and policies for men and women."* In a system currently designed for men (who form the majority), Corston (2007, p. 79) identified the need for *"a distinct, radically different, visibly-led, strategic, proportionate, holistic, woman-centred integrated approach"* for these women. Corston (2007, p.2) also advocated for a *"fundamental re-thinking about the way in which services for this group of vulnerable women, particularly for mental health and substance misuse in the community, are provided and accessed."*

Several interviewees specifically referred to the Corston (2007) report and generally there appeared to be support for a distinct approach for women, with interviewees highlighting needs around self-harm and motherhood.

> *"Their pattern of relationships with service providers is much more engaged – women are an operationally distinct group. Most female offenders when they go into prison are already in touch with mental health services when they come in...They are attractive for diversion because they are much more vulnerable if they are incarcerated."*

> *"They present very different problems and need different solutions."*

However, few interviewees articulated what specific changes they would like to see as part of the Big Diversion Project. There was evidence of some existing and planned work to support women offenders in the region. This included women-only reporting days within the two probation trusts, a wide-range of support agencies providing in-reach mental health and other support to women prisoners at HMP Low Newton and 'one-stop shops' for women offenders in the community (including the WOW project in Newcastle and REACHES in Teesside). It was acknowledged that provision of these one-stop shops was patchy and incomplete although funding has been secured from the Department of Health to extend WOW support to Sunderland.

In terms of the CJLD services, some practitioners and service developers clearly demonstrated an awareness of the need to link women with women-specific services;

> *"We know that there are groups around the North East that will deal with female [offenders] specifically...And as long as we're aware of that and know how to access those services, then we've done something. Rather than just treat it as another patient and passing them onto a generic service."*

In particular, the new CJLD service in Sunderland and the new Sunderland WOW service for women are being established in tandem with the intention of creating strong referral routes between the two services. This is a promising development.

However, some CJLD practitioners again expressed the view that everyone was treated the same and that a women-specific approach was therefore not required. As with this approach to BAME groups there is a danger that a gender-blind approach means that women's specific needs and patterns of engagement with services are ignored. National experts reported on work that had been

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undertaken in the South West region to determine why a high proportion of refusals to be seen by the CJLD service and what could be done to address this. It was found that while women were reluctant to engage with mental health services they were more willing to engage with a women's worker from a local women's service (Hean et al, 2009). Joint-working with such a centre at the court was then utilised to increase indirect take-up of the CJLD service.

> *"The women thing is quite important... There were a couple of reasons for [the increased take-up during the South-West women's pilot]: they weren't named a mental health service, they were named a women's service about solving women's problems. The other thing – and I'm not sure if there's sort of gender blindness in services or something like that – but I think the mental health label was not necessarily something that women wanted. They already had a conviction or the offender label if you like, they worried about being a parent and staying a parent, and having the mental health label won't help their case. Or that is what they perceive, so they're far more likely to seek help from a service that feels safer."*

As noted elsewhere in this report, a lack of collected data available has impeded the analysis and it was not possible to determine by gender the proportion of refusals to be seen by CJLD services in the North East. Such monitoring is an area for consideration moving forward.

One interviewee also contrasted the range of provision available for women in HMP Low Newton with available services for women in the community, in particular highlighting the lack of trauma-based mental health services or provision of Dialectical Behavioural Therapy in the community. It was suggested that CJLD services could benefit from a wider range of referral options for women.

Finally, despite a national push to improve responses to women offenders, a small number of interviewees did highlight ways in which male offenders could also be considered 'a priority' including low numbers of male referrals to mental health services such as IAPT and fewer voluntary sector services providing comprehensive and targeted support into male prisons and as alternatives to custody.

9.1b Young adults at the interface between youth and adult services

Of all the 'priority groups' identified by the commissioners of the BDP, the strongest support for prioritisation was for young adults who were consistently identified as a group for concern by national experts and regional stakeholders. This was also a theme that emerged strongly from the stakeholder engagement events.

Young adults are over-represented within the criminal justice system, constituting a significant proportion of those passing through the system. The Transition to Adulthood (T2A) Alliance convened by the Barrow Cadbury Trust campaigns around the need for a distinct approach to this group. They report that young adults make up 9.5% of the UK population but commit one-third of all crime, they take up one-third of probation caseloads, and represent almost one-third of those sentenced to prison each year (T2A Alliance, 2009, p. 10). They also have the highest re-offending rate of any adult age group (T2A Alliance, 2009, p.15). The Alliance also reports higher levels of mental health problems among young people in prison and a greater propensity to take or try to take their own life than both younger and older prisoners. (Department of Health, 2000 as cited in T2A Alliance, 2012, p.32)

Some interviewees simply identified the young adult group as 'problematic', highlighting their high crime rate and general difficulties transitioning to adulthood.

"People get lost in the transition period and cause a horrific amount of crime."

"Young adult males are the biggest problem from an 'offending' perspective."

However, many interviewees specifically reported that the problem in fact lies with a failure by current service systems to adequately respond to this group.

"The point of transfer requires attention – not the group of people themselves. Boundaries [between services] are where the risks lie – age cut-offs in services. Moving vulnerable young people [to the adult prison regime] is inherently risky."

"Sometimes I come across certain people who are just emerging from adolescence who may have had treatment…for ADHD and then suddenly there's a cut-off. And then there is a whole cacophony of offences that can follow as a response. They are a group that maybe need extra support, especially if they've had difficulties educationally."

"Nobody concerns themselves with the transition from youth to adult services. Learning disability stuff should be picked up here and it isn't. [Offenders] are dealt with in a certain way through youth justice (helping, modifying, constructive methods). They then transition, become 18 and come into the work of adult services where there is a different emphasis and different way of dealing with people."

Interviewees highlighted the different cultures, service thresholds, range of provision and distinct approaches adopted in youth and adult services, both within criminal justice and health. They reported a need for an adequately planned, supported and well managed transition from children's to adult services. The different age at which this transition takes place across different sectors was identified as a compounding problem.

The 2011 government mental health strategy, *No health without mental health* (Department of Health, 2011, p.25) emphasised the need to avoid 'arbitrary discontinuities' in care and recommends ways in which the transition process between Children's and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMH) can be improved. These include "planning for transition early, listening to young people and improving their self-efficacy, providing appropriate and accessible information and advice so that young people can exercise choice effectively and participate in decisions about which adult and other services they receive, and focusing on outcomes and improving joint commissioning, to promote flexible services based on developmental needs" (Department of Health, 2011, p.25).

Many interviewees expressed concern about the impact of a poor transition on offending behaviour. A number of stakeholders from probation and youth offending services in the region reported that it was all too common for those known to youth offending services to drop off the radar of services at 18, only to come to the attention of probation several years later following the commission of a more serious offence. Research is also currently being undertaken by YoungMinds and City University to consider the impact of a poor transition between CAMHS and AHS on any subsequent offending.

There were some promising developments reported in this area. It was reported that transition arrangements, particularly with respect to drugs services, were on the agenda of the Community Safety Partnership in South Tyneside. In Newcastle, the Youth Offending Service Manager had been so concerned with the importance of transitions that he had instigated a transitions protocol locally with probation to ensure that there was not a cliff-edge in support. However, a number of interviewees expressed disappointment that the transitions teams previously in place in TEWV had been disbanded.

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Interviewees also highlighted the need for greater provision of age-appropriate services.

> *"I think with the change of threshold, not only does it become more difficult for a young person to be referred into adult mental health services because of the threshold; the threshold is much higher, but the services are less appropriate. So the sort of interventions that they were getting with CAMHS services that would have been much more about family support, a holistic sort of intervention, the nature of the mental health problem is probably quite different to the sort of problems that AMH services are dealing with. The whole situation changes and young people find themselves not only unable to access AMH services, but probably not really wanting to be in them anyway... the adult service has to provide services that look more like CAMHS services than full adult services in that initial period."*

The Transition to Adulthood (T2A) Alliance also provided examples of age-appropriate provision for young adults in other service areas. An Addaction project in Derby provides a 'young adult' specific substance misuse service that does not have the largely opiate and crack cocaine focus that is usually seen in adult drug services but which young adults may find alienating (Revolving Doors Agency, 2010). A number of 'T2A pilots' across the criminal justice pathway also provide promising examples of tailored interventions to address offending behaviour (T2A Alliance, 2012).

In terms of the Big Diversion Project, the majority of the CJLD services in the region currently only provide a service for those aged 18 and upwards although many practitioners reported that they would certainly not to refuse to see a younger detainee who was experiencing significant mental distress. South Tees has a youth diversion service and interviewees highlighted the importance of close links and shared learning between the adult and youth services. Representatives from the Department of Health suggested that the national direction of travel was towards 'all-age' diversion services. Consequently, improved integration of the two services is an area for consideration. One interviewee emphasised the importance of joint-working with mental health practitioners within youth offending teams and suggested that there might be a role for CJLD services in supporting young offenders in transition between CAMHS and AMHS.

Once again, interviewees emphasised that diversion for young adults had to be about diversion into an appropriate intervention as much as it was about diversion from prison. Consideration should be given to the development of age-specific alternatives to custody such as the T2A pilot in Birmingham that offers a 'Probation Plus' arrangement whereby a comprehensive range of additional support is offered alongside a supervision order, but without any threat of breach of the support component. Alternatively, organisations such as St Giles Trust and the Prince's Trust have developed interventions for this age group that adopt a peer mentoring approach (T2A Alliance, 2012).

Some interviewees acknowledged that 'diversion' for young people was not purely about ensuring appropriate support for mental health problems and learning disabilities. Diversion for this group might also be considered out of a desire to keep first-time offenders out of the system. Additionally, the T2A Alliance has highlighted incomplete developmental maturity among young adult offenders with the result that consideration of maturity has recently been included as a mitigating factor in sentencing guidelines for a range of offences, including assault and burglary. It will be important to consider how assessment and provision of a range of diversionary interventions for this group might best be integrated.

9.1c Dual diagnosis

Although not identified as a specific 'priority group' by the BDP commissioners, the needs of and response to those with a 'dual diagnosis' of both a mental health and a substance misuse problem were integral to the BDP Service Specification. They were considered a core concern along with mental health problems and learning disabilities in isolation.

Research suggests that substance misuse is usual rather than exceptional among people with severe mental health problems (Department of Health, 2002, p.4) and it has been argued that co-morbidity of substance misuse can be considered the 'default' for those on the caseload of prison mental health care (Durcan, 2008); 75% of prisoners have both a mental health problem and drug or alcohol problem (OHRN, 2009b as cited in Prison Reform Trust, 2011, p.54).

Concerns nationally about the service response to those with a 'dual diagnosis' led the Department of Health to publish a good practice guide in 2002. This emphasised that "individuals with these dual problems deserve high quality, patient-focused and integrated care. This should be delivered within mental health services. This policy is referred to as "mainstreaming". Patients should not be shunted between different sets of services or put at risk of dropping out of care completely" (Department of Health, 2002, p.6). It went on to provide a range of recommendations for how "mainstreaming" might best be achieved.

Within the North East region, both mental health NHS foundation trusts have dual diagnosis leads who oversee arrangements within the Trust for the provision of dual diagnosis support. In NTW there are distinct Commissioners and commissioning arrangements for the North and South of Tyne so different models operate in the two areas. In the North of Tyne (Northumberland, Newcastle, North Tyneside) there is one dual diagnosis practitioner who provides expertise and liaison support to other practitioners within the Trust as well as some case management. In the South of Tyne area, commissioning responsibilities rest with the Addictions Commissioner so dual diagnosis practitioners are locality based. There are two in Gateshead, two in South Tyneside and three in Sunderland (one of which is embedded within the IAPT service). Again these provide expertise and liaison support as well as some case management.

Nevertheless, interviews with regional stakeholders suggested that those who present in the criminal justice system with a dual diagnosis remained a concern both in terms of their 'chaotic nature' and failure to engage; but also in terms of the response of both mental health and substance misuse services to this group.

> *"They fall between two stools…If one service is involved the other might tend to withdraw."*

> *"They are horrendous and definitely a high priority. They fall between the stools of treatment and interaction for us."*

> *"I think generally mental health services are still really poor in terms of people ending up getting pushed from mental health services, you know, who won't support them until they've had their drug and alcohol issues addressed, or vice versa. You know, even though that's been recognised for years, actually I still see it going on a lot locally. So I think that's still an issue."*

Police concerns frequently centred on the 'masking' of mental health problems by intoxication, the challenge for police in distinguishing these problems and frustration by police at the perceived reluctance of mental health teams to assess those who were under the influence. This was a central theme from the interviews as well as from an event organised by Safer Durham Partnership during the analysis phase. Difficulties facilitating access to appropriate mental health support for this group

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emerged as a concern for probation teams, as discussed in Chapter 7. Interestingly, clients with a dual diagnosis were not reported as a significant concern for prison mental health teams although there was a desire among these teams for practitioners within Integrated Drug Treatment Services (IDTS) in prisons (who are mental health trained) to undertake some of the lower-end mental health work since mental health teams caseloads were already filled with the higher end. Work is planned to increase psychosocial interventions offered by IDTS workers.

In seeking to understand the problems that remained regarding dual diagnosis, despite improvements in provision, national and regional experts highlighted that much of the focus of service development was on those who had both severe and enduring mental health problems and severe substance misuse problems. While this improvement was welcomed, many of those whose individual problems were 'less severe' when considered in isolation from one another still struggled to access support. This was equally the case for those who might have multiple diagnoses or needs and not simply a dual diagnosis.

Several interviewees and other stakeholders consulted as part of the analysis phase emphasised that it was those that fell on the borderline of eligibility for services that provided the greatest challenge and that it was improved responses to these groups that needed to be prioritised.

> *"I think it's where it's the border between the services more than anything. So your affective-psychosis [clients], or your complex needs [clients] or your borderline LD [learning disability clients]...It's where you're on the cusp of a couple of services."*

> *"The default for people entering the CJS is multiple and complex need... And the problem is that a lot of those problems are sub-threshold...They won't necessarily get into secondary mental health care services because the threshold is about severe and enduring mental illness and these people may not have that – they may have a moderate mental illness that no GP is going to be able to sort out because the GP has got to sort out their housing, their experience of trauma, their poor life skills, their poor life history, all of this other stuff...their unhelpful substance use which may or may not be an addiction... so on and so forth. And that's the other thing, and that's another barrier – we set thresholds."*

> *"It's the group...who aren't currently engaged in services, who aren't accessing services, who either have multiple difficulties or don't meet any one threshold [that are poorly served by services]. It's all of those sort of people I think."*

Solutions for this group include the consideration of a broader response such as looking to the voluntary sector where thresholds may be more flexible. There is also a need for greater integration of services so people are less likely to fall through service 'gaps' as well as joint-working, shared caseloads and an up-skilling of professionals in a range of services through adequate liaison support. In particular for the BDP it will be important for CJLD teams and Drug Interventions Programme (DIP) teams to work closely together to assess the full range of a client's needs and to identify and negotiate access into an appropriate service. There was evidence that links between the two teams could usefully be improved in many areas of the region.

9.1d Sentence-related priority groups

In addition to the groups outlined above, the BDP commissioners identified a number of sentence-related priority groups: (i) offenders sentenced for non-imprisonable offences, (ii) offenders sentenced to community penalties and (iii) offenders serving sentences of less than 12-months imprisonment.

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It was difficult to get an overview of the relative prioritisation of each of these groups of offenders since many regional interviewees were only able to talk about their specific stage of the criminal justice pathway, of which these three groups fall at different stages. Interviews with national experts also did not provide a clear case for prioritisation of these groups.

Nevertheless, the interviews identified reasons for consideration of how best to identify need and provide support to each of the three groups.

It was highlighted that those who had committed **non-imprisonable** offences often failed to receive support due to the desire for or necessity of a 'light touch' response. For example, this group might be dealt with out of courts by way of immediate sanctions. Not only does this reduce the opportunity for assessment and intervention, there were also concerns about penalties being provided that offenders might not understand or be able to comply with. It was reported that there was a lack of clarity regarding the necessity of providing an appropriate adult when cautions or immediate disposals were administered. Even where cases do progress to court, only limited disposals are available to the court. In particular, this group are ineligible for probation supervision which might allow for assessment of need and someone to facilitate access into support. Finally, a number of interviewees highlighted the importance of early intervention and the missed opportunity if need was not identified and responded to at this stage.

In terms of **community sentences**, difficulties were highlighted in providing appropriate health interventions for a group that struggled to engage with mainstream services and yet who were in the community rather than contained in an institution.

Finally interviewees acknowledged the difficulties in adequately responding to **short-term prisoners** who were not imprisoned for sufficient time for their needs to be addressed and who were not eligible for probation supervision on release from custody. The multiple needs of and difficulties in responding to this group are acknowledged in the literature (Anderson, 2011; Howard League, 2011).

Responses to these problems are considered throughout the report at the relevant stages of the criminal justice pathway.

9.2 Other priority groups identified by interviewees

9.2a Learning disabilities, autism and other related conditions

Regional stakeholders were asked to identify groups that had not been explicitly outlined by the commissioners which they felt needed to be prioritised as part of the BDP. Several stakeholders emphasised that the low staff competency and poor service responses with respect to learning disabilities, autism and other related conditions outlined throughout this report meant that this group should be considered a priority in itself.

> *"Learning disability in itself is a priority group. It is well recognised in the prison service – but woefully inadequate in the community."*

> *"I think the biggest priority group for me is those with learning disabilities, and you know, the autism spectrum. Because they are the ones that, for me, they go unnoticed."*

A study by the Prison Reform Trust reviewed research into learning disabilities in offender populations (Loucks, 2007b). The review highlighted that many studies had struggled with regards to

finding an appropriate tool for research within a criminal justice environment. A large-scale prison survey using the Quick Test (Singleton et al. 1998 as cited in SCMH, 2008a, p.14) found that 11% of men on remand and 5% of sentenced men had IQs of 70 or less. Research undertaken in three prisons (a local prison, a women's prison and a young offenders' institution) found that 6.7% were assessed as learning disabled (in a comparison of prevalence assessments using the Weschler Adult Intelligence Scale, the Vinelands Adaptive Behavioural Scale, and the Hayes Ability Screening Index (HASI) screening tools. However, it was acknowledged that there has been criticism of the limited focus on measures of adaptive functioning among this research (Mottram and Lancaster 2006; Mottram 2007 as cited in Loucks, 2007b).

These studies undertaken in prisons also indicated a much higher level of 'borderline' learning disabilities; those who have IQ levels over 70 but may struggle with adaptive functioning or may face particular challenges in their passage through the criminal justice system. Loucks (2007b) reports findings from Mottram & Lancaster (2006) that an average of 25.4% of those assessed across the three sites had an IQ between 70 and 79 (compared to a total of 8% learning disabled and borderline learning disable in the general population).

Stakeholders and experts reported a poor understanding of learning disabilities among criminal justice staff with particular confusion about the difference between learning disabilities, learning difficulties and poor literacy. It was suggested that that the large prevalence of poor literacy and low education levels among offenders masked the presence of genuine learning disabilities as these failed to stand-out as they perhaps might among the general population.

> *"There are challenging overlaps between the high levels of illiteracy and learning difficulties and separating out poor education and poor literacy or numeracy from actual diagnosable disability. I think it's something that still needs a lot of work and...I think it's poorly defined as a problem. Even people who work in the sector and who have a pretty good understanding of how it works I think still struggle with the whole issue of learning disability. It's less clinical and less systematised than perhaps mental health which is an additional challenge."*

> *"With learning disabilities I think it's less evident and there's a number of reasons for that. [Offenders] in all parts of the pathway, often themselves have learning difficulties...So if you look at things like literacy and numeracy amongst the juvenile population, it is very high in prisons. This doesn't mean they have a learning disability, but it means that [within this] population, somebody wouldn't necessarily stand out in that group as having very particular problems. So unless you're into screening and testing in some way, I think these people can sometimes pass somewhat unnoticed."*

There were consistent concerns around poor identification of those with learning disabilities. One challenge is the lack of a verified screening tool in criminal justice settings that is acceptable to both learning disability specialists and to criminal justice agencies. The latter are sometimes required to administer such tools within time constraints and in busy custodial environments, whereas clinical assessments for learning disabilities could be lengthy. Department of Health pilots have recently focused on the Learning Disability Screening Questionnaire (LDSQ) but reports from our interviewees suggested that teams in police stations and in prisons found it time-consuming to administer. Other options include the HASI but a stakeholder from learning disability services suggested that this tool was over-inclusive.

There were also particular concerns raised about those with autism who might be high functioning and therefore could prove a particular challenge to identify to a lay person. One national expert highlighted research undertaken by the Scottish government to develop a screening tool for autistic spectrum disorder in prisons. One particular challenge reported by the researchers was the need to

know the person being assessed reasonably well which meant that an initial screen approach was unsuitable. The researchers developed a tool to be carried out in the first two to three days in prison with an observation component around social interaction and behaviour. This research and the tool are as yet unpublished but were identified as a promising development.

It was suggested that inadequate processes for identification of these conditions at an early stage within the justice system resulted in significant jurisprudence concerns given the importance of an offender being able to plead, understand the legal process and instruct a lawyer. There were also concerns about abilities to understand and comply with conditions around bail and community orders. Finally, it was suggested that those with learning disabilities or autism (even those who were high functioning) might interact with the justice system in a way which might incriminate them further or appear disrespectful to courts and there was a need for awareness of this by court staff.

Problems were also identified regarding subsequent care pathways for these groups. High thresholds to receive learning disability services were highlighted as a barrier nationally for clients with a learning disability, let alone those in the borderline group. Other areas reported difficulties engaging with learning disability services, although they identified that these difficulties could be overcome with concerted efforts at engagement.

One national expert reported on a pilot in the South West to have a learning disability practitioner in court as part of their CJLD service. The pilot was perceived as unsuccessful due to the low numbers of clients who met the strict diagnostic criteria for a learning disability. It is clear that any learning disability practitioner appointed to work within CJLD services in the North East must be willing and able to work creatively to access support for those with a borderline learning disability, learning difficulties, autism, ADHD and other conditions and to support agencies in responding to their individual needs. Other services outside of the statutory sector may be needed for those who fail to meet thresholds for social care support. There were felt to be very strong ethical concerns regarding identifying need without establishing clear care pathways.

There was some promising work already underway in this area. A new autism service had been established within TEWV that had seen a dramatic escalation in referrals. In the criminal justice arena there had been a recent appointment of a learning disability nurse within the mental health team at HMP Northumberland, strong police links on the Durham learning disability partnership board and growing awareness of learning disabilities among the police associated with the drive against hate crime. There was also evidence of willingness for greater involvement in this agenda from stakeholders with strong engagement from relevant services at our stakeholder events. The possibility of increased operational support from the forensic learning disability service in TEWV was suggested and support offered at a strategic level from the North East Autism Consortium (NEAC). Learning Disability Partnership Boards were also highlighted as an important mechanism for engaging with relevant agencies.

9.2b Personality disorder

Finally there was also concern by some national experts about service responses to people with a personality disorder. Regionally, representatives from a range of criminal justice agencies including probation, police and prisons reported difficulties in facilitating access to support services for clients. They often reported that mental health support was refused leaving staff feeling that they were left *"holding the baby"*, frustrated and ill-equipped to respond adequately.

"A big problem is people diagnosed as having personality disorder – we are always advised there's not a lot we can do with them…We all have to live with them irrespective of what they are doing…They are anti-social and untreatable."

"[Our biggest problem is prisoners who] repeatedly behave in a bizarre way which we as staff don't understand, but we are told they don't have a mental health problem…We are therefore left to just get on with it and staff get demotivated by this, as these prisoners are clearly not right."

Significant work is underway nationally to improve responses to offenders with a personality disorder, including the roll-out of training for probation staff. In 2003, the Department of Health published *Personality Disorder: No Longer a Diagnosis for Exclusion* that led to a range of work nationally to improve provision for this group. The Department of Health and NOMS Offender Personality Disorder Team (2011) consulted last year on their new personality disorder strategy. Building on the previous government's Dangerous and Severe Personality Disorder Programme (DSPD) it contains proposals for "increasing the number of places available in prison for treating this group of offenders; making the treatments and interventions they receive more effective; developing the workforce and equipping them with the right skills and attitudes to work with this high risk group of offenders; developing a pathway of interventions which will support management in prison and where necessary in the community" (Department of Health and NOMS Offender Personality Disorder Team, 2011, p.5).

However, much of this work is focused on those who pose the highest risk. It was acknowledged that personality disorder services in the region are strong, however it appears that those who present as a lower risk or whose needs are less severe may struggle to access a service. Again the issue appears to be one of falling on the border of services, below the threshold for eligibility into specialist provision. As previously mentioned, services for women with a personality disorder or who had experienced trauma in the community were identified as a potential gap in provision. It also did not appear that there were clear pathways for offenders with a personality disorder from CJLD services and one national expert emphasised that:

"It's about making sure that the services that we set up around liaison and diversion don't contradict what's going on around the PD strategies."

Again, responding adequately to this group may involve accessing a wider range of services. It will be important that those within the voluntary and criminal justice sector receive training and liaison support from experts within the Trusts in order to up-skill them to adequately respond to this group.

9.2c Veterans and other groups

There were no other groups that emerged as clear priorities from the interviews. Veterans were mentioned as one group by a small number of interviewees although views differed as to whether these should be prioritised; it was suggested that there may not yet be the evidence to support such prioritisation.

However, it was clear that there was a range of work underway in the region to improve services to this group. A Veterans Champion had been appointed within NTW and there were a number of active organisations which provide 'wrap-around' support and which were looking to extend their work into the criminal justice sector. For example, we interviewed the Managing Director of the social enterprise About Turn which provides one-to-one crisis support and group work for veterans, peer support and OCN accredited courses that seek to improve veterans' ability to live in

the community. The research network PORSCHE is also currently focusing on this issue. There may be a case for future work with this group once further research has been undertaken in this area.

9.3 Priorities for future work

Young people at the interface between children's and adult services were confirmed as a priority for stakeholders; consideration should be given to how all-age diversion services might best support the transition between the two. Links need to be developed with local services for BAME groups. Gender-specific, age-specific and BAME-specific approaches all needed to be developed and there is a clear need for improved monitoring of service access and outcomes with relation to gender and ethnicity. Improved responses to those with a learning disability, autism, dual diagnosis or personality disorder were seen as a priority by stakeholders.

10
Service User Involvement

The Big Diversion Project specification included expectations of engagement of service users, families and carers and a specific request that the provider analyse and assess current arrangements for involvement and consider how these could be strengthened.

As detailed in Chapter 2, our approach included a series of four focus groups with service users. In order to better understand current arrangements for user involvement, we interviewed a series of regional experts in user involvement across criminal justice, mental health and learning disability from both the statutory and voluntary sector as detailed in Appendix 1. All of this work was completed by a team member with personal experience in using mental health services. Finally, all regional stakeholders interviewed were asked specifically about arrangements for user involvement within their service or context. Data collected through service user focus groups largely relates to experiences of the health and criminal justice systems and is incorporated within the chapters covering stages of the criminal justice pathway.

This chapter sets out the current arrangements for involvement and considers ways in which these could be strengthened. It begins by setting out the context for user involvement including the national policy context. The concept of involvement is then defined and discussed before consideration is given to involvement within a range of service contexts. The chapter goes on to describe current arrangements for user involvement in the region across mental health, substance misuse, learning disability and criminal justice agencies. For a large proportion of regional interviewees working within criminal justice agencies, the concept of involving offenders was a new or unfamiliar one. In other areas, such as mental health, there was evidence of extensive existing mechanisms for involvement and an evolved landscape of services and initiatives, including user led initiatives. The chapter concludes with some recommendations on how arrangements could be strengthened notably within criminal justice and CJLD services.

10.1 User Involvement: the national context

Over the last few decades, there has been a significant growth in service user involvement in health and social care services, often referred to as patient and public involvement (PPI). These developments have come about as a result of a number of different drivers, including moral and ethical stance concerning the rights of citizens to shape the services they use or may use, consumerist aspirations for choice, public and service user activism, and political motives to disperse power and increase accountability.

Patients, service users and disabled people across a range of health and social care fields and experiences have campaigned to have a greater say in the services they use, to become involved in decisions about their own care and in decisions made about service planning and delivery. The history of this is different in different service contexts. In some areas, user and carer involvement has arisen out of people feeling grateful for the care that they or their loved ones have received, and wanting to give something back. They want to be a part of something that has made such a big difference to them and can do for others.

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Campaigning for change has been particularly powerful in the mental health field, arguably because of the more contentious nature of the diagnoses and treatments on offer and because of the existence of the Mental Health Act, 2007 which has the potential to remove an individual's rights and choices. Equally powerful has been the disabled people's movement, from which the phrase *'nothing about us without us'* was recently borrowed by the Secretary of State for Health when announcing the white paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010). The fact that this principle has been adopted by central government – albeit in limited form – is testimony to the influence and achievement in recent years of disability activists and campaigners keen to promote principles of independent living.

10.2 Policy context

The 1990 NHS and Community Care Act (House of Commons, 1990) introduced a focus on the 'consumer' and assumed that greater choice would be brought about both by market mechanisms (e.g. fundholding GPs and case managers) and through consumer feedback which would direct the kind of services that purchasers would then demand of providers. The assumption was made that involvement would improve the relevance and quality of services for the consumer. This applied as much to the individual and their care as to the wider service provision:

> *"The individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes" (House of Commons, 1990)*

Ten years later, chapter 10 of the *NHS Plan* (NHS, 2000, p.82.) was devoted to how user involvement in the NHS could bring about a 'patient-centred service'. The National Health Service Act 2006[17] consolidated much of the legislation concerning the health service. Section 11 of the Health and Social Care Act 2001, the duty to involve and consult, became section 242 of the NHS Act 2006. This states that health services must make arrangements to involve their service users, whether directly or through representatives, in the planning, development and decision-making processes of their services. Since October 2010 both NHS and independent hospitals have had to comply with the new Essential Standards of Quality and Safety (CQC, 2010a). This includes the requirement that hospitals in both sectors ensure "service users are enabled to make, or participate in making, decisions relating to their care or treatment" (CQC, 2010a, p. 42). The guideline goes on to set out the assessed outcome that service users in all hospitals are encouraged to express their views and these views should be accommodated as far as appropriate or reasonably practicable. This has built upon previous requirements that applied to independent, as well as NHS, hospitals.

In social care the principle for involvement is integral to the core legal mandates for social care services. As stated above, the NHS and Community Care Act 1990 refers to the need to inform, consult and involve service users. Subsequent legislation, for example the Health and Social Care Act 2001, makes provision for direct payments of social care monies to be made to eligible persons to enable them to directly purchase services or support to meet their needs. This is an example of user involvement in their own care. Furthermore, the power and control through this approach to social care is very much handed over to the user. The health equivalent to this, personal health budgets, is currently being piloted across the country.

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[17] See NHS (2008)

In February 2011 the government published a new "cross governmental mental health outcomes strategy for people of all ages", called "No Health without Mental Health". The approach is based on the principles that the Government has laid down for its health reforms:

"Putting people who use services at the heart of everything we do – 'No decision about me without me' is the governing principle. Care should be personalised to reflect people's needs, not those of the professional or the system. People should have access to the information and support they need to exercise choice of provider and treatment" (HM Government and Department of Health, 2011, p. 3).

In the Health and Social Care Act, 2012 there are requirements for greater patient involvement. There are duties for the new NHS Commissioning Board and Clinical Commissioning Groups (CCGs) currently being set up in relation to promoting opportunities for patients to be fully involved in decisions about the services they receive as individuals. These duties are intended to complement the duties in the Act on these bodies to public involvement and consultation, which replicate the duties that currently apply to SHAs and PCTs as explained above.

Further to this, the new NHS Commissioning Board and CCGs have a duty to promote involvement of each patient in decisions related to the prevention and diagnosis of illness and any care or treatment they receive. The NHS Commissioning Board have a duty to issue guidance to CCGs on involvement (Department of Health (2012).

While there are legislative duties to involve the public, patients and services users in strategic, operational and to certain extent individual decisions regarding their care in statutory health and social care services, this is not necessarily the case for the voluntary and independent sector. However, in fulfilling contracts to provide services to the statutory sector, voluntary sector organisations will often be required to satisfy their requirements for user involvement. Equally, the voluntary sector has often led the way in service user involvement, perhaps in part because the moral case for involvement has been made over the years and organisations have built this into their ethos and culture. They often lead the way with empowerment initiatives, and demonstrate to others the power and relevance of the involvement of citizens in shaping existing services, or being helped to come up with solutions to their own community's problems. Some voluntary sector organisations have their roots in the coming together of patients, service users, disabled people or carers in order to establish an organisation to meet their needs where nothing previously existed to do so.

It is worth pointing out the development of 'user-led organisations' (often referred to as ULOs) as distinct from voluntary sector organisations and charities. ULOs are organisations managed and led by a majority of service users; many voluntary sector organisations are managed and led by people who represent a particular group of patients, service users or carers. ULOs gained currency and investment under the previous government and a new programme to support Disabled People's User-Led Organisations (DPULOs) has been launched by the present Government. £3million will be invested over four years that will aim to promote the growth and improve the sustainability of DPULO.

10.3 What is involvement?

Service user involvement refers to the process by which the people using a service become involved in the planning, development and delivery of that service to make changes and improvements. The

World Health Organisation (2002 as cited in Clinks, 2011, p.8) has formulated a useful working definition of service user involvement:

"A process by which people are able to become actively and genuinely involved in defining the issues of concern to them; in making decisions about factors that affect their lives; in formulating and implementing policies; in planning, developing and delivering services, and in taking action to achieve change."

In practice, user involvement can mean different things to different people, and there are many barriers to meaningful involvement (i.e. involvement that has an impact or makes a difference). The barriers include: power differentials and professional attitudes, tokenism, practical issues, funding, time and concerns about 'representativeness'. It is widely acknowledged that there are many benefits of involvement for service users if involvement is supported and undertaken in a meaningful way. It can offer service users a voice, enable them to feel valued and respected, give them a sense of ownership of services and responsibility for their lives, enhance their understanding of services and how they work, improve their skills and abilities, build confidence and further the goals of recovery through inclusion, developing life skills and enhancing self-esteem. It can be a way of bringing people together to achieve mutually desirable outcomes and access mutual support.

For service providers, user involvement can lead to service improvements: help to improve the quality and relevance of service provision: add value to service planning, development and delivery, break down organisational hierarchies, achieve effective use of resources, improve communications and understanding between staff/volunteers and service users: help staff/volunteers develop their skills, enable an organisation to draw upon and make effective use of people's skills and capabilities: fulfil possible funding requirements: improve an organisation's ability to respond to government strategies.

The following diagram is often used to describe the levels of involvement or participation. This is the ladder of citizen participation as developed by Sherry Arnstein in 1969, and it refers to citizen participation and power in society and how they interact. Although this has been subject to considerable debate over the years, it is still a popular model to understand levels of participation. The bottom rungs of the ladder describe levels of "non-participation" that have been contrived by some to substitute for genuine participation. Further up the ladder are levels of collaboration and citizen power with increasing degrees of decision-making. At the topmost rungs, citizens obtain the majority of decision-making seats, or full managerial power.

Eight rungs on the ladder of citizen participation
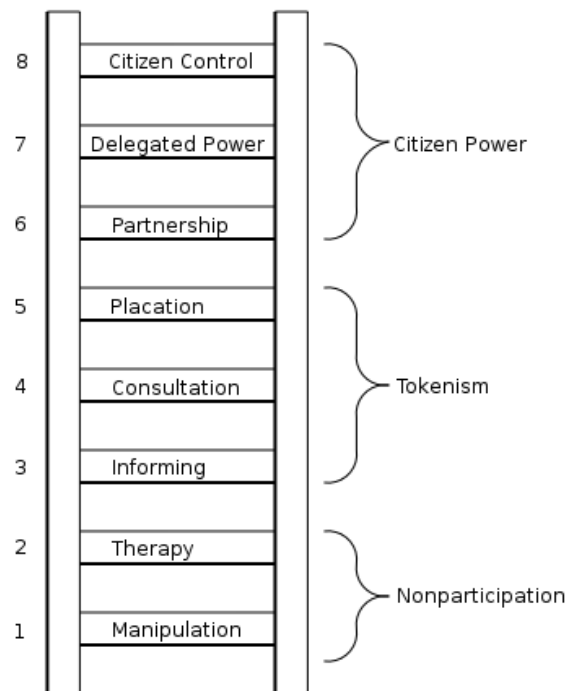
A more useful way of thinking about involvement may be to consider it in relation to the locations and levels in which it can operate (see, for example, Faulkner, 2009):

1. Individual care (e.g. advocacy, care plans, advance statements).

2. Individual services (feedback, monitoring, evaluation, delivery).

3. Trust/organisation-wide (involved in planning, committees and forums).

4. Governance (on management boards, as trustees and non-executive directors).

5. Research and development (carrying out research, commissioning, defining priorities).

6. Training and education (e.g. training of different professional groups).

7. National policy (programmes, advisory groups).

Another useful perspective was developed by the National Survivor User Network's (NSUN) national involvement partnership (NIP, 2011) in the mental health field. This is to conceive of user involvement under the following headings, which present a relatively accessible way of describing and monitoring involvement (NIP, 2011, p. 1):

- **Purpose:** having a clear purpose for involvement enables everyone to understand their role and avoids the risk of tokenism and involvement for its own sake

- **Presence:** monitoring the people who are actually involved: their numbers, and characteristics and experience in relation to the organisation or project they are involved in

- **Process:** at what level in the project or organisation are service users involved – what role(s) are they occupying? and how is the process of involvement experienced? Good practice guidelines can be referred to here

- **Impact:** what impact are the service users who are involved having on the project or organisation?

10.4 User involvement in different fields

Much of the campaigning energy of the user/survivor movement in this country has been directed at existing psychiatric services and treatments, motivated by the desire to change and improve them, which is perhaps why 'user involvement' has become such a major development. Key subjects targeted for change include: medication and side-effects, ECT, alternatives to hospital in crisis, increased access to talking therapies, coercive treatments and access to choice (See, for example, Rogers et al (1993); Faulkner (1997)).

Mental health charities – notably Mind – have taken up some of the core issues raised by service users and campaigned around them. There are a number of significant examples of this: from the closure of the large asylums, warnings about minor tranquillisers in the 1980s, to the yellow card campaign in 1996 (for reporting adverse effects of medication), through campaigning for women's services and employment discrimination in the 1990s, the alliance against the 2007 Mental Health Act proposals, to current campaigns concerning crisis services and welfare benefits.

However, groups of mental health service users and survivors have taken some of these concerns – –and organised themselves independently to achieve them. These initiatives sometimes overlap with or inform developments in 'user involvement' and sometimes remain clearly separate from contemporary psychiatric services and policy. Fundamentally, this represents the familiar political debate about campaigning from the outside *versus* changing from the inside. An excellent paper on the history and position of the Service User/Survivor movement by Peter Campbell (2006b) was published by Mind.

For people with **learning disabilities**, user involvement is perhaps less well developed at a national level. Major national policy changes have brought about significant changes for people with learning disabilities. The *Valuing People* (Department of Health, 2001), and *Valuing People Now* (Department of Health, 2009b) learning disability strategies have helped to create a user voice in strategic planning due to the move to local authority run services and away from health based services and hospitalization. Most work in this area has been on advocacy, citizen advocacy and self-advocacy so that people with learning disabilities can negotiate their way in the world, but they can also be helped to have constructive dialogues with local authorities too. Nationally there is People First (2012a). This is an organisation run by and for people with learning difficulties to raise awareness of and campaign for the rights of people with learning difficulties and to support self-advocacy groups across the country (there are People First groups in many areas). They advocate the use of the term 'learning difficulties' because, using a social model of disability, they believe that people labelled as having a learning difficulty are disabled by society: "*We choose to use the term 'learning difficulty' instead of 'learning disability' to get across the idea that our learning support needs change over time*" (People First, 2012b).

In **substance misuse services,** the National Treatment Agency (NTA, 2006) proposed that service user involvement should occur at a regional and partnership level. The NTA further suggests that "the substance misuse treatment system must recognise and value the benefit of listening and responding to users and carers and recognise that the user's experience is often the catalyst for improving the way services are delivered" (NTA 2006,p. 2).

Drugscope's 'Enhancing Drug Services' (2003) and 'Towards Treatment Effectiveness' (2005) and the NTA Business Plan for 2005/06 emphasised the importance of service user involvement in order to ensure: engagement in their own treatment journey, that services meet the needs of those they are intended to serve, that they will respond quickly and effectively to changing needs, that partnerships/local agencies gain maximum advantage from the engagement of service users in shaping their treatment, and that service users are included within the development and ongoing improvements to the treatment system to respond to the unmet needs and gaps in service provision. The Scottish government (2006) has published a good practice guide to service user involvement as part of their national quality standards for substance misuse services. They acknowledge that user involvement is less well developed in substance misuse services than it is in mental health, social care and disability services.

The Government's (HM Government, 2010b) drug strategy '*Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*' is based on a principle of recovery, which they describe as an individual, person-centred journey, as opposed to an end state, with three overarching principles: wellbeing, citizenship, and freedom from dependence. They cite evidence that treatment is more likely to be effective and recovery to be sustained where families, partners and carers are closely involved (Copello, Velleman and Templeton, 2005).

User involvement in **forensic mental health services** is fraught with some of the same challenges that face the criminal justice system. Nevertheless, forensic NHS services are governed by the same legislation as other NHS services. Faulkner and Morris (2003) identified variable views of Patients' Councils, including that they had lost the confidence of both patients and staff in some of the high secure hospitals. They also identified a number of individual attempts to improve or establish user involvement, some of which were reported to be more successful. For example, there was a Listening to Patients initiative at Ashworth hospital and a Patients' Council and Patients' Assembly at Rampton Hospital which seemed to be making serious attempts to ensure that potentially marginalised groups were heard and represented.

However, the power of the institution and the barriers it necessarily presents both to those inside and to the outside world tend to militate against good user or patient involvement. Where it has been most successful in these environments, it has often been due to trusted organisations gaining access and facilitating communications between patients and staff. Examples of this include research projects (e.g. those funded in 2003 by The National Programme for Forensic Mental Health Research and Development[18]) and the work of Wish (2012). Wish provides independent advocacy, emotional support and practical guidance for women with mental health needs in the mental health and criminal justice systems. One of the core aims of Wish is to increase women's participation in the services they receive, and to get their voice heard at a policy level.

NSUN recently carried out a scoping exercise of user involvement activity in forensic services (NSUN, 2011). They found the most common type of forum in place to be the Community (or ward) Meeting (96%), followed by the Patient's Council (47%). A lower proportion of eligible hospitals had either Men's (38%) or Women's (17%) forums in place. Although around half reported having an Independent Service User Involvement Worker and half an In-House Service User Involvement Worker, there is some uncertainty about the accuracy of this information as some were said to be the visiting advocate. The quality of the involvement activities is similarly unclear, most of the changes brought about being mainly ward-based and around immediate issues such as

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[18] See, for example, Faulkner (2006)

smoking, activities, menu changes, and environmental changes. However, the scope for change in these settings is inevitably limited.

10.5 User involvement in the criminal justice system

There is no equivalent legislation regarding service user involvement covering statutory authorities along the criminal justice pathway. The moral imperative for involvement is also somewhat compromised in this area and the identity of the 'service user' or consumer is complicated by the rights and needs of victims and families as well as of the general public. The barriers to involvement are greater as, certainly in prison, the opportunities to influence decisions are inevitably limited.

Nevertheless there are strong arguments for offenders to be involved in or consulted about the services that affect them. For example, Clinks (2011) in their review of service user involvement in prisons and probation trusts identified the following benefits:

- An opportunity for service users to voice their concerns and address a common sense of marginalisation has clear implications for rehabilitation and resettlement

- Providing a positive method through which to reduce and manage conflict

- Providing an opportunity for personal development for offenders

- Gaining a previously unknown perspective on service provision

- A method through which to instigate culture change in an organisation.

They also found a widespread belief across prisons and probation trusts that service user involvement had a role to play in reducing reoffending, and many perceived involvement to be instrumental to their core business. Many prisons were using some form of consultative group; and around a third of prisons were holding regular meetings on the wings. In some prisons, these meetings were the main form of consultation whereas for others, they were used as a stepping stone in a series of consultative forums that reached strategic level. Service user involvement in the probation service was identified as being 'more sporadic'.

There are a number of national organisations established to give a voice to offenders and ex-offenders. **Unlock** was established in 2000 by reformed offenders; they provide information for reformed offenders, signposting, run campaigns, develop and deliver projects, and establish services that assist reformed offenders in overcoming the obstacles they face due to their criminal record.

User Voice was founded in 2009 by Mark Johnson, an ex-offender and former drug user. The organisation aims to reduce offending by working with the most marginalised people in and around the criminal justice system to ensure that practitioners and policy-makers hear their voices. They argue in favour of a prison system where prisoners are more empowered and deeply engaged in the services they rely on, and where they are able to take greater responsibility in developing services that will reduce reoffending. In 2010 they published 'The Power Inside', a review of prison councils – a term used to describe a range of different forums, committees and meetings, where prisoners get a chance to voice their concerns. The evaluation found several benefits from prison councils, including improved communications between prisoners and staff, prisoners getting to voice their concerns, improved information and confidence and the achievement of small changes (e.g. family visiting arrangements, diet). The challenges included staff cynicism and resentment when prisoners gained better access to senior staff than they had themselves. User Voice concluded that there is a need to recognise and celebrate small changes within a context where prisoners have little power or control

over their daily lives, and a need to manage expectations of all those involved. Overall, the early evaluation established support for effective prison councils, despite some tough challenges. They recommend the continued involvement of ex-offenders and an external organisation such as User Voice taking on a role as 'referee', in order to maintain the momentum and to keep the council focussed.

Revolving Doors Agency has a dedicated Director of Service User Involvement and Service User Involvement Coordinator. Revolving Doors considers it is imperative that the people who have found themselves caught in the revolving door of crisis and crime have the opportunity to articulate their experiences and influence change. They are committed to enabling service users to influence and be involved in the work Revolving Doors does and to promoting their involvement in the work of other organisations. Revolving Doors has a service user forum and also a young person's forum (people aged 18 to 28 years old). The Forums bring together people from different areas of the country, who have experienced mental health and other problems and have had contact with the criminal justice system.

10.6 User Involvement in the North East

Mental Health

We found evidence of a wide range of user involvement activities and initiatives in the mental health field across the region. Involvement activities were found to be taking place in both statutory and voluntary agencies and across a range of organisations including a number of user-led organisations.

Northumberland, Tyne and Wear NHS Foundation Trust (NTW) undertakes a range of patient and public involvement activities. This work is led by a Head of Patient and Carer Engagement, who manages a team of ten staff who facilitate patient and carer engagement and involvement across the full range of Trust services.

The Trust has established a quality evaluation project called Points of You (POY), currently embedded into the urgent care wards and due for roll-out to all of the inpatient settings by April 2012. The project tests inpatient environments against twelve design principles which include valuing expertise, most appropriate response, empathetic workforce and involvement with integrity. The project is semi-independent with support from the Trust and is led by service users and carers.

Ward areas are encouraged to maximise the impact of the feedback through displays, staff supervision and using the information to direct community meeting discussions (giving patients the opportunity to raise issues anonymously). The Trust is committed to Points of You and has found that the project evolves through the understanding of patient and carer need. The project has received approximately 6,000 returns (cards and questionnaires) from patients and carers over two years. Users are also involved in staff training regularly using materials and exercises developed by service users. Film and narrative are often employed to convey the patient and carer perspective. Training can be requested from individual service areas regularly and tends to focus on building empathy in staff.

NTW employs a range of peer support workers within in-patient settings. Peer support workers run activities and offer informal support. The Patient and Carer Engagement team won the 2009 NHS Innovations Award for mental health for their Impact Quality project which has now been superseded by POY.

Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) has a team of four PPI staff led by a Patient Involvement Manager. Their role is to support patient involvement and also to support staff in involving patients across all Trust services. Users / patients currently sit on a number of reference groups, for example a pharmacy group and a spirituality group. An essential standards group, which is part of the Care Quality Commission's standards expectations, is also operational.

This group has evolved and developed into users going into wards, interviewing fellow in-patients about their care plans, the hospital environment and safety etc.

TEWV has a policy which states that patients/users should be involved in recruitment. Patients/users are involved in staff recruitment following training delivered by the Human Resources department, who maintain a database of trained users and carers which staff can access when recruiting. Trained users and carers recently worked with service users in forensic units when they were recruiting to modern matron posts recently. Both staff and service users were involved in the interviewing process including a separate user panel that fed into the whole recruitment process of interviews and presentations.

The Trust holds a database of 300+ users and carers that are willing to be involved in a range of activities and who receive a monthly newsletter providing information about upcoming opportunities for involvement. Following growing interest in involvement opportunities, the Trust now runs a leadership programme for users and carers on a rolling basis. The programme aims to promote self development and the Trust has also run a version of the training for users with learning disabilities. One of the PPI Officers offer mentoring for users after they have completed the leadership course to encourage involvement.

The Trust research department has a proactive lead researcher and there are opportunities for involvement in research which is done in partnership with Teesside and Durham Universities.

In some areas there was evidence of good partnership arrangements to support user involvement across a range of mental health services and organisations. **Stockton Borough Council and TEWV** has a joint Service User Involvement Worker post. The post holder is employed by the local authority and managed by the Trust as part of integrated mental health services. She works with the Trust PPI Team, Stockton Link and on other user generated issues. A monthly user/carer forum is held that feeds into the governance structure of the Trust and local authority. The post holder also supports SURGE (Stockton User Representative Group for Empowerment) which is a constituted user-led group of past and current service users. SURGE members go to day services to gather user's views and feed this back into the governance structures. There are 14 active members who do this work on a voluntary basis with another 100 members on their database.

The North East has a range of voluntary sector agencies offering opportunities for user involvement.

Mental Health North East (MHNE) is a consortium of Voluntary Community Sector organisations working to improve service provision for people suffering mental distress and works in partnership with both NTW and TEWV.

The pioneering role of **Mind** in the development of user involvement in Mental Health services is described above in the national context. There are eight local **Mind** associations across the North East including Middlesbrough and Stockton, Redcar and Cleveland, Darlington, Chester-le-street and Durham City, Hartlepool, Newton Aycliffe, Tyneside and Washington Mind. Alongside service delivery, all offered a range of opportunities for user involvement and a number were partially or wholly user led.

Middlesbrough and Stockton Mind, for example, has a full time dedicated Service User Involvement officer funded by the local authority. The post holder's brief is to work across Middlesbrough with mental health service users, which includes those that are not necessarily Mind users, and also as a secondary function provide some user involvement support to housing projects locally. The level of involvement is very much at grass roots level, and includes Wellness Recovery Action Planning (WRAP) work which involves training service users to be WRAP trainers for their peers, and enabling a peer support group to carry on after the initial training, to ensure sustainability.

New work includes the development of a Middlesbrough peer support group for people with a diagnosis of personality disorder.

Middlesbrough and Stockton Mind have also undertaken some specific involvement within the criminal justice system. This has included

- User consultation within a forensic medium secure unit run by TEWV which enabled service users to be involved and attend service user action team meetings within the unit.

- The provision of mental health training for the local Police Service.

Mental Health North East count among its members a number of user-led mental health charities. These include Headlight Sunderland, Service Users Reaching Forward (SURF) in Durham, SURGE in Stockton (as noted above) and Launchpad in Newcastle.

Launchpad is a user-led organisation and all staff members are themselves users of mental health services. Launchpad engage with and work alongside a range of local agencies including the Strategic Health Authority, the Primary Care Trust, NTW, Newcastle City Council, social services and Northumbria Police. They host the Newcastle Mental Health User Forum, and run a primary care Mental Health User Panel. They also host a depression and general mental health self-help and discussion group, a women's group, BLISSFUL, a social anxiety group, and the Launchpad Writing Group. Together with the Gateshead Mental Health User Forum, they run a mental health group, PRIDE IN MIND, for the Lesbian, Gay and Bisexual communities.

The Launchpad Team Leader is also the Newcastle Tyne and Wear Service User and Carer network co-chair (with the Gateshead user involvement worker). Launchpad also play a role in coordinating North East Together. **North East Together (NET)** brings together mental health user groups from the Tees Esk and Wear Valley and NTW areas. NTW network for instance has 250 members approximately, which consists of user and carer involvement leads, service users, carers, user and/or carer groups, other voluntary sector groups and allies.

Because of their wide coverage NET attract particular monies to do specific pieces of work. For example they are linked to the local Universities for under and post graduate course input, i.e. user and carer lecturers.

User Involvement in Substance Misuse Services

By comparison with mental health services, we found less documented evidence of user involvement within substance misuse services across the region. With the notable exception of fellowship organisations like Alcoholics Anonymous, we also found little evidence of other user–led substance misuse organisations in the region. There were a number of promising initiatives as set out below.

NTW provides a range of substance misuse services and a member of the NTW PPI team described above has a specific brief related to substance misuse. The post holder works across Northumbria in drugs and alcohol services as part of the wider patient and carer involvement team.

Local voluntary sector providers include the North East Council for Addictions (NECA), Lifeline, Addaction, Turning Point and Crime reduction Initiatives (CRI). The CRI care co-ordination Team in Middlesbrough have service user and peer support groups. Anecdotal evidence suggests that many providers of substance misuse services employ a proportion of former users among their staff teams though few provide evidence of this on their websites. The **Cyrenians** have recently launched a user led recovery service in support of people coping with drug or alcohol misuse in the Middlesbrough area. The service offers independent advice and support to help people move forward in their own recovery and aims to create a community of service users and carers to develop recovery-based activities in Middlesbrough.

The **Safe Newcastle Drug Support Unit** employs a service user involvement officer, whose role is to ensure that the voices of service users and carers of the drug and alcohol treatment systems and recovery communities are heard. This includes ensuring that the involvement of users remains on the agenda within drugs, alcohol and housing services and aims to impact on decision making around commission and recruitment.

The post holder convenes the **Newcastle User and Carer Forum**, which is made up of people who have or are accessing substance misuse or homelessness services in Newcastle and the North East. A high number of those attending have experience of being homeless and or of being involved in the criminal justice system.

User involvement in Learning Disabilities

We found evidence of a range of initiatives and organisations designed to involve service users with learning disabilities across the region.

The **Valuing people now** strategy is described above as part of the national context.

The **North East Learning Disability Partnership** currently meets to ensure that the views of people with learning disabilities and targets from Valuing people now (Department of Health, 2009b) are included in all the current changes to the provision of health and social care services across the North East. It includes three representatives from each local learning disability partnership including a self advocate representative, i.e. someone with a learning disability, a family member representative, and the Lead Officer for local authority commissioning or a Valuing People Coordinator.

Inclusion North is an organisation that works to promote the inclusion of people with learning disabilities, their carers and families. They take a lead role in convening and servicing meeting of the partnership. They also take a lead in training and encouraging member groups to engage and be involved in local Learning Disability Partnership Boards across the North East.

We found evidence of a range of organisations promoting and enabling the involvement of people with learning disabilities, their families and carers across the North East.

Your Voice Counts is a voluntary organisation which offers advocacy and advice for people with learning disabilities in Newcastle, Gateshead and South Tyneside. They also run a weekly involvement group for people with learning disabilities in South Tyneside.

Our Voice Our Say (2012) is an award winning website created and run by people with learning disabilities in Sunderland. It offers the user a wide range of resources including information about involvement in Learning Disability Partnerships. From a BDP perspective, it provides useful information on safeguarding and hate crime.

The North East Autism Consortium (NEAC) has been tasked with forward the commissioning of care and support services for people with Autistic Spectrum Disorders (ASD) and Asperger syndrome across the North East. The consortium is working to promote the development of person-centred care and support packages which are designed to meet the aspirations, of people with ASD and their families. We heard evidence from the consortium of recent work to look at building links with the police based on feedback from people with ASD and their families and carers.

In Durham the **People's Parliament** for people with learning disabilities has been running since January 2006. The Parliament has 25 elected members who are paid for the work they do to promote issues that affect other people with a learning disability. The members hold public meetings at County Hall in Durham. Attendance at these meeting is very good with between 50 and 120 people attending each meeting. These MPs hold discussions on a range of subjects and regularly feed back to central Government on proposed national policy changes and consultation green papers.

The Parliament works closely with the Durham Partnership Board to bring about improvements to local services. The members from each local area hold a monthly meeting to feed back to people in their areas about issues discussed at the parliament meeting and also gather their views and opinions about local issues. Issues raised at locality meetings can then be raised at a parliament or partnership board meetings for further action. Current issues include better access to health provision and reducing hate crime.

Other self-advocacy groups that exist in the North East that are part of the Inclusion North East network are: Darlington – Darlington Advocacy who support a people's parliament in Darlington; Newcastle – Better Days and Skills For People; Middlesbrough – Middlesbrough First; Northumberland – The User Forum; Hartlepool – Hartlepool Advocacy; Stockton – Stockton Helps All; Redcar & Cleveland – Skills For People support a people's parliament; South Tyneside – Talk 2 Us, and North Tyneside – User Forum.

User Involvement in the North East – along the criminal justice pathway

The challenges and potential gains of service users involvement in criminal justice agencies is described above. With the exception of the initiatives described below, we found little evidence of the involvement of offenders as service users within criminal justice agencies. There was evidence of the involvement of the public, notably by the police, as part of their community engagement role.

There was substantial evidence of user groups in other areas such as mental health, reaching out to the police, often in an attempt to improve the policing of people with mental health problems. Agencies like Middlesbrough and Stockton Mind have a strong culture of user involvement and have developed services specifically for offenders with mental health needs, in response to needs identified by their users.

From the perspective of victims of crime, the learning disability charity Your Voice Counts has worked with people with learning disabilities to deliver training to Police in order to improve police understanding of the impact of disability hate crime. NEAC has also worked with the Police to develop a leaflet designed to improve the police response to those with ASD and Asperger's Syndrome.

Other groups, such as Newcastle User and Carer Forum have identified that a number of their members has substantial experience of using criminal justice agencies.

Interviews with stakeholders revealed that none of the CJLD services in the region had any arrangements for service user involvement or consultation. There is no doubt that this relates in

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part to the transitory nature of client contact with CJLD services and to the context in which contact takes place – often in police stations or court at a time of crisis. Current monitoring arrangements within the services make it difficult to see how retrospective consultation could be carried out. Crisis services with NTW currently use a card feedback system and one practitioner suggested that a similar system could be used for CJLD services. Both NTW and TEWV have established PPI departments and there is scope to use their expertise and that of their users in designing and delivering a mechanism for service user involvement and consultation among users of CJLD services. We also found evidence of a broad range of user involvement organisations and initiatives in the mental health arena across the region. Consideration should be given to ways in which this resource and expertise can be harnessed by CJLD services to involve and consult service users.

There was some evidence that the lack on involvement of service users within criminal justice agencies was changing. **Northumbria Probation** is working with the national organisation **User Voice** to set up a User Council for Northumbria Probation Trust. The vision is that elected members will form the user council and receive training to do so. They would meet with the Probation Board regularly to input their views and start a dialogue about service delivery and improvement. User Voice is attempting to get a balance of gender, and age in the council.

During the course of interviewing staff we did hear of encouraging pockets of interest around user involvement and some initiatives to improve services through asking service users for feedback.

At HMP Low Newton, women prisoners with relevant experience had been consulted about strategies to address needs related to self-harming behaviours. This has included involvement of women prisoners in a staff training and awareness programme on self-harming behaviours. One interviewee reported that this work had been important in the instigation of the trauma service which was subsequently developed.

There was also a range of other promising practice at HMP Low Newton including the presence of a prisoner representative at the Safer Custody meetings, diversity representatives who see all new prisoners, a forum for prisoners serving indeterminate sentences, peer mentoring to improve literacy within the education department and a peer housing advice worker.

10.7 Conclusion and Recommendations

There is evidence of a wide range of user involvement work in the area of mental health. Both NTW and TEWV have dedicated PPI teams to facilitate user involvement within their services and both work in partnership with local authorities or voluntary agencies to strengthen the user voice. There was evidence of a diverse range of voluntary organisations working on user involvement in the mental health field and an infrastructure network to support this work. Finally, the North East is home to a number of user-led mental health initiatives and there was evidence that these are working in partnership with each other and with the mental health trusts.

These resources should be deployed in the next phases of the BDP to ensure that the future work of the BDP benefits from users' voice and experience.

The learning disabilities field has a comprehensive range of self-advocacy groups with a coordinating body that ensures the user voice is heard.

The involvement of users in substance misuse services did not appear to be as evolved as that within mental health services though there was evidence of emerging promising practice.

Within criminal justice agencies and as with the national picture, there was evidence of considerable work to be done to involve users of criminal justice agencies. There were however, areas of promising practice and the Northumbria probation work with User Voice offers the potential for learning and potential replication across the region.

As recommended above, CJLD services should draw on the resources within their Trust PPI teams and on the network of voluntary sector user initiatives to improve consultation and involvement within CJLD services.

11
Making the financial case

Applying the Revolving Doors Financial Analysis Model

to the North East

11.1 Introduction

The need for improved criminal justice liaison and diversion services is underpinned by a desire to improve health outcomes, reduce reoffending and achieve efficiency savings in both criminal justice and health services. There is a growing evidence base informing the business case for diversion, for example *Diversion: the business case for action* by the Centre for Mental Health, Rethink and the Royal College of Psychiatrists (2011) shows that even with intensive community supervision for up to two years, diversion from custody is still much cheaper than just a few weeks in prison.

Much of this growing body of evidence, however, focuses on services for people facing severe mental health problems. Interviews with CJLD practitioners suggested that the majority of those seen by the service had common mental health problems or personality disorder combined with a range of coexisting needs. Regional stakeholders reported that improved responses to those with a dual diagnosis or personality disorder were seen as a priority and many stakeholders lamented the paucity of responses for those seen as experiencing a range of "sub-threshold" problems. Overall, the need for CJLD services to broaden their response to address a range of needs was a key theme emerging from the analysis.

People in contact with the criminal justice system who experience mental health problems below the threshold to access secondary care including common mental health problems and personality disorder often experience mental health problems alongside other problems such as substance misuse. This group often have ineffective contact with a range of services (Revolving Doors Agency, 2011a) and without targeted, coordinated support, become trapped in a 'revolving door' cycle of crime and mental health problems, incurring huge cost to themselves and the public purse.

In 2010, Revolving Doors Agency developed a Financial Analysis Model[19] which identifies the public costs incurred when people move towards or become trapped in this 'revolving door' cycle. The model uses data from three services which aim to break this cycle to illustrate how these costs change as people are supported to address their problems. It illustrates how much public expenditure might be saved through investment in similar services across England, and where in the system costs may fall.

Although the model does not demonstrate direct cost benefit of liaison and diversion services, it does provide evidence to support the case for investment in services working with people with common mental health problems and multiple needs in contact with the criminal justice system. For

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[19] The intellectual property and copyright for the Financial Analysis Model is owned jointly by Revolving Doors Agency and the Department of Health.

the purposes of the BDP, the model has therefore been adapted for the North East, as described below.

The three services[20] on which the model is based all provide a similar model of support – a lead professional or link worker who provides one-to-one support, helping individuals access a range of support services in the community. All three are targeted at people with multiple needs in contact with the criminal justice system, and have a specific focus on people with mental health problems which fall below the threshold for secondary services.

The North East-specific version of the model suggests that an annual regional investment of £1.5 million in services for people in contact with the criminal justice system and experiencing mental health problems that are below the threshold for secondary care would result in a potential reduction in costs across a range of public services of £133 million over three years.

Given the way the model works, these should be regarded as the minimum possible savings and it is likely that further savings could be generated by larger investments.

Two important points should be noted when applying Revolving Doors Agency Financial Analysis Model to the BDP.

Firstly the model does not illustrates costs relating to all offenders with mental health problems and learning disabilities, but a sub-group; those whose mental health problems are below the threshold for secondary care, and who also experience multiple problems such as substance misuse and homelessness. While this is likely to represent a significant proportion of offenders with mental health problems and learning disabilities, it does not for example include those subject to S136 assessment or detainment.

Secondly, the model does not illustrate costs directly relating to liaison and diversion services as such, but rather services which are targeted at people with multiple needs in contact with the criminal justice system and use a lead professional or link worker approach to provide one-to-one support, helping individuals access a range of support services in the community. The model supports the recommendation in Chapter 5 that CJLD services should link with such projects in the community in order to provide a broader response.

This chapter describes the basic elements of the Financial Analysis Model and how it has been applied to the North East. It outlines headline findings and illustrates how these support the case for the recommendations set out in this report.

11.2 The Revolving Doors Financial Analysis Model

Revolving Doors Agency's Financial Analysis Model was developed in order to quantify the cost of the services used by people who are caught in a cycle reoffending as a result of their multiple unmet

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[20]The three services on which the model is based are:

- **The Revolving Doors Service in Warrington** works with the police to link up people with significant unmet needs and moderate or common mental health problems with a full range of services in the community.
- **The Milton Keynes Link Worker +** project receives referrals from a wide range of sources. Link workers support clients who have traditionally struggled to engage with services to access appropriate support in the community.
- **The HMP Lewes to Brighton** scheme targets short term prisoners with multiple problems returning to Brighton and Hove. A Project Coordinator works with prisoners in the prison to identify support needs, and liaises with agencies to establish a lead to coordinate the support required on discharge from prison

needs and to establish how these costs might be reduced by interventions that effectively divert this group away from crime into support services to meet their needs. The model focuses solely on expenditure by public services, and does not take into consideration costs such as lost earnings or cost to victims, which other approaches such as Social Return on Investment include.

The Financial Analysis Model is based on the premise that individuals go through different distinct stages, which are characterised by different patterns of service use. It identifies nine different stages typically experienced by people with multiple needs in contact with the criminal justice system.

For each stage, the model identifies which services people are likely to use and how often, and how much this service use is likely to cost. The stages are then mapped to different typical journeys or trajectories. There are different trajectories depending on whether people stay trapped in a 'revolving door' cycle or whether they are supported to address problems and achieve greater stability. The trajectories show how costs build up over time and how effective support can generate substantial savings to the public purse.

The model was developed drawing on government-recognised published cost data, evidence from the three projects described above, testimonies of expert witnesses, and consultation with a panel of people from Revolving Doors Agency's National Service User Forum who have experienced contact with the criminal justice system, mental health problems and multiple needs. It was subsequently strengthened through research relating to women's centres published in the Revolving Doors Agency (2011b) report *Counting The Cost: The financial impact of supporting women with multiple needs in the criminal justice system, findings from Revolving Doors Agency's women-specific Financial Analysis Model.* The model was adapted for the North East using a range of government data sources, local data where this was available and through interviews with key regional experts.

11.3 Structure of the model

Revolving Doors Agency's Financial Analysis Model identifies nine distinct stages typically experienced by people with multiple needs in contact with the criminal justice system each of which involves different levels of contact with services and therefore different costs. It starts with modelling the costs of service use by individuals then applies population assumptions to produce national projections, or in the case of the North East version, regional projections. The process of building the model is explained below. The model itself consists of interlinking Excel spreadsheets.

11.3a Stages

The model uses nine different stages, the different situations or scenarios that people typically find themselves in, as illustrated by the diagram below.

Stages
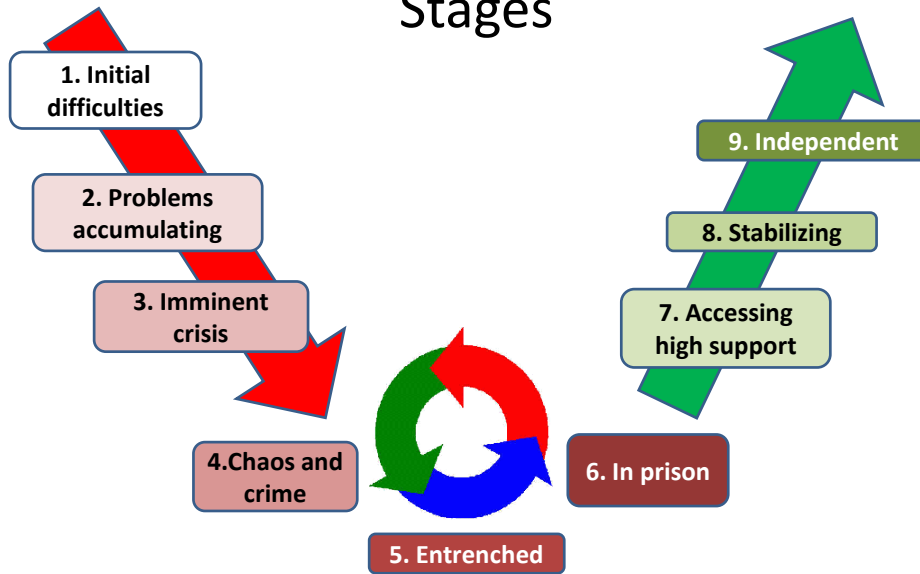
The stages were developed through consultation with members of Revolving Doors Agency's National Service User Forum and separately with providers. The patterns were confirmed in consultation with women taking part in the research for *Counting the Cost* (Revolving Doors Agency 2011b). Each stage describes a pattern of service use across a range of services. A description of each stage is provided in Appendix A.

The following should be noted:

- The stages are mutually exclusive
- Stages seven (accessing high support) and eight (stabilizing) include a recognition that people do not stop offending or address other problems immediately.

Adapting the model for the North East

The same stage definitions are used in the original model and in the North East version.

Costing stages

The monthly cost of each stage is calculated using the following formula, applied to a range of services.

Probability of service use (p) x Frequency of contact (f) x Service unit cost (u) = Likely service cost (s)

Probability of service use (p)

In each stage an individual is more or less likely to make use of a particular service. For example, in stage one (initial difficulties) someone is much less likely to be arrested than in stage four (chaos and crime). In stage six they are in prison so the likelihood of them being arrested is 0. Probabilities are measured on the range 0 to 1 where 1 is 100%.

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Frequency of contact (f)

The frequency is the number of times in a month an individual is likely to make use of the service. In some cases such as housing benefit or being in prison, the frequency remains at 1 as the individual is deemed to use the service once during the month. Other service have variable frequencies, for example, the frequency of arrest rises when people reach stages four (chaos and crime) and five (entrenched).

Service unit cost (u)

For each stage, contact with the following services is considered: housing support (Supporting People), higher housing benefit to cover the rent element of a hostel place, GP consultation, ambulance, Community Mental Health Team, in-patient mental health services, A&E, fire service, arrest, courts, Crown Prosecution Service, probation, prison, community sentences, ASBO, drug treatment, Job Seekers Allowance or Income Support, and Employment Support Allowance or Incapacity Benefit. For each type of service (U^1, U^2 etc) a unit cost has been identified. As appropriate, these are monthly costs or the cost of an individual event, e.g. arrest, ambulance call out, etc.

A full list of unit costs is provided in Appendix B. The source of each cost is also identified. For many services there is a clear source, for example the cost of a prison place is funded by the Ministry of Justice. Some are less clear however. For example, mental health services are provided by mental health trusts but commissioned by the Primary Care Trust. In the case of the police this is particularly complex. Police costs are split between three sources: the Home Office (HO), Communities and Local Government (CLG) and local authorities (LA). The percentage split varies between forces. The model is based on information from Devon and Cornwall Police giving the following breakdown:

- HO Police grant (39%)
- CLG Revenue Support Grant (3%)
- LA Council Tax Precept (33%)
- LA Business Rates (25%)

It should be noted that not all public services are considered. The model focuses on those where contact changes significantly depending on the stage. So for example services such as refuse collection are not included, but arrest is. Furthermore, some services such as alcohol treatment are not included due to a lack of sufficiently robust data.

All the service costs are referenced to the original source in the model and are predominately government published figures. Where a range of figures has been available the one most appropriate to the subject group has been chosen.

Likely service cost (s)

By multiplying the probability (p), frequency (f) and unit cost (u), the likely cost of each service per month is established.

$$p \times f \times u^1 = s^1$$

Monthly stage cost (m)

The monthly cost of each stage is calculated by adding together the likely service cost(s) of each service, e.g. likely cost of arrest + likely cost of housing benefit + likely cost of GP etc.

$$m = s^1 + s^2 + s^3 \text{ etc.}$$

It should be noted that the monthly cost of each stage only includes the costs of the services that have been included in this model. The total cost of each stage can be broken down by source of spending. Where central government funding is the source, the originating government department is identified.
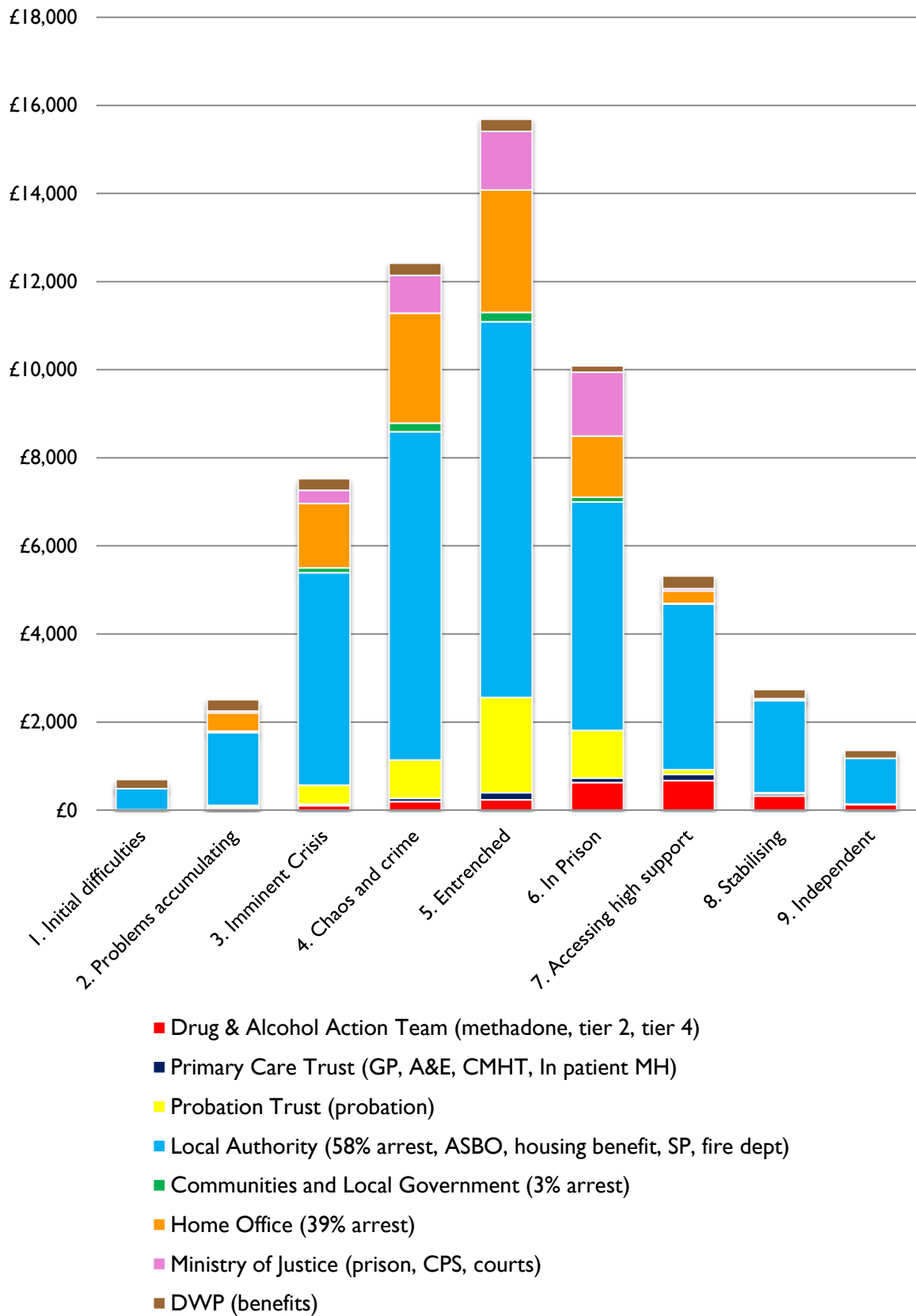
Adapting the model for the North East

In adapting the model for the North East, unit costs were updated to the most recent figures available and, where possible, adapted to be specific to the region. For example, the rate for rent covered by housing benefit was reduced from the original model to reflect lower housing costs in the North East, using the January 2012 Housing Allowance rate for a one bedroom property in Newcastle. A full summary of updated unit costs is provided in Appendix B.

Marginal adjustments have also been made around assumptions of levels of homelessness and benefit claims but that these have little or no impact on the overall level of savings, and if anything reduce the assumed level of savings.

The chart below shows the total cost of a month in each stage, broken down by source of spending. This refers to costs specific to the North East version of the Financial Analysis Model.

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Figure 11.1: Monthly cost of stages

Legend:
- Drug & Alcohol Action Team (methadone, tier 2, tier 4)
- Primary Care Trust (GP, A&E, CMHT, In patient MH)
- Probation Trust (probation)
- Local Authority (58% arrest, ASBO, housing benefit, SP, fire dept)
- Communities and Local Government (3% arrest)
- Home Office (39% arrest)
- Ministry of Justice (prison, CPS, courts)
- DWP (benefits)

Stages (x-axis):
1. Initial difficulties
2. Problems accumulating
3. Imminent Crisis
4. Chaos and crime
5. Entrenched
6. In Prison
7. Accessing high support
8. Stabilising
9. Independent

The above breakdown shows a clear illustration of how costs accumulate as people become more entrenched in the 'revolving door' cycle, and how these reduce as people access support and become more stabilized. The biggest variable in cost is arrest. In stage two (problems accumulating) an individual is likely to incur £1,068 per month in arrest costs on average. This rises to £7,120 in stage five (entrenched), and falls to £71.20 in stage seven (stabilizing), recognising that there is still a slim possibility an individual may have some police contact.

The largest proportion of cost is attributed to local authorities, as a range of different services are funded by funding streams administered by councils. The above graph includes 58% of arrest costs (the largest proportion), Anti Social Behaviour Orders (ASBOs), rent covered by housing benefit, housing support services funded by Supporting People funds and fire services.

A more detailed analysis of the above breakdown is available on request.

11.3b Trajectories

Trajectories describe the different patterns of how individuals typically move through stages over time. The model illustrates a range of trajectories reflecting changing patterns of service use as individuals engage with support services.

The model maps trajectories for individuals who engage successfully with the services described above, and corresponding journeys for those who are in a similar situation to those referred, but receive no support and continue to live chaotic lives. It should be noted that the model does not assume that all service users of the project successfully change trajectory.

By adding the costs of each stage together the cumulative cost of different trajectories can be calculated. Comparing trajectories shows the difference in cost to services and the savings achieved.

Adapting the model for the North East

The same trajectory assumptions are used in the original model and in the North East version. This assumes that the likelihood of service effectively working with a client to change their trajectory (i.e. reduce offending, address drug and alcohol issues etc.) is the same in the North East as in the original services.

The following graph illustrates the five year trajectory of an individual who is referred to a service similar to a community scheme when they are in stage five (entrenched) and successfully works with practitioners to change their trajectory. It compares this trajectory to that of an individual who does not receive support and continues to live a chaotic life. This graph uses data specific to the North East as defined above.

Figure 11.2: Cumulative cost profile over five years for individual at stage five (entrenched) referred to community scheme
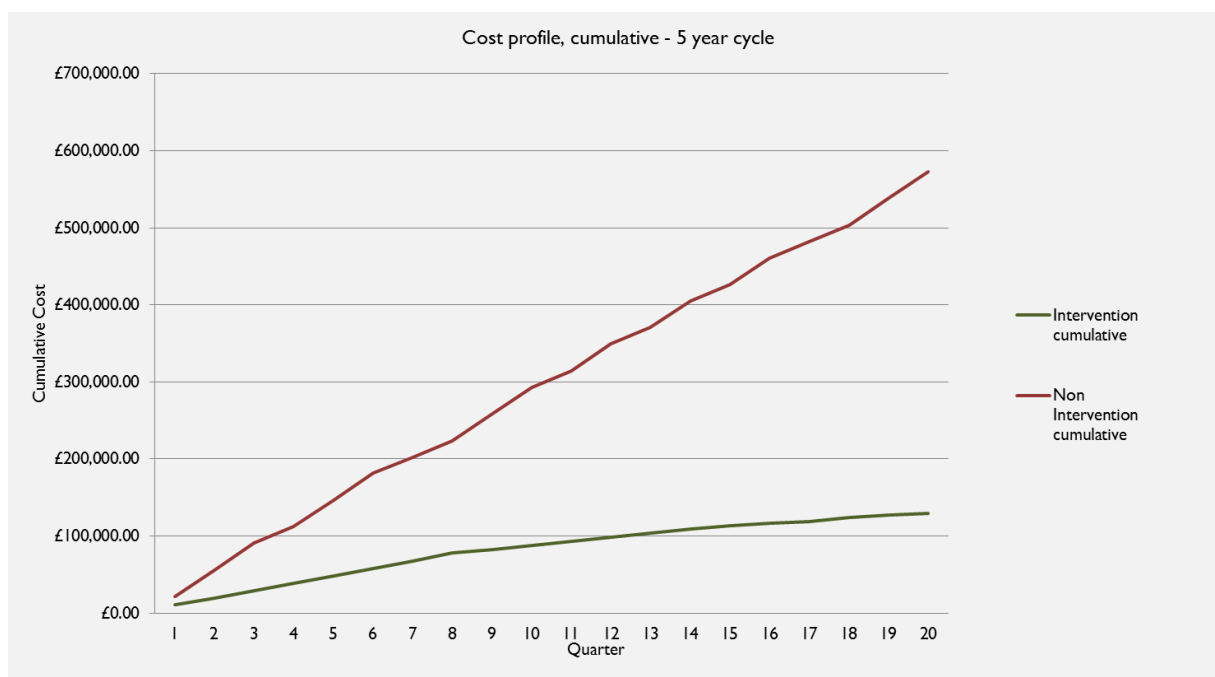
The table below illustrates how these costs are distributed by government department

Figure 11.3: Five year total cost by department for individual at stage five (entrenched) referred to community scheme

Spending source	Intervention	Non intervention	Difference	% Change
Communities & Local Government	£564	£9,932	£9,368	94%
Department for Work & Pensions	£14,040	£13,119	-£921	-7%
Home Office	£7,331	£129,121	£121,790	94%
Local Authority	£72,860	£204,067	£131,207	64%
Ministry of Justice	£1,571	£83,055	£81,484	98%
Primary Care Trust	£4,732	£8,093	£3,361	42%
Probation Trust	£3,120	£100,742	£97,622	97%
Drug & Alcohol Action Team	£25,556	£24,776	-£780	-3%
Total	**£129,773**	**£572,906**	**£443,133**	**77%**
Cost of diversion: £1,363				

The figures above show that an intervention that successfully works with an individual to change their trajectory can result in a 77% overall reduction in cost to public services. Those that see the biggest difference in spending are the criminal justice services, with the Probation Trust spending 97% less, the Ministry of Justice spending 98% less and the Home Office spending 94% less. Local

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Authority spending includes a significant proportion of the cost of arrest and this also sees a significant reduction in cost. Notably, spending on benefits and on drug and alcohol treatment increases while other spending decreases.

This illustration is for an individual who is referred when they are at stage 5 (entrenched) to a community-based service. The Financial Analysis Model includes similar calculations for people referred to schemes in both the community and the prison at a range of different stages.

11.3c Population projections

The original Financial Analysis Model was designed to estimate how much public expenditure might be saved through investment across England in services similar to the three used in this research.

A population assumptions methodology was used to estimate the possible savings across England as a whole. Referral data from the Milton Keynes Link Worker + and HMP Lewes to Brighton projects[21] was used to estimate the number of people nationally who are currently in stages three (imminent crisis) four (chaos and crime) and five (entrenched) and calculated the cost of 'non intervention' trajectories for this population

Using outcome data from the projects the percentage of referrals who are likely to successfully change trajectory and follow the 'with intervention' trajectory was estimated.

Using local population data as a proxy for national data, the total savings that could result if similar services were available across the country were estimated.

Adapting the model for the North East

For the North East model these final population assumptions were adjusted based on an analysis of three factors:

- The size of the population in the North East
- The relative incidence of common mental health issues in the North East. Based on data from the North East Public Health Observatory (Glover 2008), the North East has a relatively higher level of common mental health problems – 12.18% higher than Milton Keynes.
- The relative levels of crime in the North East. Based on the British Crime Survey, overall crime levels in the in the North East are 67.4% of those in our baseline area, Milton Keynes.

From these figures it was estimated that if services of this type were implemented across the region they would handle an estimated caseload of 2,099 people per year.

Of these, an estimated 452 (46.67%) people currently in stages three (imminent crisis) to five (entrenched) would change trajectory as a result of the intervention.

Similarly, it was estimated that if prison based services were implemented across the region, then they would deal with a caseload of around 176 people per year of which 62 (35%) would change trajectory.

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[21] See footnote in section 11.1 above

> The location of these services would be most efficient if geared towards areas of the region with higher levels of crime.
>
> It should be noted that higher caseloads and therefore greater cost reductions might be possible with greater investment.

11.4 Regional findings

Using the above population projection, the model concludes that, in the North East, the potential caseload of 2,099 would cost a total of £381 million over three years with no intervention.

Providing services in the community for this group would cost £1.2 million per annum, while providing services in prison would cost £271,000 per annum.

This could result in a potential decrease in service cost of £133 million over three years.

The above illustration of monthly cost per stage shows that costs are distributed across a wide range of services. This supports the case for mechanisms such as joint commissioning and pooled budgets to be considered as a means of investing in these services. This is supported by the fact that the Milton Keynes Link Worker + scheme, one of the services on which the model is based, is jointly funded by probation, the local authority, the mental health trust and the police.

11.5 Limitations of the model

The findings from applying the Financial Analysis Model to the North East provide a well-informed estimate as to the potential financial implications of supporting people with mental health problems and multiple needs in contact with the criminal justice system.

However, a number of limitations should be acknowledged. Firstly, the savings illustrated are not all immediately "cashable". For example, if one prison sentence is avoided, the saving will not be realised by the prison service until an entire wing of a prison can be closed.

Secondly, as highlighted in Chapter 4, police forces across the country record the number of arrests, but not the number of people arrested. This means it is normally impossible to obtain data on the number of people being repeatedly arrested. There is also little data collected on the prevalence of common mental health problems amongst arrestees. Given the lack of available data, our estimates of frequency of arrest have been derived from expert opinion from former service users, police officers and caseworkers.

Thirdly, consultation with service users used to inform the development of stages and trajectories was limited to Revolving Doors National Service User Forum, comprising people who had generally experienced stages five (chaos and crime) and six (in prison). This may skew the data towards describing people who at one point in their lives are in chaos. It is not the case that all those experiencing mild difficulties will progress to chaos and arrest; this has been attempted to be reflected this in the modelling. The population assumptions that generate the final figures do not include people in stages one and two.

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As outlined above, the stages and trajectories of the original model have not been amended to be specific to the North East, but apply to England as a whole. (Only the unit costs, probabilities, frequencies and population projections have been adapted.) An area for development could be the verification or adaptation of these elements through more detailed consultation with service users and practitioners and analysis of client data from services in the region.

A further area for development would be the introduction of sensitivity testing. This has not been possible within resources to date, but is an area Revolving Doors will be developing in the near future.

Finally, many public sector services are currently experiencing unprecedented reorganisation and budget cuts. This clearly has an impact on the availability of services and may also have an impact on unit costs. Available data used in this modelling, whilst accurate at the time of research, may not be a wholly accurate projection of future spend.

11.6 Conclusion

The application of the Revolving Doors Agency Financial Analysis Model in the North East suggests that an annual investment of £1.2 million in services for people in contact with the criminal justice system and experiencing mental health problems that are below the threshold for secondary care would result in a potential reduction in costs across a range of public services of £133 million over three years.

With savings made across a number of sectors, there is considerable evidence to support arguments for joint funding of these services. However, the fact that not all funders spend less money when people successfully change trajectory presents a significant challenge. There is much further work to be done in making the case for reinvestment of savings across departments at a local, regional and national level. Pooled budgets and joint commissioning should be considered.

The analysis of this distribution of costs may be particularly useful if the model were to be adapted for use as part of the evaluation of pilot initiatives in the next stage of the BDP. As the model illustrates a particular approach, further research would be required to adapt various elements to reflect the pilot, but the basic approach is highly applicable.

As highlighted above, one limitation of this model has been a lack of data on the numbers of people repeatedly arrested (as opposed to the number of arrests made), and data on common mental health problems amongst arrestees. The development of pilot initiatives based in police custody would provide a timely opportunity to improve data collection in this area. This could then be fed into the Financial Analysis Model to strengthen the findings.

The development of pilot initiatives also provides an opportunity to increase data collection in other areas which would inform future financial modelling. These include the type of housing and access to housing support; patterns of use of health care services; engagement with the criminal justice system, including number of arrests, court appearances; type, length and number of sentences; number and length of periods of remand or other incarceration; engagement with substance misuse treatment services; welfare benefits claims; and volunteering or work.

Viewed alongside other publications setting out the business case for diversion[22], the North East-specific version of the Financial Analysis Model provides a compelling case for investment in services supporting people with mental health problems in contact with the criminal justice system.

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[22] For example Centre for Mental Health, Rethink and the Royal College of Psychiatrists (2011), *Diversion: the business case for action*, available at: http://www.centreformentalhealth.org.uk/pdfs/Diversion_business_case.pdf

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Legislation

Disability Discrimination Act, 2005

Health and Social Care Act, 2001

Health and Social Care Act, 2012

Local Government and Public Involvement in Health Act, 2007

Police and Criminal Evidence Act (PACE), 1984

Mental Health Act, 1983

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Appendix A – List of interviewees

Expert/Stakeholder	Job Title	Organisation	Focus of the meeting	Status
National				
Graham Durcan	Associate Director	Centre for Mental Health	Police screening	Completed
Mike Partridge	Inspector, Mental Health Project Team	Metropolitan Police	S.136 & police screening	Completed
Lynn Emslie	Head of Offender Health Development	NHS South Of England	Court reports, info to police (set up Bristol court pilot)	Completed
Linda Bryant	Operations and Development Manager Forensic Mental Health Practitioner Service	Together	Court reports, info to courts, MHTRs	Completed
Angus Cameron	Mental Health Advisor	London Probation Trust	Court reports, info to courts, MHTRs	Completed
Sarah Gates	Mental Health Liaison Officer	Sussex Police	Police screening	Completed
Dave Spurgeon		Formerly NACRO Mental Health Unity	CJLD	Completed
Colin Dale		LD expert (unattached)	All – LD	Completed
Lis Pritchard	Chief Executive	National Appropriate Adult Network	Police screening	Completed
Iain McKinnon	Doctoral Research Fellow	Newcastle University	Police screening	Completed
Max Rutherford	Transition to Adulthood alliance	Barrow Cadbury Trust	All – Young Adult & Transitions	Completed
Jenny Talbot	Lead on No One Knows programme	Prison Reform Trust	All – LD	Completed
Mark Gale	Campaigns and Policy Officer	Mencap	All – LD	Completed
Sue Staddon	Project Manager, SW Courts Mental Health	Offender Health, South West	CJLD, info to courts, MHTRs	Completed

	Assessment Pilot			
Gillian Ormoston			CJLDs, Mental health courts, MHTRs	Completed
Glyn Thomas		Dept of Health	National overview, vision for CJLD development, offender health good practice	Completed
Andy Hunt	Project Lead	Police Healthcare Transfer Project Manager, Department of Health	Police custody, transfer of healthcare	Completed
Commissioners				
Julie Dhuny	Head of Commissioning	NEOHCU	Scope of BDP, strategic overview of ambitions, etc	Completed
Andrew Gray		PORSCH NE	Scope of BDP, existing research, regional developments	Completed
Local/Regional				
Health				
7 x CJLD practitioner		NTW; TEWV	Practice within CJLDs	Completed
Maria Leonard	Band 7 nurse, Manager CJLD services	NTW	Practice within CJLDs	Completed
Helen Marriott / Sara Cochrane	Band 7 nurse, Manager CJLD Services	TEWV	Practice within CJLDs	Attended Inreach focus group and stakeholder engagement event
Mark Bradley	Service Manager Offender Pathway	TEWV	Practice within CJLDs, care pathways between prison and community, prison mental health care	Completed
Steve Moody	Clinical Community Manager Forensic Services	NTW	Practice within CJLDs, overview of Forensic Community Mental Health provision	Completed
Ron Weddle	Directorate Manager, Urgent Care Services	NTW	Community support, developing links between CJLDs and crisis teams, S.136	Completed

Lesley Crawford	Head of Adult MH Services and substance misuse	TEWV	Community support, developing links between CJLDs and crisis teams, S.136	Completed
Jo Dawson	Head of Adult MH services – Durham and Darlington	TEWV	Community support, developing links between CJLDs and crisis teams, S.136	Completed
Chris Watson	S.136 Lead	NTW	Practice and barriers with S.136	Completed
Mel Wilkinson	S.136 Lead	TEWV	Practice and barriers with S.136	Completed
David Muir	Forensic Learning Disability Lead	NTW		Completed
Paul Cartmell	Forensic Learning Disability Lead	TEWV	Provision for LD in Trust area; Whole pathway LD support	Completed
David Crawford	Dual diagnosis Lead	NTW	Dual diagnosis provision, specific barriers for this group	Completed
Samantha Clerk	Dual diagnosis Lead	TEWV	Dual diagnosis provision, specific barriers for this group	Attended Stakeholder Engagement event; unable to secure time for interview.
Lisa Boyd	Senior Therapist	Talking Therapies, Durham & Darlington	Planned work to introduce IAPT clinics into probation	Completed
Jeannie Bowler	Clinical Practice Manager	NE Ambulance Service	Transport issues around S.135 / 6	Completed
7 x manager of InReach		NTW; TEWV	Focus group to discuss care pathways and information flow from prison to community	Completed
Pauline King	PALS/Public & Patient Involvement Manager	Tees Esk & Wear Valley NHS Foundation Trust	Service User Involvement	Completed
Sandra Hutton	Head of Patient and Carer Engagement	*Northumberland, Tyne and Wear NHS* **Foundation** *Trust*	Service User Involvement	Completed
Angela Glascott	Service User Development Worker	*Northumberland, Tyne and Wear NHS* **Foundation** *Trust*	Service User Involvement	Completed
NOMS				
Paul Alderton	Offender Health	NEOHCU	Regional perspective on offender health in	Completed

	Development Manager (HMPS)		prisons	
Probation				
Dave Gardener	Dep Chief Executive and Director of Operations	Northumbria Probation Trust	Info to courts, CJLDs, MHTRs, care pathways from prison to community, probation barriers and training needs	Completed
Keith Norman	Mental Health Lead	Durham & Tees Valley Probation	Info to courts, CJLDs, MHTRs, care pathways from prison to community, probation barriers and training needs	Completed
Lucy Ford	Court Services Manager (North of Tyne)	Northumbria Probation	Info to courts, CJLDs, MHTRs, training	LF had to postpone interview, could not rearrange until March so no 1:1 interview conducted
Karin O'Neill	Head of Offender Management (South Tyneside Courts & Victims)	Northumbria Probation	Info to courts, CJLDs, MHTRs, training	Completed
Barbara Randall	Probation Officer	Northumbria Probation Trust	Service User Involvement	Completed
Courts & legal staff				
Kerrie Bell	Head of Mags Court Unit North East	CPS	Info to courts, MHTRs, court reports, disposals	Completed
Ian Palmer	District Crown Prosecutor	CPS	Info to courts, disposals	Completed
Ann Attwood	Seconded Lawyer	HMCTS North East / NHS Offender Health	Psychiatric Court reports and processes at court	Completed
Jules Preston	Magistrate – Chair of Youth Panel and Non Exec Chairman NTW		Info to courts, MHTRs, court reports, disposals	Completed
Police				
Rob King	Sergeant, MH Lead, Joint Lead for Offender Pathway	Cleveland Police	Police screening / s.136	Completed

Sean White	Asst Chief Constable	Cleveland Police	S.136, police screen, CJLD support	Completed
Dan Maddison	Inspector responsible for custody	Cleveland Police	S.136, police screen, CJLD support	Completed
Jane Spraggan	Crime & Justice Commander; BDP advisory group	Durham Constabulary	S.136, police screen, CJLD support, also on BDP Steering Group	Completed
Liane Green	Inspector	Durham Police	S.136, police screen, CJLD support	Completed
Dave Harris	Chief Inspector	Northumbria Police; Force Custody Manager	S.136, police screen, CJLD support	Completed
Vince Stubbs	Supt	Northumbria Police	NHS Healthcare in Police Custody	Gordon Milward suggested as alternative
Gordon Millward	Lead on healthcare transfer	Northumbria Police	NHS Healthcare in Police Custody	Completed
Local authorities				
Paul Fallon		Providing support to Newcastle City Council	Large involvement in ongoing scrutiny review into mental health needs of offenders	Completed
Prisons				
Steve Wells	Head of Offender Management	Durham Prison	Care Pathways from prison to community	Completed
Jim Willoughby	Head of Reducing Reoffending	Holme House Prison	Care Pathways	Completed
Bronia Banecki	Head of Resettlement	Low Newton Prison	Care Pathways	Completed
Tony Brewiss	Learning Skills and Employability Manager	Durham Prison		Completed
Other police custody contacts				
Phil Taylor	Regional Operations Manager	Reliance	Police custody, screening , S.136	Completed

Other				
Richard Deehan		YOT Pathfinder	Youth	Completed
Emma Howitt	CEO	Middlesbrough & Stockton Mind	Appropriate adult service, court support & prison resettlement programmes	Completed
Lisa Boyak	Manager	Women Outside Walls	Women	Completed
Ollie Batchelor	CEO	Cyrenians	Housing services, women and provision within the voluntary sector	Completed
Jan Ford	Area Manager	Addaction	Arrest referral services Cleveland	Completed
Idrees Rashid	CEO	BME Network Middlesbrough	VCS BME perspective	
David Shipman	Durham Joint Commissioner	Durham	Also NE Autism Consortium lead	Completed
Tony Wright	MD About-Turn	North East	Ex Forces Personnel	Completed
Wendy Dyer	Senior Lecturer in Criminology	Northumbria University	Data collection & evidencing outcomes	Reports reviewed
Wendy Balmain	Deputy Regional Director for Social Care and Partnerships	Department of Health	Pre-arrest and community, S.136, partnership arrangements, Appropriate adults, care pathways	Completed
Dawn Downey	Involvement Officer	Middlesbrough and Stockton Mind	Service User Involvement	Completed
Samm Goodall	Criminal Justice Coordinator	Middlesbrough and Stockton Mind	Service User Involvement	Completed
Kelly Hall	Service User Involvement Worker	*Stockton-on-Tees* Borough Council	Service User Involvement	Completed
Jo Whaley	Policy Officer	Vonne	Service User Involvement	Completed
Catherine Haigh	Chair	Middlesbrough Link	Service User Involvement	Completed
Kate Upshall-Davis	Mental Health Coordinator	Crisis	Service User Involvement	Completed

Samantha Clark	Chief Executive	Inclusion North	Service User Involvement	Completed
Alisdair Cameron	Team Leader Co-Chair	Launchpad Northumbria, Tyneside & Wear Service User & Carer Network (NET)	Service User Involvement	Completed
Mish Loraine	Chair Co-Chair	Gateshead Mental Health User Voice Northumbria, Tyneside & Wear Service User & Carer Network (NET)	Service User Involvement	Completed

Appendix B – Ensuring methodology engages all relevant

	Stakeholder		Strategic		Operational				
			Overarching high-level stakeholder	Other key stakeholder	Op staff interviews	Focus groups	Survey	Site visits	Stakeholder events
Community	MH Crisis Teams	NTW	Ron Weddle						Invited
		TEWV	Lesley Crawford						Invited
	Adult CMHTs/EIP teams & other secondary mental health	NTW							Invited
		TEWV	Lesley Crawford						Invited
	Community LD services	NTW							Invited
		TEWV							Invited
	Forensic LD services	NTW	David Muir						
		TEWV	Paul Cartmell						
	Forensic Community MH Services	NTW	David Muir	Steve Moody					
		TEWV	Levi Buckley / Gillian Taylor						
	Place of Safety	NTW	Ron Weddle						
		TEWV	Lesley Crawford; Jo Dawson	Simon Lancashire					
	S. 136 leads	NTW		Chris Watson					
		TEWV		Mel Wilkinson					
	Dual Diagnosis Service	NTW		David Crawford					
		TEWV		Samantha Clerk					Samantha Clerk
	PCTs								Invited
	Directors of Public Health								Invited
	IAPT services				Lisa Boyd (Durham & Darlington)				Invited
	NE Ambulance Service				Jeannie Bowler				
	Drug Treatment Agencies		Jan Ford; Jo Dawson; Lesley Crawford						Invited
	Alcohol Treatment Agencies								Invited
	LA Learning Disability Services								Invited
	LA Housing Services								Invited
	Community Safety Partnerships								Invited
	VCOs								Invited through VONNE
Police	Police	Cleveland	Sean White	Dan Maddison; Rob King	Very informal			Middlesbrough	
		Durham and Darlington	Jane Spraggan	Liane Green	Attended Safer Durham event				
		Northumbria	Gordon Millward; Dave Harris						
	FME providers	Northumbria							
		Durham							
		Cleveland	Phil Taylor		Informal interview			Yes	
	Reliance (custody)							Yes	
	Arrest referral providers	Turning Point							Invited
		NECA							Invited
		Addaction							Invited
	Appropriate Adult providers			Emma Howitt (Mind)					Invited
Police; courts	CJLD services	NTW	Steve Moody	Maria Leonard	Yes			Yes	
		TEWV	Mark Bradley; Rob King		Yes	Attended Inreach focus group		Yes	

	Stakeholder		Strategic		Operational				
			Overarching high-level stakeholder	Other key stakeholder	Op staff interviews	Focus groups	Survey	Site visits	Stakeholder events
Court	Courts Service (Clerks of Court)		Ann Attwood				Yes	By Ann Attwood	
	Magistrates		Jules Preston					By Ann Attwood	
	Probation	Northumbria	Karin O'Neill (Dave Gardiner; Keith Norman)	Lucy Ford			Yes	By Ann Attwood	
		Durham and Tees Valley					Yes	By Ann Attwood	
	CPS		Kerrie Bell; Ian Palmer					By Ann Attwood	
	Defence							By Ann Attwood	
	GEOamey				Informal			Yes	
Prison	NEOHCU (Prison-focused)		Paul Alderton						
	Inreach teams	TEWV		Mark Bradley		Yes			
		Resettlement/reducing re-offending	Steve Wells' Bronia Banecki; Jim Willoughby						
		Healthcare							Invited
		Safer Custody							Invited
		Education	Tony Brewiss						Invited
		Healthcare							Invited
		Safer Custody							Invited
	Prison advice services e.g. CAB/housing								Invited
	CARATs								Invited
Probation	ATR Providers								Invited
	DTR Providers								Invited
	MHTR Providers								Invited
	Probation	Northumbria	Dave Gardiner				Yes		Invited
		Durham & Tees Valley	Keith Norman				Yes		Invited
Priority Groups	Minority: BAME			Idris Rasheed					Invited through BECON
	Minority: Women			Lisa Boyak/ Ollie Batchelor					
	Transition			Richard Deehan					Invited youth services
	Autism		David Shipman						Invited through NEAC
	Text in red = Interview not secured								

Appendix C – Description of stages used in Revolving Doors Financial Analysis Model

Stage or life situation (not chronological)	
1. Initial difficulties	Adult living alone or in relationship starting to experience problems, fails to get support, problems accumulate, if employed loses job? Relationship breakdown? Early signs of stress, anxiety, depression.
2. Problems accumulating	Adult living alone or in relationship has deteriorating mental health, early substance misuse, likely to be in arrears with rent, early indications of ASB? Or vulnerability to crime? Domestic violence, relationship breakdown. Early contact with police. Possible first contact with courts.
3. Imminent crisis	Housing unstable, increasing contact with police and possibly other emergency services, mental health deteriorating, ability to cope damaged, increasing substance misuse, occasional crime – shop lifting etc, accommodation at risk of hijack by dealers. Possible repeat arrests, second or third court appearances. Fines, Community sentences?
4. Chaos & crime	Tenancy is fragile, possibly homeless and sofa surfing. Substance misuse high, crime increasing in frequency and seriousness. Repeat arrests. Some overlap with PPO/IOM cohort, due to frequency of offending. Females possibly involved in sex working.
5. Entrenched	Person has been leading a chaotic life for a long time, has served multiple prison sentences, may be banned or self excludes from services, repeatedly arrested and picked up by ambulances. Likely to only be claiming benefits intermittently.
6. In prison	Person spends repeated periods on short prison sentence.
7. Accesses high support	Person is linked to a range of services in a coordinated way including supported housing, substance misuse services, mental health support etc.
8. Stabilizing	Person access semi independent accommodation or floating support, makes use of primary health care, attends appointments at Job Centre etc, starts volunteer work and job seeking, substance misuse reduced or ended. Health improving.
9. Independent	Person living independently, stable, perhaps working, improving health, improving relationships with family, has support network, much less reliant on services.

Appendix D – Unit costs used in North East version of Financial Analysis Model

Spending source	Likely costs	unit	unit cost (£)	per month (£)	Source	Notes
LA	Rent covered by HB	week	91.15	394.98	https://lha-direct.voa.gov.uk/SearchResults.aspx?LocalAuthorityId=54&LHACategory=999&Month=1&Year=2012&SearchPageParameters=true	NB Jan 2012 Housing Allowance rate for Newcastle for one bedroom property. This cost is reduced to reflect lower housing costs in the N East
LA	Housing support (SP)	month	451.43	451.43	http://www.communities.gov.uk/publications/housing/supportingpeopledataq4	Average costs from the SP budget for the whole of the N East for 2010/11; for Mentally Disordered Offenders and people at risk of offending divided by number in each category. This cost is reduced, informed by local data, not clear if this is due to local circumstances or national changes in SP.
LA	Fire department	response	2645	2645	http://www.communities.gov.uk/documents/fire/pdf/144524.pdf	
LA	Investigation /arrest	arrest	1032.4	1032.4	HCJ Delivery plan 2009, states diversion saves a cost of £1780 per arrest	
HO	Investigation /arrest	arrest	694.2	694.2		
CLG	Investigation /arrest	arrest	53.4	53.4		
PCT	GP surgery consultation	consultation	36	36	http://www.pssru.ac.uk/uc/uc.htm	One consultation =11.7 minutes see page 167
PCT	Ambulance	response	211	211	http://www.dh.gov.uk/en/PublicationsandstatisticsPublications/PublicationsPolicyAndGuidance/DH_123459	Tab TCPTPARA 25 Psychiatric / Suicide Attempt; mental / Emotional

					URL	Notes
PCT	A&E	presentation	113	113	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098945	Total OPATT average A&E episode cost. Service code 180
PCT	CHMT	month	150.17	150.17	http://www.pssru.ac.uk/uc/uc.htm	Curtis £1802 per patient per annum. This figure was not previously available.
PCT	In patient MH	day	349.27	349.27	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123459	Taken from HRG codes. Tab TPCTMHSU Tab Average cost for PICU, low and medium secure treatment episode. This is a new data source which is believed to be far more accurate.
PCT	Tier 4 NHS	day	142	4319	http://www.pssru.ac.uk/uc/uc.htm Curtis 3.2	updated 2012 Reduction is just revised data
MOJ	CPS	case	880	880	http://www.cps.gov.uk/publications/finance/abc_intro.html#a05	Average cost of all the different finalisation categories at Magistrate court. NB this takes no account of the frequency of each category
MOJ	Courts, inc Legal Aid	case	716	716		Cost of magistrate Court £717.43m in 2007/8. (Magistrates' Courts and Crown Court expenditure, 1999–2009. Centre for Crime and Justice Studies). Number of criminal cases 1,736,000 (NAO 2007). Average =£413. Input-indicators-legal-aid.xls, lower case costs £303. www.justice.gov.uk. This is recalculated using newly available data and gives a more credible figure
MOJ	Prison	year	26,978	2248.16	http://www.justice.gov.uk/downloads/publications/statistics-and-data/hmps/prison-costs-summary-10-11.pdf	MOJ (2011) Cost per place and costs per prison by individual prison. (Cost per prisoner -all categories, £26,978)
Probation Trust	Probation	offender	4333	4333	http://www.swmprobation.gov.uk/wp-content/uploads/2010/03/Probation-brochure-lo-res1.pdf	Probation Association. Cost of a one year community order is £2500-£8000 depending on the requirements of the order. Taken figure of £4333 as 1/3 of the way up the range. This is recalculated taking 1/3rd up the range rather than the bottom, this is because published reports reference that the cost of additional components of orders such as drug or alcohol treatment add significantly to the costs.

DAAT	Methadone prescribing	week	50	216.67	http://www.pssru.ac.uk/uc/uc.htm Curtis 3.3	Updated 2012. The lower cost is due to revisiting the assumptions. Curtis give a cost per unit, but no explanation of what unit is; we took a unit as a day and assumed 7 day treatment. The figure is not credible so we have assumed a unit is presentation at a clinic
DAAT	Tier 4: vol sector	week	628	2721.33	http://www.pssru.ac.uk/uc/uc.htm Curtis 3.1	updated 2012. Reduction is just revised data
DAAT	Tier 2 group work	day	54	1080	http://www.pssru.ac.uk/uc/uc.htm Curtis	Not updated 2012. Not available. However we revisited our assumrtion on the intensity of interventions and reduced the figure
DWP	IS/JSA	week	67.5	292.5	http://www.lawcentreni.org/EoR/benefit-rates.html#Income Support / JSA(IB)	
DWP	ESA/IB	week	67.5	292.5	http://www.direct.gov.uk/en/MoneyTaxAndBenefits/BenefitsTaxCreditsAndOtherSupport/Illorinjured/DG_171896	

Glossary of acronyms

A&E	–	Accident and Emergency
ABI	–	Acquired Brain Injury
ACCT	–	Assessment, Care in Custody and Teamwork (prison based document for those at risk of harm to themselves)
ACPO	–	Association of Chief Police Officers
ADHD	–	Attention Deficit Hyperactivity Disorder
AMH	–	Adult Mental Health Services
AMHP	–	Approved Mental Health Professional
ASD	–	Autistic Spectrum Disorder
ATR	–	Alcohol Treatment Requirement
BAME	–	Black And Minority Ethnic
BCU	–	Basic Command Unit
BDP	–	Big Diversion Project
BDP AG	–	Big Diversion Project Advisory Group
BECON	–	Black Minority Ethnic Community Organisations Network
BMA	–	British Medical Association
BME	–	Black and Minority Ethnic
CAGE	–	Cut down, Annoyed, Guilty, Eye-opener (questionnaire for screening of alcoholism, the name is an acronym of its four questions)
CAMHS	–	Children's and Adolescents Mental Health Service
CARATs	–	Counselling, Assessment, Referral, Advice, and Throughcare services
CareFirst	–	(social care case management system for adult and children's services)
Cat	–	Category
CBT	–	Cognitive Behavioural Therapy
CCG	–	Clinical Commissioning Groups
CCP	–	Chief Crown Prosecutor
CDRPs	–	Crime and Disorder Reduction Partnerships
CEO	–	Chief Executive Officer
CJLD	–	Criminal Justice Liaison and Diversion
CJS	–	Criminal Justice System
CMH	–	Centre for Mental Health
CMHT	–	Community Mental Health Team
C-NOMIS	–	National Offender Management Information System
CPA	–	Care Programme Approach
CPN	–	Community psychiatric nurses
CPS	–	Crown Prosecution Service
CRI	–	Crime Reduction Initiatives
CSP	–	Community Safety Partnership
CQC	–	Care Quality Commission
DBT	–	Dialectical Behaviour Therapy
DCLG	–	Department for Communities and Local Government
DH	–	Department of Health
DIP	–	Drug Interventions Programme
DIR	–	Drug Interventions Record
DPULO	–	Disabled People's User-Led Organisations

DRR	–	Drug Rehabilitation Requirement
DTR	–	Drug Treatment Requirement
ECT	–	Electroconvulsive Therapy
EDT	–	Emergency Duty Team
FME	–	Forensic Medical Examiners
FTE	–	Full time Equivalent
GEOAmey	–	(company providing prisoner escort and custody services)
GPs	–	General Practitioners
HASI	–	Hayes Ability Screening Index
HMCTS	–	Her Majesty's Courts and Tribunals Service
HMIC	–	Her Majesty's Inspectorate of Constabulary
HMIP	–	Her Majesty's Inspectorate of Prisons
HMP	–	Her Majesty's Prison
HMYOI	–	Her Majesty's Young Offender Institution
IAPT	–	Improving Access to Psychological Therapies
IDTS	–	Integrated Drug Treatment Services
IOM	–	Integrated Offender Management
IPCC	–	Independent Police Complaints Commission
JSNA	–	Joint Strategic Needs Assessment
LA	–	Local Authority
LASPO	–	Legal Aid Sentencing and Punishment of Offenders Bill
LCJB	–	Local Criminal Justice Board
LD	–	Learning Disability
LDFS	–	Learning Disability Floating Support
LDSQ	–	Learning Disability Screening Questionnaire
LGBT	–	Lesbian, Gay, Bisexual, Transgender
LINks	–	Local Involvement Networks
MAPPA	–	Multi-Agency Public Protection Arrangements
MARAC	–	Multi-Agency Risk Assessment Conference
MDO	–	Mentally Disordered Offender
MH	–	Mental Health
MHA	–	Mental Health Act 1983/ 2007
MHTR	–	Mental Health Treatment Requirement
MIND	–	(mental health charity for England and Wales)
MOJ	–	Ministry of Justice
NAAN	–	National Appropriate Adult Network
NACRO	–	National Association for the Care and Resettlement of Offenders
NCALT	–	National Centre for Applied Learning Technologies
NE	–	North East
NEAC	–	North East Autism Consortium
NECA	–	North East Council for Addictions
NEOHCU	–	North East Offender Health Commissioning Unit
NHS	–	National Health Service
NICHE	–	(police records management system)
NIP	–	National Involvement Partnership
NOMS	–	National Offender Management Service
NPIA	–	National Policing Improvement Agency

NPIX	–	(police computer system)
NSPIS	–	National Strategy for Police Information Systems
NSUN	–	National Survivor User Network
NTW	–	Northumbria, Tyne and Wear
OASys	–	Offender Assessment System
OHRN	–	Offender Health Research Network
PACE	–	Police and Criminal Evidence Act 1984
PARIS	–	Patient Record Information System
PCC	–	Police and Crime Commissioner
PD	–	Personality Disorder
PER	–	Prisoner Escort Record
PCT	–	Primary Care Trust
PNC	–	Police National Computer
PPI	–	Patient and Public Involvement
PPO	–	Prolific or other Priority Offenders
PRT	–	Prison Reform Trust
PSR	–	Pre-sentence report
RAPID	–	Referral, Assessment, Pre-release and In-prison Discharges
RCPSYCH	–	Royal College of Psychiatrists
REACHES	–	(local women's centre)
RGN	–	Registered General Nurse
RIO	–	(clinical information systems offering electronic patient records)
ROTA	–	Race on the Agenda
RSO	–	Registered Sex Offender
SDVC	–	Specialist Domestic Violence Court
SHA	–	Strategic Health Authorities
SLA	–	Service Level Agreement
SW	–	South West
SWIFT	–	(social care computer system)
SystmOne	–	(prison healthcare computer system)
T2A Alliance	–	Transition to Adulthood Alliance
TBA	–	To be announced/ arranged
TEWV	–	Tees, Esk and Wear Valley
ULO	–	User-Led Organisation
VCOs	–	Voluntary Care Organisations
VONNE	–	Voluntary Organisations Network North East
WRAP	–	Wellness Recovery Action Programme
YOT	–	Youth Offending Team