

REPORT

SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change



Blurring the Boundaries

The convergence of mental health and criminal justice policy, legislation, systems and practice

Max Rutherford

With a Foreword by Rt Hon Lord Bradley

a **better** way



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Contents

Acknowledgements	4
Foreword by the Rt Hon Lord Bradley	6
Executive summary	8
Introduction	11
1: Policy and legislative developments 1990-2010	13
2: Criminal Justice Liaison and Diversion services	20
3: Mental health court pilots	23
4: Mental Health Treatment Requirement	26
5: Imprisonment for Public Protection	29
6: Hospital and Limitation Direction	32
7: Dangerous and Severe Personality Disorder Programme	46
8: Systems convergence	59
9: The rise of forensic mental health	62
10: Legislative convergence	65
11: Managing ‘dangerous’ and ‘anti-social’ people	69
12: Examples of non-convergence	74
13: The future of convergence	80
14: The benefits of convergence	83
15: Concerns about convergence	86
Final remarks	88
References	89



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Foreword by the Rt Hon Lord Bradley

In April 2009, I published my review of people with mental health problems or learning disabilities in the criminal justice system. The criminal justice and mental health systems are both vastly complicated, even more so when the two are brought together. I was therefore very pleased to be asked to write the foreword to this important report, which for the first time sets out what convergence means for those at the sharp end of it.

My review, and the Government's new five-year strategy, *Improving Health, Supporting Justice*, are part of a momentum that has been building for more than two decades. Previous reports by Dr John Reed, by the HM Chief Inspectors of Prisons, by government departments, academics and commentators, have all found evidence of increasing convergence between mental health and criminal justice.



As a former Home Office Minister I was well aware that a criminal justice system is often a gatekeeper to health and social care services. However, while it is common for an offender to have a complex mix of health and social care needs, services rarely respond in a joined-up way. Rather, as I found in my review, services often work in silos, leaving individuals and their families without the support they need.

In recent years there have been major improvements in the levels of care that offenders receive, both in the community and in custody. The introduction of in-reach services was a milestone to improving mental health treatment in prisons. And in the community, many local professionals are already working together at police stations and courts precisely in the way criminal justice liaison and diversion services should operate everywhere. But there is still a long way to go before it can be said that good practice is universal.

Too often the way services respond to offenders with mental health problems is inconsistent and disjointed. Too many people are either left to flounder in the gaps between services or are caught in a 'revolving door'. Too frequently it is only due to the hard work of enthusiastic pioneers that improvements have been made in local areas. Diversion should not be subject to a postcode lottery; it should be standard practice and available everywhere.

Convergence between mental health and criminal justice tends to happen most at the latter end of the criminal justice system, in the courts at the point of sentencing. Yet interventions at the earliest opportunity are crucial if diversion is to be most effective. Achieving this means reconfiguring the way that health services work with the police, and helping police officers change the way that they engage and respond to people with mental health problems.

This Sainsbury Centre report details the increasing convergence between mental health and criminal justice. It identifies how convergence has contributed to much of the progress that has already been

made, but also provides a timely reminder for the future and alerts policy-makers and practitioners to the many potential implications of increased convergence.

Perhaps most importantly, this report exposes the differences that do and should exist between mental health and criminal justice. It rightly argues that mental health and criminal justice have fundamental distinctions that should never be allowed to converge completely. “Where and when should convergence stop?” is a question that we must all keep asking.

A handwritten signature in black ink that reads "Keith Bradley". The signature is written in a cursive style with a long horizontal flourish underneath the name.



Executive summary

This report demonstrates that a convergence is taking place between mental health and criminal justice legislation, policy, systems and practice. There are more and more instances in which the health and justice systems are having to work together for the care, support, rehabilitation and punishment of people with mental health problems who have, or are suspected of having, offended.

The report also summarises both the benefits and the risks of convergence. It is intended to inform policy-makers and practitioners about where convergence can be useful and where caution is required.

While it is clear that convergence may also be relevant in relation to child health and youth justice services, this report focuses only on adults and the adult system in England.

Examples of convergence

The report examines six examples of convergence in detail:

Criminal Justice Liaison and Diversion

Criminal Justice Liaison and Diversion services are a clear example of convergence. Current provision of liaison and diversion is patchy and inconsistent. Yet with sufficient resources and authority, CJLD services could act as a gateway to mainstream mental health care for offenders.

Mental Health Courts

Mental health courts potentially provide specialist knowledge and support on mental health to the criminal court system, but they often function in a parallel system that is only accessible by a small number of people. At present it is not entirely clear what mental health courts offer that cannot already be achieved within the existing courts' structure.

Mental Health Treatment Requirement

Mental Health Treatment Requirements (MHTRs) are available to sentencers as part of a community sentence. But they have been little used. Much more joint-working between mental health and criminal justice agencies is needed to enable greater use of this potentially useful diversion tool, which can be a robust alternative to short custodial sentences.

Imprisonment for Public Protection

Introduced in 2005 by the Criminal Justice Act 2003, indeterminate sentences of Imprisonment for Public Protection have been widely used. There were nearly 6,000 IPP prisoners at the start of 2010. Independent research has highlighted that the IPP population has higher and more complex mental

health and other needs than the general prison population, many of which are made worse by the nature of their indeterminate sentence.

Hospital and Limitation Direction

The Hospital and Limitation Direction has been and remains a controversial concept. It is in essence a ‘hybrid order’ that enables a judge to order an offender to hospital and at the same time pass a prison sentence. In its first ten years, it was only available for people diagnosed with ‘psychopathic disorder’, but the expansion of its application to all mental disorders in November 2008 means that it may now be used more frequently.

The HLD overcomes the judicial dilemma of having to choose either to order an offender to treatment in hospital or to give a prison sentence. This could mean that fewer offenders with a serious mental illness end up in prison. But there are a host of financial, clinical and ethical problems, not least the potential for an ‘avalanche effect’ on services.

‘Dangerous and Severe Personality Disorder’ programme

The DSPD programme is a ten year government pilot project that has cost nearly half a billion pounds. The programme operates in prisons and high security hospitals with places for around 350 people, but is not found in statute despite a number of attempts by government.

The evidence suggests that it is now time for the DSPD programme to be phased out in favour of prison-based personality disorder services. Reinvesting the DSPD Programme’s operational costs of £60 million per year in mainstream prison-based personality disorder interventions would have a substantial impact on the 70% of prisoners who have a form of personality disorder.

The benefits of convergence

There have been a number of improvements to services and benefits for offenders with mental health problems in recent years as a result of convergence. They include:

- An improvement to mental health treatment and care in the criminal justice system, in particular the introduction of NHS prison in-reach services. Although under-resourced, these services have driven up standards in prisons and, in some cases, they now provide high-quality mental health care.
- Information-sharing is improving between health and criminal justice agencies, and there are now effective models for sharing information in partnership to the benefit of both the individual and society.
- A cross-government, multi-department National Delivery Plan for implementing the Bradley Report. This is the most substantial and significant example of policy convergence in twenty years.

In addition, potential future benefits of convergence include:

- Increased multi-agency provision of services for offenders with mental health problems, and substantially raised levels of understanding across disciplines.
- Improved commissioning between criminal justice and health agencies, based on Joint Strategic Needs Assessments that include offenders and pay specific attention to the health and social care needs of this group.
- A national network of criminal justice liaison and diversion services, if fully implemented.

- Engaging the police with health services, so that they can become partners in diversion and early intervention services, would be of great benefit to both individuals and services.

The risks of convergence

There have also been negative implications to convergence, most prominently seen when the fundamental differences between the objectives of health and criminal justice agencies are brought to the fore. IPP sentences and the DSPD programme are both risk-based interventions that have had a big impact on offenders with mental health problems. Yet each is having minimal success in terms of demonstrating reduced reoffending or health improvement, and both are costing a great deal of public money.

There are also risks to increased convergence which need to be anticipated and mitigated. They include:

- The lines between prisons and hospitals may become overly blurred. Prisons should never be a substitute for hospitals, and hospitals should not be designed like prisons.
- There is a danger that convergence will increase stigma for offenders with mental health problems, who may receive a dual labelling of ‘criminal’ and ‘mentally ill’.
- It is inevitable that criminal justice and health agencies have different aims and objectives, and it is important to recognise that convergence can never be total.
- There is a risk that convergence may de-professionalise workforces and that practitioner roles will become increasingly blurred. It is important that health and criminal justice staff retain their individual identities, and in particular that clinical and ethical principles are not eroded.
- It is widely recognised that Black and Minority Ethnic (BME) groups are overrepresented in both the criminal justice system and the secure forensic mental health services. Convergence should seek to reduce this problem through better joint and strategic commissioning and service planning for BME groups.

Prospects for the future

The Bradley Report and the Government’s National Delivery Plan for implementing it are likely to lead to further convergence in the future. If managed correctly and with the necessary ethical checks and balances in place and correctly observed, convergence can be a process that raises the standards of mental health services for offenders to the level that our post-Bradley expectations now demand.



Introduction

Research has shown that there is a high prevalence of mental health problems among people in the criminal justice system (Singleton *et al.* 1998; Gunn 2000; Fazel & Danesh 2002; Durcan 2008). This high prevalence has combined with great pressures on criminal justice and health agencies working within the criminal justice system.

It is also clear that in the last two decades there has been a convergence between mental health and criminal justice policy, legislation, systems and practice, and that boundaries between the two systems are becoming increasingly blurred. There are many benefits to convergence, but also a number of risks.

This report provides a literature, policy and legislative analysis of recent and current examples of convergence, and considers the implications of convergence for the future. The relevant recommendations from Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (Bradley 2009) are summarised, as are the delivery objectives detailed in the Government's National Delivery Plan *Improving Health, Supporting Justice*, published in November 2009 (HM Government 2009a).

The report is divided into the following chapters:

Chapter 1 presents an overview of offender mental health policy and legislation developments from 1990–2009 with a timeline of events.

Chapters 2 to 5 present four current examples of convergence between mental health and criminal justice:

- Criminal Justice Liaison and Diversion services
- Mental Health Courts
- Mental Health Treatment Requirement
- Imprisonment for Public Protection

Chapters 6 and 7 describe two examples of convergence in detail. First, the Hospital and Limitation Direction (Section 45a of the Mental Health Act, initially called the 'Hybrid Order'), which, since November 2008, enables judges to give an order for secure hospital treatment and at the same time pass a prison sentence of potentially indeterminate length.

The second is the Dangerous and Severe Personality Disorder (DSPD) programme, a high-cost service that has been in operation as a pilot programme for nearly a decade.

Chapters 8 to 11 draw specifically from written submissions from twenty-three experts working in the fields of mental health and criminal justice. The experts included individuals and organisations working in central and regional government departments, academics, practitioners and clinicians. Each was invited to submit a written response to these three questions:

1. To what extent do you think that criminal justice and mental health have converged in recent years?

2. Do you expect the convergence to occur increasingly over the next ten years?
3. What is your opinion about the convergence of mental health and criminal justice?

The vast majority of the experts believed that convergence has occurred in recent years and was doing so at an increasing rate, but responses did vary as to the degree to which it has occurred and the precise nature of the convergence. While all of the experts gave some specific examples of convergence, many gave examples of where the two systems remain quite distinct (described in chapter 12).

Chapter 8 presents a summary of where convergence has had a direct impact on the operations of mental health and criminal justice systems, including the closure of the large hospitals, the introduction of mental health in-reach teams into prisons, and the use of the Care Programme Approach with offenders.

Chapter 9 summarises convergence seen in the rise of forensic mental health services, and the establishment of forensic psychiatry and forensic psychology as academic and clinical disciplines.

Chapter 10 details two examples of legislative convergence that were established or gained prominence as a result of the amendments made by the Mental Health Act 2007: Community Treatment Orders (and Supervised Community Treatment) and Sections 135 and 136 related to the police's role in removing people to 'places of safety'.

Chapter 11 highlights three examples of convergence that each relate to recent measures introduced to aid the management of 'dangerous' or 'anti-social' people: Multi-Agency Public Protection Arrangements, Potentially Dangerous Persons provisions, and Anti-Social Behaviour Orders.

Chapter 12 summarises a number examples of non-convergence, where mental health and criminal justice still remain much separated in their respective management of offenders.

Chapters 13 to 15 form the conclusion of the report. Chapter 13 outlines our hypothesis on whether or not convergence will occur increasingly in the future, while chapters 14 and 15 summarise the advantages of, and concerns about, convergence.



Policy and legislative developments 1990–2010

In the last two decades there has been an increasing focus from government on mental health in the context of criminal justice. Between 1990 and 2010, a number of policies have been developed and introduced which have led to a growing convergence between mental health and criminal justice.

1990–1996

In 1990, the Home Office issued Circular 66/90 intended to promote diversion of people with mental health problems in the criminal justice system (referred to in the circular as ‘mentally disordered offenders’) to appropriate care and treatment by mental health services instead of a criminal justice sanction.

This was followed in the early 1990s by the multi-volume Reed Reports, which were a catalyst for placing mentally disordered offenders in national policy focus (1992–4). Reed’s reports called for the creation of a national network of court assessment and diversion services, a large-scale investment in secure mental health services for offenders, and closer working between health and criminal justice agencies.

In 1996 Her Majesty’s Chief Inspector of Prisons produced a consultation paper *Patient or Prisoner? A new strategy for health care in prisons* (HM Inspectorate of Prisons 1996). This paper placed a spotlight on the high rates of mental illness in prisons. It called into question whether government was doing enough to ensure that prisoners were receiving adequate mental health treatment in custody. The major recommendation was that the NHS should take on the commissioning responsibility for prison health services, rather than the arrangement at the time where health services were individually commissioned by each prison. This change, it was argued, would introduce health services for prisoners that were ‘equivalent’ to those they could access in the community.

1997–2001

In March 1997, the Crime (Sentences) Act, a Conservative Bill but a Labour Act, introduced the ‘Hospital and Limitation Direction’ to the Mental Health Act (S.45a), but only for ‘psychopathic disorder’ (see chapter six).

In 1998, the Office for National Statistics produced research on the psychiatric morbidity of prisoners (Singleton *et al.* 1998), finding that up to 90% of prisoners had a diagnosable mental health problem, including within its definition drug and alcohol dependency and personality disorder, and that 70% had two or more (see chapter eight).

Also in 1998, the Crime and Disorder Act introduced Anti-Social Behaviour Orders (ASBOs; see chapter eleven).

In 1999, the HM Prison Service and NHS Executive Working Group report, *The Future Organisation of Prison Health Care*, endorsed the Chief Inspector of Prisons' recommendation "to give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service" (HMPS NHS 1999, p. i).

Also in 1999 the *National Service Framework for Mental Health* (Department of Health 1999), a ten year plan that addressed the mental health needs of working age adults in England, was published. It set out national standards and service models, local action plans with national programmes for implementation, and a series of milestones to assure progress, with performance indicators to support effective performance management. In addition, an organisational framework for providing integrated services and for commissioning services across the spectrum was also included. Significantly, the Framework applied to prisons, with an emphasis on mental health promotion and suicide prevention, and supported the earlier proposals in *The Future Organisation of Prison Health Care* (HMPS NHS 1999).

In July 1999, the Home Office published *Managing Dangerous People with Severe Personality Disorder: Proposals for policy development*. It introduced the concept of a service for those with 'Dangerous and Severe Personality Disorder' (or DSPD). The following year, a Government Green Paper (HM Government 2000) entitled *Reforming the Mental Health Act Part II: High Risk Patients* proposed that a DSPD Programme would form part of a new Mental Health Act. The attempt to change the Mental Health Act failed due to widespread opposition. However, following an election win and a Labour 2001 election manifesto commitment, the DSPD programme was established as a pilot project in 2001 with capital funding of £128m, and £40m per annum operational funding (see chapter seven).

In 2000, Sir Richard Tilt's report commissioned by the Department of Health, *Report of the Review of Security at the High Security Hospitals*, (Department of Health 2000) resulted in the downgrading of many high secure ('special hospital') mental health beds to 'medium security'. Medium secure forensic mental health beds capacity rose sharply (see chapter nine).

2001–2005

A major step towards reform was made in 2001 with the publication of the Department of Health and HM Prison Service report, *Changing the Outlook: A strategy for developing and modernising mental health services in prisons* (Department of Health 2001). The report stated that it was:

"A joint Department of Health and Prison Service approach to far-reaching development and modernisation of mental health services in prisons over the next 3-5 years, in line with the National Service Framework (NSF) for Mental Health and the NHS Plan" (Department of Health 2001, p. 5).

Significantly the report demanded that:

"By 30 September 2002 all prisons and their local NHS partners will be expected to have completed a detailed review of mental health needs, based on their existing health needs assessment work, to identify gaps in provision between what is currently available and that set out in ... this document, and to have developed action plans to implement the changes needed to fill those gaps. This work should include a training needs analysis for prison staff and NHS in-reach teams. Prisons and their local NHS partners should work together to achieve this" (Department of Health 2001, p. 6).

In July 2002, the Social Exclusion Unit's report, *Reducing Re-offending by Ex-prisoners*, established a clear link between offending, re-offending and other wider factors that influence offending and re-offending, including mental health problems.

In January 2003, Department of Health guidance *Personality Disorder: No longer a diagnosis of exclusion* asserted that "All Trusts delivering mental health services need to consider how to meet the needs of patients with a personality disorder" (Department of Health 2003) and to design personality disorder services by 2006.

In November that year, the Criminal Justice Act 2003 introduced new indeterminate sentences, including Imprisonment for Public Protection (IPP) (see chapter five), as well as new community sentences (Community Orders and Suspended Sentence Orders) with 12 new requirements, including the Mental Health Treatment Requirement (see chapter four). The Act also introduced Multi-Agency Public Protection Arrangements (MAPPA) onto statute (see chapter eleven).

In 2004, following a review by Lord Carter, the National Offender Management Service (NOMS) was established, in an attempt to ensure 'end to end offender management', creating nine Regional Offender Managers (later ten Directors of Offender Management).

The 2005 government policy paper *Offender Mental Health Care Pathway* (Department of Health / NIMHE 2005) set two 'fundamental aims' for mental health care for prisoners:

"The first is that no-one with acute severe mental illness should be in prison. The second is that prisons should be safe places for people with mental health problems and that suicides should be increasingly prevented" (p. 2).

This was perhaps the first government policy paper that identified what is now commonly referred to as the 'offender health pathway'. The pathway model would soon become part of mainstream thinking in the field of offender health.

2006-2009

At the beginning of 2006, a Home Office report *A Five Year Strategy for Protecting the Public and Reducing Re-offending* (Home Office 2006a) was published with emphases on protecting the public, punishment, reparation and rehabilitation.

Devolution of commissioning responsibilities for prison health care was completed in all prisons in 2006 and, as part of this, mental health 'in-reach' teams, based on the NSF model of community mental health teams, were introduced into prisons following a £20 million per annum investment and 300 clinical staff (see chapter eight).

In May 2007, the Government created the Ministry of Justice, delivering the correctional services element previously under the remit of the Home Office.

Later in 2007, the Department of Health-led cross-government consultation paper *Improving Health, Supporting Justice: A strategy for improving health and social care services for people subject to the criminal justice system* (Department of Health 2007) attempted to gauge the views of stakeholders, practitioners and service users in order to create a vision that drew on the progress that had been made since 1990, promising that:

“Health and social care services will be designed to meet the challenging range of needs offenders and their families have ... Offenders and their families will receive standards of care equivalent to that of the wider community which are well resourced and their effectiveness measured” (p. 9).

However, before the planned strategy was completed and published, three independent reports were published in quick succession that focused in part or in whole on mental health and criminal justice: The Corston Report (2007) *Review of Women with Particular Vulnerabilities in the Criminal Justice System*; HM Inspectorate of Prisons report (2007) *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*; and the House of Commons Select Committee on Justice (2008) report *Towards Effective Sentencing*.

In addition, a plethora of research and reports were produced by non-government organisations across the political spectrum, which highlighted major challenges and shortfalls in investment in mental health services throughout the criminal justice system (including Sainsbury Centre for Mental Health, Prison Reform Trust, the Centre for Social Justice, Policy Exchange and Nacro).

While all of these reports recognised that progress and improvements had been made, they were widely critical of the Government’s shortfalls in meeting its promises to ensure ‘diversion’ and ‘equivalence’ for offenders. The primary concerns included:

- The prevalence of prisoners with mental health problems in prisons was as high as ever;
- Multi-agency working and diversion services in police stations and courts were piecemeal and highly varied across the country;
- Secure mental health services for offenders were extremely expensive, admission and discharge arrangements problematic, and outcomes uncertain; and
- Funding and quality of mental health services in prisons were still well short of being ‘equivalent’ to those available in the community.

In July 2007, the Mental Health Act 2007 received royal assent. The new Act amended the Mental Health Act 1983, introducing Community Treatment Orders (and Supervised Community Treatment) for people discharged from inpatient units, enabling recall if non-compliant with discharge conditions (see chapter ten). The amendments also reclassified ‘personality disorder’ as a mental disorder, and extended the application of Hospital and Limitation Directions to any mental disorder (see chapter six).

On 5 December 2007, Lord Carter’s report on prison capacity (*Securing the Future: Proposals for the efficient and sustainable use of custody in England and Wales*, Carter 2007) was published. On the same day, perhaps largely because diversion was identified as a way to reduce the overcrowded prison population, the Secretary of State for Justice, Jack Straw, asked former Home Office minister Lord Bradley to undertake an independent review “on diverting more offenders with severe mental health problems away from prison and into more appropriate facilities”.

Following a request from Lord Bradley in early 2008 to extend the terms of reference of his review, the final report, published in April 2009 (Bradley 2009, *Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*) was more far reaching and examined the whole of the criminal justice system.

The Bradley Report’s eighty-two recommendations and the Government’s initial response (Ministry of Justice 2009), led to what was probably the culmination of twenty years of progress in policy development, and created unprecedented expectation and attention on mental health and criminal justice.

The resultant government strategy, *Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board* (HM Government 2009a), set out the Government's five year strategy for offender health. The Plan set out a specific timetable for addressing all of Bradley's recommendations, as well as delivery targets for women offenders, alcohol and drug problems and issues relating to physical health needs. Prominent in the Plan was a five year timetable for establishing a national network of criminal justice liaison and diversion services, which had been the centrepiece of Lord Bradley's report (see chapter two).

The Delivery Plan was supported by the cross-government strategy for mental health, *New Horizons: A shared vision for mental health* (HM Government 2009b).

Policy and legislation timeline

1990

Home Office Circular 66/90 on the *Provision for Mentally Disordered Offenders* is published

1992-4

The reports by Dr John Reed ('The Reed Reports') are published:

Review of mental health and social services for mentally disordered offenders and others requiring similar services: Vol. 1: Final summary report (1992)

Review of mental health and social services for mentally disordered offenders and others requiring similar services: Vol. 2: Service needs (1993)

... *Vol. 3: Finance, staffing and training* (1993)

... *Vol. 4: The academic and research base* (1993)

... *Vol. 5: Special issues and differing needs* (1993)

High security and related psychiatric provision (1994)

Services for people with psychopathic disorder (1994)

1996

October: HM Chief Inspector of Prisons' consultation paper, *Patient or Prisoner? A new strategy for health care in prisons*, is published

1997

March: Crime (Sentences) Act receives royal assent – introduces 'Hospital and Limitation Directions' to the Mental Health Act (S.45a) for 'psychopathic disorder'

May: Labour defeats Conservatives in the general election

1998

July: Crime and Disorder Act 1998 receives royal assent – introduces Anti-Social Behaviour Orders

Office for National Statistics research on the psychiatric morbidity of prisoners is published

1999

March: HM Prison Service and NHS Executive Working Group report *The Future Organisation of Prison Health Care* is published

September: Department of Health ten-year *National Service Framework for Mental Health in England (NSF)* is published

July: Home Office proposal *Managing Dangerous People with Severe Personality Disorder: Proposals for policy development* is published – introduces the idea to create a service for those with ‘Dangerous and Severe Personality Disorder’

2000

January: Sir Richard Tilt’s *Report of the Review of Security at the High Security Hospitals*

December: Government Green Paper *Reforming the Mental Health Act Part II: High Risk Patients* is published, proposing the creation of a DSPD Programme

2001

May: Labour wins the general election with a manifesto commitment to create 300 DSPD places

December: Department of Health/HM Prison Service report *Changing the Outlook: A strategy for developing and modernising mental health services in prisons* is published

2002

July: Social Exclusion Unit report *Reducing Re-offending by Ex-prisoners* is published

2003

Transfer of commissioning responsibilities for prison health care to NHS begins in all prisons

January: Department of Health guidance *Personality Disorder: No longer a diagnosis of exclusion* is published

November: Criminal Justice Act 2003 gets royal assent – introduces new community sentences (including provision for the Mental Health Treatment Requirement) and Imprisonment for Public Protection (IPP)

2005

January: Department of Health/NIMHE paper *Offender Mental Health Care Pathway* is published

2006

February: Home Office report *A Five Year Strategy for Protecting the Public and Reducing Re-offending* is published

NHS-funded mental health ‘in-reach’ teams, based on the NSF model of community mental health teams, introduced into prisons with a £20m per annum investment

Transfer of responsibility and funding for prison health services from the Prison Service to the NHS is completed

2007

March: Baroness Corston's Report, *A Review of Women with Particular Vulnerabilities in the Criminal Justice System*, is published

July: Mental Health Act 2007 receives royal assent: amends the Mental Health Act 1983, introducing Community Treatment Orders (CTOs) and Supervised Community Treatment (SCT) and extending the application of Hospital and Limitation Directions to any mental disorder

October: HM Inspectorate of Prisons' *Thematic Review of the Care and Support of Prisoners with Mental Health Needs* is published

November: Department of Health-led cross-government consultation paper, *Improving Health, Supporting Justice: A strategy for improving health and social care services for people subject to the criminal justice system*, is published

December: Lord Carter's report, *Securing the Future: Proposals for the efficient and sustainable use of custody in England and Wales*, is published

December: Secretary of State for Justice commissions what becomes the Bradley Report

2008

June: Criminal Justice and Immigration Act 2008, amending legislation to increase the threshold for which judges can give an IPP sentences to a two year tariff

April: Ministry of Justice and Department of Health paper, *Dangerous and Severe Personality Disorder (DSPD) High Secure Services for Men: Planning and delivery guide*, is published. By the end of 2008, the DSPD Programme's bed capacity reaches 400, with an operating cost of £60m per annum, but remains a 'pilot programme' with 'no plans' for a statutory basis.

July: Justice Select Committee report, *Towards Effective Sentencing*, is published

2009

April: Lord Bradley's *Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System* is published, making eighty-two recommendations

April: Government's initial response to Bradley Report accepts all but three of Bradley's recommendations at least 'in principle'

High-level government National Programme Board is established to oversee delivery of Bradley's recommendations

July: Mental health court pilots are officially launched in Brighton and Stratford, East London

November: *Improving Health, Supporting Justice: The national delivery plan of the Health and Criminal Justice Programme Board* is published

December: *New Horizons: A shared vision for mental health* is published



2

Criminal Justice Liaison and Diversion services

There are currently around 150 Criminal Justice Liaison and Diversion (CJLD) services in operation in England and Wales, varying significantly in both scope and effectiveness. The best CJLD services operate as an interface between mental health services and criminal justice agencies (such as the police and courts) to ensure that offenders with mental health problems are diverted to appropriate treatment, either instead of or in addition to a criminal justice sanction. Lord Bradley aimed to build upon the current arrangements in his vision for a national network of Criminal Justice Mental Health (CJMH) teams, which would be accessible to every police station and court in the country. Both the current arrangements of CJLD services and Lord Bradley's proposals represent a clear example of a convergence.

Background

CJLD teams were piloted in the early 1990s (see Bradley 2009, pp. 81–87). In 1990, the Home Office proposed plans for better diversion of offenders with mental health problems away from the criminal justice system towards mental health treatment, delivered by court liaison and diversion services (Home Office 1990). The first organised scheme for diversion in England and Wales was implemented as a pilot in 1989.

The concept was supported in 1992 by the Department of Health-commissioned reports led by Dr John Reed, particularly in the *Review of Mental Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services*, which stated that:

“There should be nationwide provision of properly resourced court assessment and diversion schemes ...The longer term future of many schemes is not yet assured but experience increasingly suggests that, where diversion schemes became established, these come to provide a broader multi-agency focus which, of itself, can make effective disposals easier” (Reed 1992).

Following the Reed Reports, and subsequent Home Office guidance, there was a substantial expansion of such services. By the mid 2000s, about 150 CJLD schemes were in existence around the country. Most of these schemes operated in magistrates' courts, but some based their operations in police stations, with the earliest schemes led by psychiatrists. They focused mainly on identifying cases of severe mental illness among those coming into contact with the criminal justice system and facilitating transfers to psychiatric hospitals.

Yet, as only a relatively small proportion of offenders with mental health problems are sufficiently ill to require admission to hospital, many schemes came to develop a liaison function, signposting people with lower level mental health problems to mental health and other services in the community. Over time, this has become the predominant form of activity for most schemes, and an increasing number are now led by nurses rather than by psychiatrists.

Limitations of the current arrangements

Lord Bradley noted in his report that:

“The absence of a centralised strategy over the intervening years has meant that schemes have developed at different rates, or not at all, with many pilot schemes being set up with insecure funding arrangements that are not embedded into the health service or criminal justice infrastructure” (Bradley 2009, p. 81).

The workings of these schemes have been described and reviewed in a number of studies (see in particular Nacro 2005, Pakes and Winstone 2006, Sainsbury Centre 2009b), and it is clear from those studies that, despite the expansion of schemes since 1989, coverage remains well short of the nationwide network recommended by the Reed report. Studies have found that:

- Existing arrangements seriously under-perform in delivering potential benefits;
- In the absence of prescriptive national guidance, diversion services have developed in a piecemeal and haphazard way;
- Many schemes are insecurely funded and there is a wide degree of variation in their ways of working;
- The coverage of schemes is patchy. Some areas have no arrangements at all, while others have only minimal coverage. It has been estimated that just one-fifth of the potential national caseload is seen by current schemes, and even cases of severe mental illness are often missed because many schemes rely on police or court staff to identify individuals who may need their support;
- Many schemes take a modest view of their role. They tend only to focus on assessing people with mental health problems and signposting them towards appropriate services;
- Generally current schemes do not seek to influence decisions taken within the criminal justice system on charging, remand or sentencing;
- Little is done to ensure that offenders who are signposted towards appropriate services effectively engage with them on a continuing basis. In the absence of assertive interventions, drop-out rates are often high, which substantially reduces the potential benefits of diversion.

Yet well-designed arrangements for diversion have the potential to yield three major benefits:

- Cost and efficiency savings within the criminal justice system;
- Reductions in re-offending; and
- Improvements in mental health.

Taken together, these benefits constitute a powerful moral and economic case for diversion. There is a particularly strong case for diverting offenders away from short prison sentences and towards effective mental health treatment in the community. Purely on value for money grounds, and using conservative assumptions, it is estimated a national network of CJLD services would lead to savings of over £20,000 per diversion (see Sainsbury Centre 2009b).

The future of CJLD

Lord Bradley made several major recommendations in relation to “the development of a national model of Criminal Justice Mental Health Teams with agreed common elements and its roll-out across the country” (Bradley 2009, p. 130).

Bradley called for these new teams to play a pivotal role in diverting people with mental health problems to treatment and support at all stages of the criminal justice system. In place of the current piecemeal provision, Bradley proposed that CJMH teams would work not just in the courts but also in police custody suites and with recently released prisoners.

To ensure his vision for CJMH teams to be established across the country to consistent standards, Bradley stated that implementation guidance must detail a:

- Set of core minimum standards for each team;
- National network structure;
- Reporting structure;
- National minimum dataset;
- Performance monitoring system;
- Local development plan; and
- Key personnel criteria.

The Government’s initial response was that “As a medium term goal, every police custody suite and every court will have access to mental health liaison and diversion services able to carry out timely assessments and, where appropriate, refer offenders to treatment” (Ministry of Justice 2009, p. 24).

One of the central deliverables of the Government’s National Delivery Plan was a five-year timetable for introducing a national network of CJLD services:

“Over the next five years we expect to see the overall goal of police and court liaison and diversion services in place” (HM Government 2009a, p. 39–41).

Assessment

Criminal Justice Liaison and Diversion services are a clear example of convergence. The evidence is clear that a national network of these teams, as Lord Bradley has advocated, would have a positive impact on systems and those who use services within them. They also have the potential to reduce offending, improve health, and save the public money.

It is vital that the funding for these teams, ideally jointly funded by criminal justice and health agencies, is sufficient to enable them to maintain contact with offenders throughout the offender health pathway to ensure continuity of care and access to services.

Given sufficient resources and authority, CJLD services could act as a gateway to mainstream mental health care for offenders, a group of people who are both hard to reach and frequently excluded from services.



Mental health court pilots

Mental health courts are another example of convergence. These specialist courts could offer one way of achieving diversion for offenders with mental health problems. However, the current evidence as to their effectiveness is mixed, and such services would probably not be needed if CJLD services were to be established nationally (see chapter two).

Two mental health court pilots were established in England in 2009. Rather than acting as stand-alone courts, the two mental health court pilots in England have adopted a problem-solving approach in mainstream magistrates' courts. In doing so, they bring together health and criminal justice professionals who otherwise tend to work in a fragmented way. These pilots build on similar models developed for other problem issues, such as drug courts and domestic violence courts.

Background

Mental health courts are well established in parts of the United States, where several now exist. The US versions generally act as stand-alone courts for defendants who have been assessed as having severe mental health problems, and work in parallel to the mainstream criminal courts. They employ mental health professionals to work alongside court staff to identify practical ways of addressing an individual's offending while also ensuring that they engage with services. Where possible this is done without using custody.

Since the beginning of 2009, there have been two mental health court pilot projects operating in England, one in Brighton (East Sussex), and the other in Stratford (East London). These court pilots differ from the US model in that they work within the local magistrates' court and not in parallel to the mainstream system. These court pilots are therefore a closer relation of Lord Bradley's CJMH teams than the US-style mental health courts.

The mental health court pilots in England

On 2 July 2009, the Secretary of State for Justice, Jack Straw, officially launched the two mental health court pilots in England. He stated that:

“Mental health courts represent a new and innovative way to deal with the root-causes of offending and so limit re-offending. They operate as either a dedicated session or within the normal case list in a magistrates' court dealing with sentencing of offenders who have mental health problems or learning disabilities.”

In addition, the Ministry of Justice noted that:

“There are several key benefits which drive the Government’s commitment to problem-solving courts. They help reduce re-offending, increase public confidence by addressing the needs of local communities, and create a more effective and efficient criminal justice system.”

The Ministry of Justice noted that the volume of cases going through the two court pilots was about 350 per year (Ministry of Justice, July 2009).

Potential benefits of mental health courts

Lord Bradley, in his report on people with mental health problems in the criminal justice system, focused on mental health courts as a possible model for effective diversion (see Bradley 2009, p. 77). He identified several potential benefits of mental health courts, including:

- Enhanced psychiatric services at the court so that mentally disordered offenders are identified at an early stage and appropriately assessed;
- Increased interaction between criminal justice agencies and health providers to speed up the delivery of assessment and court reports;
- Clustering of cases on a particular day at sentence, review and breach stage;
- Sentencers specially trained on mental health issues;
- Availability to sentencers of specialist sentences; and
- Regular review of sentences by the same sentencer to monitor progress and encourage compliance.

Concerns about mental health courts

Although there are a number of potential benefits that could be derived from the mental health court pilots’ models, their services would potentially duplicate the functions of CJLD services. As Lord Bradley stated in his report:

“I would question the value of such courts if the role of liaison and diversion services is to be developed as recommended ...The majority [of the benefits that mental health courts can deliver] could be met by effective liaison and diversion services which would eventually be available to all courts, rather than just a small proportion” (Bradley 2009, p. 78).

Bradley’s report expressed a number of concerns with US-style mental health courts:

- There are a very limited number of places available and places are allocated on the basis of availability of services for each individual;
- Although US versions are badged as ‘mental health’, the cases were overwhelmingly dual-diagnosis, with alcohol being a particular problem;
- The courts had been running for some time, but continued on a pilot basis; and
- They had generally not been integrated into mainstream services, and most mental health courts only sat on certain days of the week.

Perhaps revealingly, neither mental health courts in general, nor the mental health court pilots specifically, were mentioned in the Government’s National Delivery Plan (HM Government 2009a).

Assessment

Mental health courts potentially provide specialist knowledge and support on mental health to the criminal court system, but they often function in a parallel system that is only accessible by a small number of people.

At present it is not entirely clear what mental health courts offer that cannot already be achieved within the existing courts structure. It would also not be sensible to introduce a parallel service through US-style mental health courts in order to compensate for the shortcomings of the current system (Sainsbury Centre 2009b, p. 56).

Even where mental health courts are in operation, a mechanism for ensuring that the right people are directed there is still required. Currently, most offenders with mental health problems are not identified prior to appearance in court and would therefore end up in mainstream courts. Contrarily, the high number of offenders with mental health problems would mean that mental health courts would be overwhelmed if all offenders with mental health problems were directed to them.

The full evaluation of England's mental health court pilots is due to be completed in 2010. However, financial resources for the mental health court pilots in England were only guaranteed on a short-term basis, and their absence in the National Delivery Plan suggests that a long term central government commitment, and therefore the opportunity to demonstrate their effectiveness, is unlikely.



4

Mental Health Treatment Requirement

The Mental Health Treatment Requirement (MHTR) is one of 12 options available to sentencers when constructing a community sentence (either a Community Order or a Suspended Sentence Order). MHTRs can be given to an offender who has mental health problems that would benefit from treatment if treatment under the Mental Health Act is not required. If an offender gives their consent to receiving an MHTR, they will receive clinical mental health treatment for a specified period under supervision by probation. The MHTR is therefore a potentially effective diversion intervention and an appropriate alternative to a custodial sentence.

Problems with MHTRs

At least 40% of offenders on community sentences are thought to have a diagnosable mental health problem (Sainsbury Centre 2009a), yet there has been very little uptake of the MHTR in England and Wales since its implementation in 2005. Only 918 Mental Health Treatment Requirements (MHTRs) were given to offenders as part of community sentences in 2008, and just 848 in 2007 (Sainsbury Centre 2009a). By comparison, ten times as many drug treatment requirements were given in each of those years.

Sainsbury Centre identified a number of other reasons that the MHTR has been so little used (see Sainsbury Centre 2009a). These include:

- A lack of knowledge and understanding about MHTRs among criminal justice and health professionals;
- A lack of unified view among professionals as to the main purpose of MHTRs;
- Unclear criteria as to who should receive an MHTR;
- Poor identification of offenders with mental health problems in the courts;
- Unclear breach process for those managing MHTRs;
- Poor inter-agency communication, especially between health and criminal justice professionals;
- A preferred use of the Drug Rehabilitation Requirement (DRR) in cases of dual diagnosis; and
- A lack of central targets around use of the MHTR, as with DRRs.

Unfulfilled potential

Despite the challenges presented by the MHTR, it has a largely unfulfilled potential to offer diversion to offenders with mental health problems and to be a robust alternative to a short prison sentence. That potential can be realised through practical improvements to the way the MHTR works on the ground and through improved communication between health and criminal justice agencies. Measures that would greatly improve the MHTR and increase its use include:

- Central government should provide practical guidance for criminal justice and health professionals on how to construct and manage MHTRs;
- Primary care trusts should commission services that enable the courts to issue MHTRs;
- Local agencies should agree funding arrangements for psychiatric court reports;
- Protocols need to be developed between the courts, probation and health services to enable the appropriate use of the MHTR; and
- Diversion and liaison schemes should be involved in the MHTR to organise timely psychiatric reports and make sentencing recommendations (see Sainsbury Centre 2009a).

Lord Bradley's view of MHTRs

Lord Bradley identified the MHTR as having significant potential as a diversion tool. In his report, Bradley made three recommendations related specifically to the MHTR, all accepted by the Government (Ministry of Justice 2009, pp. 15–16).

Bradley asked for “further research into the use of MHTRs”; “a Service Level Agreement to ensure that MHTRs can be provided to offenders when requested by courts”; and “the development of clear guidance regarding the use of MHTRs” (Bradley 2009, p. 96).

The Government's National Delivery Plan (HM Government 2009a) announced three deliverables related to MHTRs that would be achieved within twelve months:

- “We will issue guidance to NOMS and PCTs on the use of community order requirements containing elements of health and social care to support offenders with mental health or learning disability as part of the overall offender health commissioning guidance, by September 2010.
- “In addition, we will support the sentencing Guidelines Council to consider whether any revision is necessary to the current sentencing guidelines, insofar as they affect mental health treatment requirements, by April 2010.
- “We will issue guidance to enable probation to better access health service providers, in order to ensure that offenders' mental health and learning disability needs are addressed within pre-sentence reports and community orders, by September 2010” (HM Government 2009a, p. 39).

Assessment

The Criminal Justice Act 2003 allows sentencers considerable creativity when making a community sentence. The three ‘treatment’ requirements (drug, alcohol and mental health) provide the court with an option to engage the offender in assertive treatment. This can mean that the courts can ensure co-operation from both the offender who has given their consent, and from the criminal justice and health professionals to work together to provide a service.

Much more joint-working between mental health and criminal justice agencies is needed to enable greater use of this potentially useful diversion tool. Lord Bradley's three recommendations on MHTRs and the Government's subsequent delivery plans could go a significant way to realising that potential.

Yet few offenders have mental health problems in isolation – often they are in combination with a drug, alcohol or other health need. Sainsbury Centre welcomes Lord Bradley's recognition that ‘dual diagnosis’ is the norm among offenders. We would like to see community sentences given to address

both mental health and drug/alcohol problems. Central government might give consideration to introducing a generic 'health treatment requirement' with community sentences, which could provide basic interventions where an offender has a complex mix of lower level health needs.



Imprisonment for Public Protection

Imprisonment for Public Protection (IPP) is a custodial sentence found in criminal law. It is not a mental health intervention, although recent research, including Sainsbury Centre's report, *In the Dark* (2008b), suggests that IPP is an example of convergence between criminal justice and mental health.

Background

Imprisonment for Public Protection (IPP) was created by the Criminal Justice Act 2003 and implemented in April 2005. It is an indeterminate sentence, available when an offender is identified by the courts as 'dangerous', but where the offence does not warrant a 'life' sentence.

Offenders sentenced to IPP (or Detention for Public Protection for under eighteen-year-olds) are given a minimum term they must serve in prison, known as a 'tariff'. After the IPP prisoner has served the tariff, the Parole Board consider their release and, if it can be shown that they no longer pose a risk and that they can be managed safely outside prison, they may be released. Released IPP prisoners are then managed by the Probation Service on a 'life licence', subject to recall to prison if they breach any of the terms of their licence.

On 19 January 2010 there were 5,828 prisoners serving IPP sentences (Eagle 2010a), and more than 2,130 IPP prisoners had served their tariff by November 2009 (Tunncliffe 2009). By 15 January 2010, 94 IPP prisoners who had served their tariff and had their sentences reviewed by the Parole Board had been released. 23 of those released on licence had been recalled to prison (Eagle 2010b).

Mental health of IPP prisoners

During 2008, researchers from Sainsbury Centre interviewed 55 IPP prisoners and twenty prison staff in three prisons, as well as analysing government data on the mental health of 2,200 IPP prisoners. The resultant report, *In the Dark*, was the first to examine the mental health implications of the IPP sentence (Sainsbury Centre 2008b).

The research revealed a high level of mental health and emotional problems, and showed that levels of mental and emotional distress are higher among IPP prisoners than among either the general prison population or prisoners serving life sentences. The Government's data show that:

- More than half of IPP prisoners have problems with 'emotional wellbeing' compared with two-fifths of life prisoners and one-third of all prisoners;
- Nearly one in five IPP prisoners has previously received psychiatric treatment, while one in ten is receiving mental health treatment in prison and one in five is on mental health medication;

- On 14 January 2010, Ministry of Justice records showed that there were 115 prisoners in secure forensic mental health hospitals under powers of the Mental Health Act 1983, who were also serving indeterminate sentences of Imprisonment for Public Protection (Eagle 2010c).

Practical problems and the mental health implications

IPP prisoners and prison staff discussed the practical difficulties created by the IPP sentence and the effect this had on the mental health of prisoners and their families.

One of the main practical problems identified was that there is too little information and too much misinformation, available to IPP prisoners about their sentence. This can cause frustration and distress to the individual and members of their family.

The research also demonstrated that the indeterminate nature of the IPP sentence was itself damaging to IPP prisoners' mental health:

- Many IPP prisoners said they were emotionally distressed because they had no release date and believed that indeterminacy was eroding any sense of hope;
- Indeterminacy can damage relationships with family and friends, particularly for prisoners with children;
- Being refused release by the Parole Board was very difficult to cope with, especially for prisoners who believed they had done everything they could in prison to demonstrate that they were ready to be freed;
- Access to offender behaviour programmes is especially difficult for prisoners with mental health problems. Prisoners whom staff consider to be unsuitable to participate because of mental illness or emotional instability are often excluded from taking part in programmes entirely (Sainsbury Centre 2008b).

The impact of the IPP sentence

Prison mental health staff told Sainsbury Centre researchers that they were over-stretched and insufficiently resourced to manage IPP prisoners' mental health needs. Prison in-reach services are often focused on medication, with little or no provision for other services such as talking therapies or counselling. Only a few IPP prisoners said they had received helpful support from prison mental health services:

- Some IPP prisoners said they refuse mental health services or medication because they fear it will prevent them from completing their sentence plan, and that this might mean that they would never be released;
- Several said they needed help but had been inadequately assessed or needed medication but did not receive it; and
- Some received informal support from other prisoners, family and friends (Sainsbury Centre 2008b).

These research findings were addressed by then Health Minister, Lord Darzi, who stated that:

“We welcome *In the Dark*, the Sainsbury Centre report on imprisonment [for] public protection sentences and mental ill health ...The report raises some important points about the information available to prisoners and about access to treatment and care that we will certainly incorporate into our offender health strategy to be published early next year” (Darzi 2008).

Lord Bradley recognised the detrimental effect of indeterminacy (Bradley 2009, p. 99) and, as a result, he recommended that:

“A study should be commissioned to consider the relationship between imprisonment for public protection sentences and mental health or learning disability issues” (Bradley 2009, p. 100).

The National Delivery Plan deliverable on IPP sentences promised:

“A study of the relationship between indeterminate public protection (IPP) sentences and mental health or learning disabilities” (HM Government 2009a, p. 30).

In the short term, it is important that the Department of Health should ensure that offender health commissioners are aware of IPP sentences and understand the levels of needs among IPP prisoners, so that they can commission services accordingly. The IPP sentence is another example of convergence, and one that has had significant implications for the mental health of offenders.



6

The Hospital and Limitation Direction (HLD)

This chapter describes in detail a further example of convergence: The Hospital and Limitation Direction (HLD: Sections 45a and 45b of the Mental Health Act 1983 as amended by the Mental Health Act 2007). The HLD provision has, since November 2008, enabled judges to order an offender to hospital for treatment of indeterminate length and also to pass a prison sentence.

The HLD is perhaps the clearest example of legislative convergence. It is in effect a ‘hybrid order’ that enables a crown court judge to send an offender to hospital for treatment under the Mental Health Act, and at the same time pass a prison sentence under criminal law.

The concept of a ‘hybrid order’ was first proposed in the early 1980s, and formally introduced as policy by the Conservative Government in the 1990s. However, after sustained and vocal opposition to early proposals, it was limited in legislation to offenders diagnosed with ‘psychopathic disorder’ and has been rarely used since its introduction in 1997. Changes implemented in November 2008, however, expanded its application to use with any mental disorder.

What is the Hospital and Limitation Direction?

The Hospital and Limitation Direction is comprised of two components. The ‘hospital direction’ sends a person to hospital, while the ‘limitation direction’ ensures that they are subject to restrictions in hospital by the Secretary of State for Justice. Clinicians can discharge a person who has been given a 45a from hospital but, if there is still time remaining on the custodial part of the HLD (the custodial term begins immediately after sentencing), the Secretary of State for Justice can demand they are sent to prison to complete any time that remains of the original prison sentence. If the prison sentence has been served during the period spent in hospital, the patient can be discharged without the Secretary of State’s approval, or detained by clinicians in hospital as an unrestricted (i.e. civil) patient.

From 1997 to November 2008, HLDs could only be given to an offender diagnosed with ‘psychopathic disorder’. This meant that only a very small number of HLDs were issued by courts because ‘psychopathic disorder’, (now for the most part recognised as ‘personality disorder’), was for a long time a ‘diagnosis of exclusion’. This meant that many clinicians and psychiatric services were unwilling or unable to provide treatment.

At the end of 2008 only 13 people were detained in forensic mental health services on a HLD (Ministry of Justice 2010). Table 1 shows new annual HLD admissions between 1999 and 2009.

Table 1: New annual HLD admissions

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
New annual HLD admissions	8	3	3	3	4	2	2	4	5	2	3

(Source: Ministry of Justice 2010; and Unpublished, Public Protection and Mental Health Group, November 2009)

However, changes brought about by the Mental Health Act 2007 (as implemented in November 2008, see page 44) resulted in ‘psychopathic disorder’ being removed from mental health legislation, and the introduction of a ‘single definition’ of mental disorder. This meant a full expansion in the application of HLDs to people with ‘any disorder of the mind’.

A judge’s decision to make a HLD is one that explicitly converges mental health and criminal justice, deliberately combining treatment with punishment. The Guidance notes that:

“In selecting a disposal, the Court may be seeking to balance the offender’s treatment needs with the long term protection of the public from further harm” (Ministry of Justice 2008).

With the HLD, a judge does not face the dilemma of whether to divert an offender with mental disorder to hospital for treatment, or send them to prison. Rather, the HLD enables a convergence of choice.

How is a Hospital and Limitation Direction used?

The law relating to HLDs is complicated, but the Department of Health’s *Reference Guide to the Mental Health Act 1983* (as amended by the 2007 Act) provides a useful explanation (pp 57–60), as summarised in Box 1. The Guide details the criteria for making hospital and limitation directions.

Following sentencing and issuing of a HLD, the person must be taken to hospital within 28 days. Once detained in hospital, patients subject to hospital and limitation directions are treated in the same way as patients subject to hospital orders and restriction orders (ss. 37/41) or a prison transfer (ss. 47/48).

HLDs are similar in effect to a transfer direction with a restriction (which would be the likely status of a prisoner transferred to hospital under Sections 47/48), with the important difference that they are given at the point of sentencing by a judge.

They are different to a Hospital Order (Sections 37/41) because the person also receives a prison sentence in addition to the order to hospital.

The Department of Health guidance notes that there are three other important differences:

1. Limitation directions may be time-limited

A limitation direction ends automatically on the patient’s ‘release date’. The patient’s release date is the day that the patient would have been entitled to be released from prison (or its equivalent) had the patient not been detained in hospital. If the patient is serving a life sentence, or an indeterminate sentence, the release date is ordered by the Parole Board.

Although the limitation direction ends on the release date, the hospital direction does not. So patients remain liable to be detained in hospital from then on like unrestricted hospital order patients.

HLD patients who are absent without leave (or are otherwise liable to be taken into custody) under the Act are also treated as being unlawfully at large from prison (or its equivalent).

Box 1: The Hospital and Limitation Direction

May be given by	The Crown Court
In respect of a person who is	Convicted before that court of an offence punishable with imprisonment (other than murder).
If the court is satisfied	On the written or oral evidence of two doctors, at least one of whom must be approved under Section 12, and at least one of whom must have given evidence orally, that: <ul style="list-style-type: none"> ■ The offender is suffering from mental disorder of a nature or degree which makes it appropriate for the offender to be detained in a hospital for medical treatment; and ■ Appropriate medical treatment is available.
And the court	Has first considered making a hospital order, but has decided instead to impose a sentence of imprisonment (or its equivalent for young offenders).
And it is also satisfied	On the written or oral evidence of the approved clinician who would have overall responsibility for the offender's case, or of some other person representing the managers of the relevant hospital, that arrangements have been made for the offender to be admitted to that hospital within the period of 28 days starting with the day of the order.

(Source: *Reference Guide to the Mental Health Act 1983*, Department of Health 2008c, p. 57)

2. While a limitation direction is in force, patients may be removed to prison

Unlike hospital order patients, HLD patients are detained primarily on the basis of a prison sentence. Therefore, while the limitation direction remains in effect, the Secretary of State for Justice may direct that they be removed to prison (or equivalent) to serve the remainder of their sentence, or else release them on licence.

This occurs when the Secretary of State for Justice is notified by the patient's responsible clinician, any other approved clinician, or by the Tribunal, that:

- The patient no longer requires treatment in hospital for mental disorder; or
- No effective treatment for the disorder can be given in the hospital in which the patient is detained.

When notified in this way, the Secretary of State may:

- Direct the patient’s removal to a prison (or another penal institution) where the patient could have been detained if not in hospital; or
- Discharge the patient from the hospital on the same terms on which the patient could be released from prison.

In practice, the Secretary of State for Justice expects clinical staff from the hospital and prison to meet to plan the patient’s future care (a ‘Section 117 meeting’) before directing the patient’s removal to prison.

3. While a limitation direction is in force, discharge by a Tribunal requires the consent of the Secretary of State

If the Tribunal thinks that a patient would otherwise be entitled to be discharged but the Secretary of State does not consent, the patient will be removed to prison. That is because the Tribunal has decided that the patient should not be detained in hospital, but the prison sentence remains in force until the patient’s release date.

The patient can remain detained in hospital if the Tribunal thinks the patient would be entitled to conditional discharge, but recommends that the patient remain in hospital if the Secretary of State does not agree to a conditional discharge.

Transfer to prison

If an offender is removed to prison (or its equivalent), both the hospital direction and the limitation direction end when the offender arrives at the relevant prison or other institution. Any remaining time from the original sentence must be served in prison. This has occurred eight times since 1997 (source: Public Protection and Mental Health Group, 2009).

Under HLD provisions, the Court can add a direction to hospital to a prison sentence if it has also heard evidence which would justify making a Hospital Order. This is to address cases where a court believes that a prison sentence was necessary to protect the public, but where medical evidence indicated that appropriate treatment was available in hospital (*Mental Health Act 2007: Guidance for the courts on remand and sentencing powers for mentally disordered offenders*, March 2008).

The Ministry of Justice’s guidance notes that:

“A prisoner subject to a hospital direction will subsequently be managed exactly as if he had been transferred to hospital after sentence by the Secretary of State. He can be transferred to prison by the Secretary of State at any time, on the responsible clinician’s advice that his detention in hospital for treatment is inappropriate” (Ministry of Justice 2008).

Release from prison in this case is determined by the original sentence, as if no hospital direction had been made. The Guidance notes that:

“If the sentence is determinate, he may be detained in hospital as if a civil patient, if he is still there after his release date. If he has an indeterminate sentence, his release will be determined by the Parole Board once his tariff is served. He will be released on life licence and subject to recall to prison” (Ministry of Justice 2008).

The following sections provide a summary of the literature on HLDs, from its conception as a ‘hybrid order’, to the critique and opposition that followed, through to the recent changes that could change the way the courts manage offenders with mental disorder.

The origins of the HLD

The HLD originated from a Department of Health and Social Security / Home Office Consultation Document produced by the Working Group on Psychopathic Disorder in 1986 (Home Office / Department of Health 1986).

The group was established to consider the implications for people with ‘psychopathic disorder’ of the newly implemented Mental Health Act 1983.

The catalyst for this group was “located primarily in a degree of departmental anxiety about the release of psychopathic patients” (Peay 1988, p. 67), following a number of homicides committed by discharged psychiatric patients.

The Consultation Document had noted that there was “anxiety about a small number of cases where tribunals, applying the statutory criteria, have discharged restricted patients on the ground that the individual was no longer suffering from psychopathic disorder or no longer suffering from it to a nature or degree which made it appropriate for him to be liable to be detained in hospital for medical treatment but that the public was nevertheless felt to be at risk” (Home Office/Department of Health 1986, para. 15iii).

Three legislative options were put forward by this group:

Option A: Replace the Hospital Order (s. 37) with a hybrid order that would enable the option to send a person to hospital with a prison sentence also attached;

Option B: Prevent sentencers from giving Hospital Orders in the case of an offender with psychopathic disorder, meaning a prison sentence would be given followed by a potential prison transfer if treatment were required; or

Option C: Only allow a Hospital Order if the person does not require a Restriction Order. If they do require restriction, then Option B should be followed.

Following a four month period of opposition and challenge, largely from professionals and clinicians, all three options were dropped (see Peay 1988). However, the concept of a ‘hybrid order’ for people with a psychopathic disorder, would resurface less than a decade later.

The Reed Reports

The Reed Committee (see Department of Health / Home Office 1992), established by the Government to review services for mentally disordered offenders, set up a special Working Group to examine in detail the needs of offenders with a diagnosis of psychopathic disorder (see Reed 1994b).

Among its many recommendations was a proposal for a ‘hybrid order’, similar in essence to that of ‘option A’ proposed in 1986 (see previous). The Group concluded that a hybrid order would have a number of benefits, including that it might help clinicians to overcome their concerns with the situation when a patient who was ‘untreatable’ but was nevertheless deemed too dangerous to be released.

Dr John Reed, chair of the Committee, later commented that:

“Psychopathic disorder is a very important subject; it presents the criminal justice system and the health and social care systems with some of their greatest challenges.” (Reed 1996, pp. 4–9).

Reed reflected in detail on the pros and cons of a hybrid order, and concluded that:

“Such an order would be new to the legal and the mental health care systems; the proposal should be discussed more widely” (Reed 1996, pp. 7–8).

Indeed, further consideration was given that same year to another version of this proposal, resulting in even more controversy.

The introduction of the HLD

In March 1996, the Home Office published a White Paper: *Protecting the Public: The Government’s Strategy on Crime in England and Wales* (Home Office 1996). In a chapter entitled ‘Sex Offenders and Mentally Disordered Offenders’ it stated that:

“The Government proposes changes in the arrangements for the remand, sentencing and subsequent management of mentally disordered offenders to provide greater protection for the public and improve access to effective medical treatment for those offenders who need it” (1996, p. 42).

The Government went on to elaborate on proposals for a ‘hybrid order’, which:

“Might be made available in respect of offenders suffering from all types of mental disorder currently covered by mental health legislation” (1996, p. 42).

Specifically, it proposed:

“The provision of a ‘hybrid order’ for certain mentally disordered offenders for whom the present form of hospital order is unsatisfactory, particularly those who are considered to bear a significant degree of responsibility for their offence. The order would enable the courts, in effect, to pass a prison sentence on an offender and at the same time order his immediate admission to hospital for medical treatment” (1996, p. 42).

The Government argued that this would:

“Substantially increase the flexibility of arrangements for dealing with mentally disordered offenders at all stages from remand through to rehabilitation” (1996, p. 42).

This new measure, it was claimed, would take proper account of the offender’s need for treatment, the demands of justice, and the right of other people to be protected from harm:

“An offender would remain in hospital for as long as his mental condition required, but if he recovered or was found to be untreatable during the fixed period set by the court, he would be remitted to prison” (1996, p. 42).

The White Paper concluded with a promise of a consultation on the ‘hybrid order’, which would be published the following month.

At the end of April 1996, the Mental Health Unit at the Home Office published *Mentally Disordered Offenders: Sentencing and Discharge Arrangements: A discussion paper on a proposed new power for the courts*. The paper introduced the ‘hybrid order’ as a ‘Hospital Direction’. In substance, as with the

‘hybrid order’, the ‘Hospital Direction’ would “enable courts to attach to a prison sentence an immediate direction to hospital” (Home Office 1996, para 1.1).

The Government argued that the need for this new disposal arose from “cases in which the powers currently available to the courts appear to be insufficiently flexible to meet the needs of sentencing” (1996, para. 1.4).

This, it was argued, occurs specifically when the court accepts that the offender requires treatment, but where the court:

“Is not certain that treatment will sufficiently address the risk to the public posed by the defendant, or a punitive element in the disposal is required to reflect the offender’s whole or partial responsibility” (1996, para 1.4).

The Government also referenced Reed’s Working Group report, adding that another benefit would be to:

“Make it easier for hospitals to offer useful treatment for offenders whom they might be reluctant to admit under an indeterminate hospital disposal because of the fear that treatment might fail or not do enough to reduce the risk of serious offending” (1996, para 1.6).

The Government put forward its reasons for not limiting the measure to psychopathic disorder.

Firstly, it argued that the courts could already pass sentences of imprisonment when the defendant had any mental disorder, and could order a defendant to hospital for any mental disorder (1996, para 1.7).

Secondly, it argued that “the borderline between the legal category of psychopathic disorder and the other categories of disorder defined in the Mental Health Act is widely acknowledged to be unclear” (1996, para 1.8).

“There may be, for example, multiple or changing diagnoses. By extending the hybrid order to all disorders, the court could decide on whether treatment with or without restrictions, prison without immediate treatment, or treatment with a prison sentence attached, was the most appropriate course, regardless of the specific diagnosis at the time of sentencing” (1996, para 1.8).

The Government, perhaps anticipating a hostile reaction to the proposals, acknowledged that “the development of the ‘hybrid’ concept beyond the use envisaged for it by the Reed Working Group may raise difficult issues for sentencers and for psychiatrists advising the courts and treating patients” (1996, para. 1.9). However, the Government believed that “the choice of disposal should be for them [the court] to make, having regard to all the circumstances of the case” (1996, para. 1.10).

Following extensive opposition to the Government’s proposals from a wide-ranging and vocal opposition however (described below) the HLD was passed into legislation as an amendment in the Crime Sentences Act 1997, but with the limitation of use to ‘psychopathic disorder’.

Concerns about the HLD

These proposals from 1996 for how the Hospital Direction would work in practice are, in essence, the same for how the HLD has operated in England and Wales since November 2008.

Therefore, in order to understand the implications of the new arrangements, it is important to revisit the commentary, objections and concerns that were raised in the late 1990s.

Parliamentary debates on the Crime Sentences Bill, which passed through parliament in 1997, were critical of the Government's plans for a hybrid order for all mental disorders. Academic and legal commentary was also largely critical, with one academic calling it "the most important challenge to confront modern British forensic psychiatry" (Eastman 1996, p. 481). Eventually, the Government limited the hospital direction to 'psychopathic disorder', claiming this concession was on the basis that further analysis was needed of the costs to the NHS of expanding the provision to all mental disorders (Section 45a(10) of the Mental Health Act 1983). The major concerns expressed about the proposals introduced in 1996 were:

1. Apportioning blame and responsibility

Since the proposals required judges to determine 'partial criminal responsibility' in order to give a 'hybrid order', a major concern was raised about how judges would determine 'partial tariffs', and who would be given the task of determining whole or partial blame. At the time it was noted that:

"It seems likely that the judges will turn necessarily towards psychiatrists for guidance. This will raise the 'medicine versus morality' problem ... Psychiatrists are likely to resist such direct involvement in sentencing decisions, both for ethical reasons and because there is no scientific basis upon which such evidence could be given to a court" (Eastman 1996, pp. 487–8).

Others reflected on the controversy created by the 'diminished responsibility' laws, and asserted that:

"It is unreasonable for the court to ask, and expect the medical profession to answer, questions outside their sphere of competence" (Laing 1996, p. 134).

A consultation document by the charity Mind, published in May 1996, noted their concerns that:

"The criminal law is an unsophisticated instrument for determining blame. Apart from the specific defences of insanity and diminished responsibility, there is no specified way in which defences are framed which make allowances for the state of mind for a person who commits a criminal act. It must therefore be acknowledged that the criminal law may operate unfairly in relation to people labelled as mentally disordered offenders.

"Attempts to correct the system's inadequacies through the sentencing process confuses: (1) people who are fully responsible, but may have a mental health problem not connected with the offence and (2) people who may commit an offence because they have a mental health problem ... It is not difficult to come to the conclusion, given the thrust of the proposed hybrid orders, that the aim is one of punishment and control rather than care and treatment either in secure psychiatric provision or in less secure settings in the community" (Mind 1996, p. 9).

Several years after the proposals for the 'hybrid order', it was noted that:

"It has become evident that the psychiatrist's role in sentencing has derived increasingly from a dubious expertise in relation to protective sentencing; this, not in diverting offenders into therapeutic regimes or in mitigating sentence generally, but in (perhaps unwittingly) aggravating the punitiveness of sentencing" (Peay 2000, p. 72).

2. Interrupting continuity of care

The parliamentary debates on the hybrid order took place in the early months of 1997. On 13 January 1997, Alex Carlile MP, now a Liberal Democrat Peer, argued that the HLD would likely interrupt continuity of care if a 'treated' patient were discharged to prison:

“In cases of diagnosable and definable mental illness, it is beneficial for rehabilitation to be managed in a flexible timeframe and for there to be continuity of care if the patient is to make a successful return to the community with minimum risk to the public ...The machinery simply does not exist in prison to provide the follow-through that would be needed” (Carlile 1997).

On 27 January, Lord Dubs expressed similar concerns:

“The idea of continuity of care for mentally ill people, or for people who are mentally disordered, will not be possible if the first three or four years of the sentence are in a secure unit and the next four or five years are in a prison. It is difficult to envisage that the same type of care will continue from the secure unit in hospital into the prison system. There is a problem therefore about what will happen when the individual is released” (Dubs 1997).

A number of commentators echoed the views of some parliamentarians that being sent to prison after hospital would undo any benefits of treatment:

“There is a real danger that by subsequently directing such offenders into prison their condition will simply deteriorate and the Government will be faced with the problem of increasing numbers of mentally ill offenders inappropriately placed in and burdening the prisons system” (Laing 1996, p. 136).

As the parliamentary debates recognised, continuity of care is essential for preventing a recurrence of mental illness (see Sainsbury Centre 2008d). Prisons have often been shown to be poor at delivering continuity of care, even for moderate mental health or drug problems. It was argued that the hybrid order could undermine the benefits of treatment by interrupting continuity of care:

“Offenders suffering from a serious mental illness who successfully recover in hospital should not then simply be directed into prison for the remainder of their sentence. There is a need for continuity of care in order to prevent relapse. Such offenders will be especially vulnerable at this stage and this should not be unnecessarily subjected to the damaging and detrimental effects of the prison regime” (Laing 1996, p. 135)

Eastman also highlighted this problem:

“Rehabilitation through and from the prison system, as would occur if a treated patient was remitted there, would be substantially inferior to NHS mental health care which was both more expert and also continuous out into the community” (Eastman 1996, p. 489).

In addition, the Government’s pledge that “any new power must work in a way which is consistent with the effective delivery of health care services ... and the effective management of throughcare overall” (Home Office 1996, para 2.1) is “almost certainly unachievable” (Eastman 1996, p. 489).

3. The hybrid order is fundamentally anti-therapeutic

It has been written that an order to hospital that has a prison sentence ‘suspended’ until treatment has been completed is in itself potentially untherapeutic and gives ‘the wrong message’:

“It may be that giving such a ‘double message’ (of treatment and punishment) is correct in logic but it may be psychologically confusing or unhelpful to a patient ... A patient’s health may suffer [and] public protection may suffer. Although there may be better short-term protection of the public through the operation of a tariff, there may be poorer long-term protection because of inferior patient co-operation in the community” (Eastman 1996, p. 489).

In addition, “since psychotherapeutic intervention (by contrast with drug therapy) necessarily requires a degree of therapeutic co-operation, this seems not only ethically wrong but scientifically suspect” (Peay and Eastman 1998, p. 107).

4. Doctor becomes the ‘gaoler’

A hybrid order has the potential to ‘undermine the doctor-patient relationship’ (Laing 1996, p. 139), and instigate a ‘gaoler effect’ (Eastman 1996, p. 488). It has been asserted that it also heavily blurs the distinction between patient and prisoner, a theme examined by Lord Ramsbotham in *Patient or Prisoner?* (HM Inspectorate of Prisons 1996).

The creation of a hybrid order may mean that in turn the forensic psychiatrist must play the role of gaoler in order to fulfil his or her therapeutic responsibility (and not discharge a patient to prison), and therefore hospitals may also become prisons:

“At the point where the ‘positive’ symptoms of a patient’s mental illness have been successfully treated in hospital, the clinical team would be faced with a choice: either to remit the patient to prison to serve the remainder of the sentence, where the ‘negative’ symptoms of the patient’s illness would be sub-optimally treated and where he or she might cease to take medication (because there would be no constraint under the Mental Health Act to do so); or to keep the patient in hospital beyond the clinical necessity, such that the patient (and the staff) would become rehabilitatively stuck” (Eastman 1996, p. 488).

Eastman also noted that a hybrid order “flies in the face of NHS common sense” and that it would:

“If used extensively by the judges instead of ordinary hospital orders, result in Health Authorities funding mentally disordered offenders in high, medium and low secure care, as well as ordinary psychiatric care, beyond when it was ‘needed’ for their health and, therefore, solely in order for patients to finish their prison sentences (albeit not in prison). Doctors would not be likely to send schizophrenic patients, whose florid symptoms had been successfully treated but who remained with chronic disabilities of the illness, to be cared for by still poorly resourced prison health care services, particularly given that prison doctors could not, in any event, impose continued medication. To send patients to prison in that way would often be unethical” (Eastman 1997, p. 130).

In response to the proposals of 1996 and their subsequent inclusion in the Crime Sentences Bill 1997, Eastman urged that:

“Doctors should resist the proposals since they represent a requirement on psychiatrists to behave unethically in court, by assisting directly in sentencing, and because they represent a break with a centuries old tradition of treating the mentally ill and disabled with humanity. These proposals are trebly dangerous. They are immoral, they will damage professional morale, and they will also be extremely expensive to the NHS” (Eastman 1997, p. 131).

5. Resource pressure

In the current economic climate of cuts and limited public service resources, the HLD may face its greatest challenges on cost grounds alone. The financial situation in the mid 1990s was not dissimilar, and concerns were also expressed about hybrid orders on a cost basis.

Lord Dubs raised the issue of resource pressure in parliament on 27 January 1996:

“It may well be that a consequence of the [hybrid order] provision is that more mentally disordered people will be in secure units in hospitals for the mentally ill. That will increase the cost to the health

service and make life more difficult. There is already an enormous pressure on beds in such units” (Dubs 1997).

Laing also identified the lack of resources as a barrier to implementation:

“To many it would seem that the new power will simply be solving the prison service problems but will undoubtedly, in turn, increase those facing the medical professionals and impose an increasing burden upon an already stretched health budget ...The new proposals do not address the real issue of resources and the lack of appropriate health service facilities and this is, undoubtedly, the most glaring practical obstacle” (Laing 1996, p. 146).

It was argued that the hybrid order’s potential ‘double cost’ would result in costs to both the health and prison services (where hospital treatment is followed by the custodial sentence). Since 2008, there emerged the potential for an order of ‘double indeterminacy’, where a HLD is combined with a sentence of Imprisonment for Public Protection (see chapter five).

Resources are still perhaps the “key practical problem of securing the admission to hospital of mentally disordered offenders” (Ashworth 1996, p. 457). This is even more apparent when it is remembered that while the courts “do not have the power to compel hospitals to accept such patients, the prisons on the other hand have no choice but to accept them” (Laing 1996, p. 140).

6. ‘The avalanche effect’

While use of the HLD has been very limited, the widening application of use since November 2008 could lead to what was termed an ‘avalanche effect’ (Eastman 1996).

Wider use is almost inevitable, for “if hybrid orders are available then judges will, effectively, always have to consider their imposition” (Eastman 1996, p. 490). Judges might reserve their use where treatability is uncertain, but it seems likely that:

“Judges will extend the criteria they use in considering hybrid orders to culpability and punishment and to the pursuit of public protection. Since nearly all convicted mentally disordered offenders must surely have some measure of culpability, there will always be some tariff” (Eastman 1996, p. 490).

Making HLDs applicable to all mental disorders could, it was argued, reduce the use of traditional hospital orders, with judges preferring the more risk-averse HLDs:

“Is it just possible that the courts might be tempted to use this hybrid order as what someone called ‘an easy option’? In other words, it may be said, ‘Well, that’s a way of dealing with people. They will get some treatment in hospital and then they will serve the rest of their time in prison’. Surely there is a danger that we might end up with more people in prison than under the present system. I suggest that that would not be protecting the public; it would simply mean more people in prison, even though those individuals were mentally disturbed at the time of the offence and when the sentence was imposed upon them” (Dubs 1997).

If this were to happen, an ‘avalanche effect’ could follow (Eastman 1996, p. 492), which could have the following detrimental implications:

- Psychiatrists will be used in court more often for assessment of culpability and risk than for diagnosis;
- Clinicians may resist taking offenders subject to a HLD to avoid the ‘gaoler effect’ and the resultant high costs and ethical ‘no win’ situation;

- Psychiatrists might be reluctant to recommend a hospital order to a court, if it might then result in a HLD being given;
- There will be increased NHS costs and a substantial increased need for secure beds;
- There will be more, not fewer, mentally disordered offenders in the criminal justice system, contrary to all current thinking;
- There will be resource implications for prison in-reach services, who will have to cope with increased numbers of potential relapses following patients discharged to prison from hospital on HLDs;
- A ‘punitive culture’ would be likely to develop in forensic mental health services as a result of the ‘gaoler effect’;
- The punitive culture could result in a ‘substantial diminution of forensic psychiatric morale’ and a reduction in the ability to recruit clinicians to the speciality;
- There could be increased pressure on defence solicitors to produce, and the courts to consider, insanity defences, to avoid HLDs by avoiding a guilty verdict, as well as any other psychiatric defences.

Eastman concluded that the introduction of a hybrid order for any mental disorder could result in an unprecedented “shift of perception of mentally disordered offenders from ‘patients who have committed offences’ to ‘prisoner/patients’ [and] should not be undertaken lightly by any humane society” (Eastman 1996, p. 493).

Possible benefits of a HLD

Despite all of the opposition to the proposals presented here, there are a number of potential benefits to the HLD that the Government presented and others have acknowledged.

Firstly, it may “overcome psychiatric resistance generally to ‘have a therapeutic go’ with offenders with mental illness” (Eastman 1996, p. 486) where doubts exist about treatability.

Secondly, the HLD enables ‘greater judicial flexibility’ in sentencing (Home Office 1996, para. 1.4). This may mean treatment is more readily offered, with a prison sentence given mainly as ‘back up’, where a judge might otherwise have been reluctant to order an offender to hospital due to concerns about risk and/or treatability.

Thirdly, the HLD allows for an expression of punishment “in order to reflect the offender’s whole or partial responsibility” for their offence (Home Office 1996, para. 1.4). This means that public confidence is maintained and may better meet the needs of victims, providing at least a ‘notional’ prison sentence to reflect the seriousness of the offence.

Fourthly, the Government argued that the HLD was required on public protection grounds:

“There may be many instances where [offenders] need treatment and, having been treated, need to be remanded back to prison. If someone was deemed sufficiently dangerous to be given a long sentence – perhaps a large importer of drugs, who merited a sentence of 10 years or more – but appeared to need mental treatment at the time of sentence, it would be wrong for the court not to have the flexibility to allow that treatment to be given, with the prisoner then being remanded back to prison” (Sackville 1997).

Finally, it has been argued that having HLDs applicable for all mental disorders makes more logical sense than restricting their use to psychopathic disorder. Post-November 2008, the HLD allows for “the psychiatric reality of a ‘diagnostic spectrum’, where an individual’s diagnosis can move along the spectrum of disorder between illness and developmental or personality abnormality” (Eastman 1998, p. 486).

The impact of the Mental Health Act 2007

Changes to the HLD were introduced by the Mental Health Act 2007, not through a direct amendment to expand its use, but from a change to the definition of ‘mental disorder’ (see Box 2).

Box 2: Amendment to the Mental Health Act 1983

A Mental Health Act 2007 amendment to the Mental Health Act 1983 states that:

Mental disorder

1 Removal of categories of mental disorder

- (1) Section 1(2) of the 1983 Act (key definitions) is amended as set out in subsections (2) and (3).
- (2) For the definitions of ‘mental disorder’ and ‘mentally disordered’ substitute – ‘mental disorder’ means any disorder or disability of the mind; and ‘mentally disordered’ shall be construed accordingly.
- (3) The following definitions are omitted:
 - (a) those of ‘severe mental impairment’ and ‘severely mentally impaired’,
 - (b) those of ‘mental impairment’ and ‘mentally impaired’, and
 - (c) that of ‘psychopathic disorder’.

(Source: OPSI 2007, p. 1)

By introducing a single definition of mental disorder to the Mental Health Act, and removing the sub-category of ‘psychopathic disorder’, the HLD could be used in cases of any ‘mental disorder’, defined as ‘any disorder or disability of the mind’.

And so in 2008, more than a decade after the Government’s proposals for a hybrid order for any mental disorder had been withdrawn after fierce criticism and vocal opposition, the Government implemented what was, in effect, the original proposal of 1996.

Assessment

The HLD has been and remains a controversial concept. It is in essence a ‘hybrid order’ that enables a judge to order an offender to hospital and at the same time pass a prison sentence. Its ten year availability only for psychopathic disorder greatly restricted its use, but the expansion of its application to all mental disorders in November 2008 means that it may now be used more frequently.

In its post-November 2008 form, the HLD overcomes the judicial dilemma of having to choose either to order an offender to treatment in hospital or to give a prison sentence. This could mean that fewer offenders end up in prison with a serious mental illness, which would reduce the pressure on prison in-reach and the numbers awaiting hospital transfer. The HLD enables sentencers to have a ‘therapeutic go’, with a prison sentence in reserve as a safety net. This may be welcomed by judges, and could eventually cause the demise of the traditional hospital order, with HLDs used in the hundreds per year rather than tens.

However, there are a host of financial, clinical and ethical problems, concerns originally raised in the late 1990s. There remains the potential for an ‘avalanche effect’ on services and for the anti-therapeutic use of a hybrid order. These concerns are now wholly relevant again.

Key to the use of the HLD is whether there are beds available in forensic mental health services. The rise of the independent sector and its increasing readiness to take on long stay patients mean that bed availability is not the ultimate barrier. Rather, the use of HLDs will most likely be determined by local commissioning and funding arrangements.



Dangerous and Severe Personality Disorder Programme

This chapter details the Dangerous and Severe Personality Disorder (DSPD) programme, a high-cost government pilot service that has been in operation for nearly a decade.

What is the DSPD Programme?

The Dangerous and Severe Personality Disorder (DSPD) programme is a government pilot project that began in 2001, jointly managed by the Ministry of Justice, the National Offender Management Service (NOMS), the Department of Health and the NHS.

It provides 300 high secure places, 75 medium secure places, some community places for men, a small medium secure service for women, and a research and development programme. Primarily, the programme operates in two high security prisons (HMP Whitemoor and HMP Frankland), two high secure hospitals (Broadmoor and Rampton) and a 12-bed unit for women ('Primrose', located at HMP/YOI Low Newton).

The DSPD programme treats an average of 234 people each year (as of 2008–9). The average length of stay for its users varies considerably between each of the units, from 1.6 to 4.2 years (Eagle 2009a).

The DSPD Programme notes that its aim is to deliver “services specifically for people who present a high risk of committing serious sexual and/or violent offences as a result of severe personality disorder” (see Ministry of Justice and Department of Health 2008 and <http://www.dspdprogramme.gov.uk>), and that:

“A candidate for the DSPD High Secure units can be admitted if assessment (evidenced by previous and/or current offending behaviour) confirms that:

- He or she is more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover; and
- He or she has a severe disorder of personality; and
- There is a link between the disorder and the risk of offending” (Ministry of Justice and Department of Health 2008, p. 8).

People can be detained in DSPD services as ‘prisoners’ in prison units under criminal law for those still serving their sentence, or under the Mental Health Act as ‘patients’ in hospital units for those who have been transferred from prison or those who have completed their prison sentence.

The DSPD programme is one of the longest running and most expensive pilot programmes in UK history. Nearly a decade old, it has cost £488 million since 2001. This is comprised of capital expenditure between 2001–3 of £128m, and annual spending from 2003–4 to 2005–6 of £40 million. From 2006–07 onwards, annual spend was increased to £60 million per year due to an expansion of DSPD places (Eagle 2009b).

The Government estimated in April 2007 that there could be 2,000–2,500 individuals in the prison population who could meet DSPD criteria (Winterton 2007), but nine months later, following further investigation into the numbers who could be eligible for DSPD, an estimate of 3,000–5,000 was proposed (Lewis 2008).

Despite several attempts by the Government to cement DSPD in legislation, firstly in 2000 and on several subsequent occasions since, it has never reached the statute books. In June 2009, the Government stated that “There are no plans to change the statutory basis of the Dangerous and Severe Personality Disorder programme” (Eagle 2009a).

Evidence of the effectiveness of DSPD has been limited, and research has found little to support the high costs and treatments as a way to reduce risk of re-offending or provide effective treatment for personality disorder. The DSPD programme’s website notes that “The DSPD programme is still relatively new, and so far few people have completed treatment. Hence a full evaluation of the effects of treatment is some way into the future.” (<http://www.dspdprogramme.gov.uk/research.html>) There is virtually no outcome research for DSPD, and many academics and professionals have expressed concerns over its ethical and legal status.

The origins of DSPD

DSPD was the creation of a Home Office-led, cross-governmental proposal published in July 1999 (Home Office 1999, *Managing Dangerous People with Severe Personality Disorder: Proposals for policy development*). The Proposals stated that they were intended to address “the challenge to public safety presented by the minority of people with severe personality disorder, who because of their disorder pose a risk of serious offending” (1999, p. 2). It noted that:

“[There] is a small group of people who are very seriously disordered and who pose a very high risk to the public ... Over 90% of these people are men, and at any time most are in prison or in secure hospitals. But the law as it stands fails to protect the public from the danger these people represent” (1999, p. 3).

It stated that the Government intended to develop a co-ordinated package of arrangements to address these challenges, which would achieve better protection for the public while being consistent with human rights law. The Proposals acknowledged from the outset that DSPD would create convergence:

“Dealing with this problem brings together criminal justice and health and social policy and raises complex and sensitive ethical questions” (1999, p. 2).

The Proposals promised that the DSPD programme would be “firmly grounded in evidence from research and capable of adapting over time as new research comes forward” and to be a service that “provides better value for money than the present arrangements” (1999, p. 3). However, the Proposals themselves were not based on research or evidence but had emerged from “extensive informal discussions” (1999, p. 2), and justified on the basis that “decisions on the direction of policy development for managing this group cannot be delayed until the outcomes of research are known” (1999, p. 3).

The Proposals presented two options for future policy. Option A would entail:

“Introducing measures within the present framework of criminal and mental health law and is based on improving arrangements in both prisons and the health service. It would strengthen existing legislation so that dangerous severely personality disordered people would not be released from prison or hospital whilst they continued to present a risk to the public. Any individual who had been

convicted of a criminal offence and who was subject to a sentence of imprisonment would be held in prison. Anyone else would be held in a health service facility. Although services would continue to be managed separately, commissioning could be centrally co-ordinated” (1999, p. 4).

Option B, the preferred choice of ministers, was more controversial. It proposed new laws to allow indeterminate preventive detention based not on the committal of an actual offence but on the perceived risk of offending:

“Under the second option a new legal framework would be introduced to provide powers for the indeterminate detention of dangerous severely personality disordered people in both criminal and civil proceedings. Those detained under the new orders would be managed in facilities run separately from prison and health service provision. The location for detention would be based on the risk that the person represented and their therapeutic needs rather than whether they had been convicted of an offence” (1999, p. 4).

The then Home Secretary, Jack Straw, had noted in the House of Commons that:

“We are talking about taking away the liberty of individuals who have not been convicted of a proportionate criminal offence. It is a very grave step to take. None of us should be under any illusions about that. It would be preposterous if we were to treat such a matter lightly” (Straw 1999).

Option B was informed by the Government’s observations of the Dutch TBS system (‘Terbesschikkingstelling’), which had been operating since 1928 managing high-risk violent and sexual offenders. Maden (2007) notes:

“An important stimulus for the development of the DSPD Programme in the UK was the feeling that the Dutch, just across the North Sea, were doing things so much better” (s. 9).

Following publication of the Proposals, a Green Paper was published in December 2000, outlining the legislative changes that would need to be brought in for implementing the Proposals (HM Government 2000). The Green Paper noted that:

“The Government has decided that before taking final decisions on how best to provide services for this group in the long term, it needs to pilot and evaluate the assessment process and the various treatments available for this group within existing services. At the same time, we will bring forward those legislative changes that will be required whether Option A or Option B is adopted” (HM Government 2000).

In 2001, The Labour Party’s general election manifesto promised that:

“To deal with the most dangerous offenders of all – those with a dangerous severe personality disorder – we will pass new legislation and create over 300 more high-security prison and hospital places” (Labour Party 2001, p. 32).

Neither option A nor option B ever transpired into legislation and after ten years the DSPD programme remains a pilot project. It is likely that this lack of legislative foundation has contributed to the DSPD programme’s haphazard development.

The reaction to the Proposals and the Green Paper

The reaction to the DSPD Proposals and the Green Paper at the time and since from clinical and legal professionals outside of government have been almost exclusively oppositional. A great deal of research and commentary has consistently criticised DSPD for more than a decade, from its initial conception in 1999 through to the present day. Research studies assessing the outcomes of DSPD have been limited in number and scope, but predominantly they have concluded that the service provides poor outcomes. A summary of the commentary and research is outlined here.

Treatability of ‘personality disorder’

In the late 1990s, attention had focused on mental health services following the trial and conviction of Michael Stone, a man diagnosed with personality disorder who murdered two people after (it was incorrectly claimed) he had been turned away from psychiatric services. The Stone case ignited a war of words between the Home Office and the psychiatric profession. The latter were portrayed, both by the press and by some in Parliament, as only willing to take on patients whom they regarded as treatable.

The then Home Secretary, Jack Straw, criticised what he perceived as unwillingness among psychiatrists to treat people with personality disorder:

“Twenty years ago [psychiatrists] were adopting what I would say was a commonsense approach to serious and dangerous persistent offenders. These days they have gone for a much narrower interpretation of the law. Quite extraordinarily for a medical profession, they have said they will only take on those patients they regard as treatable. If that philosophy applied anywhere else in medicine there would be no progress whatsoever. It’s time, frankly, that the psychiatric profession seriously examined their own practices and tried to modernise them in a way that they have so far failed to do” (BBC 1998).

Following the publication of the Green Paper, Haddock *et al.* (2001) surveyed forensic psychiatrists for their opinion on the DSPD proposals, finding that:

“Opinion remains divided over diagnosis, treatability and assessment of risk in personality disorders. The medicalisation of DSPD to allow indeterminate detention in unconvicted cases is unacceptable to the majority (75%) ... Only a minority (20%) of psychiatrists would work in a new specialist service, which has significant implications for service development ... Furthermore, these units may become isolated and standards could be hard to maintain” (Haddock *et al.* 2001, p. 293).

It would be another five years before the Government would formally try to quash clinical doubts about the treatability of personality disorder (see Department of Health 2003, *Personality Disorder: No longer a diagnosis of exclusion*), but it still remains a problematic issue in 2010.

Ethical concerns

Many of the early criticisms of DSPD were ethical. One of the first critiques noted that:

“The Government’s philosophy and resolve are clear. In pursuing, above all, public protection, it intends services which essentially hybridise punishment and health care, with law that allows preventive detention of even the unconvicted” (Eastman 1999, p. 549).

Describing the convergence evident in the Proposals, Eastman noted that:

“The fragility of the distinction between public health psychiatry and crime prevention has never before been so starkly represented as it is now in this proposal” (1999, p. 551).

Only a few months later, a damning editorial in the *British Medical Journal* argued that:

“The Government’s proposals masquerade as extensions of mental health services. They are in fact proposals for preventive detention ... They are intended ... to circumvent the European Convention on Human Rights, which prohibits preventive detention except in those of unsound mind. With their promises of new money and research funding, they hope to bribe doctors into complicity in the indefinite detention of certain selected offenders. Discussion of the ethical dilemmas that these proposals present for health professionals is absent, presumably because they are ethically and professionally indefensible” (Mullen 1999, p. 1147)

A report from 2001 noted some of the immediate challenges that DSPD created, which the authors argued were created by a coming together of the:

“Complex issues of criminal justice and health, arising from the mad/bad conundrum. A chief concern is the unprecedented convergence between criminal justice and mental health which these proposals signify and make the area difficult ethically, philosophically, medically but also practically” (Rutherford and Telford 2001, p. 4).

‘DSPD’ as quasi-medical terminology

The very term ‘DSPD’ and the notion of a ‘dangerous and severe personality disorder’ have been fraught with controversy. This was highlighted by the House of Commons Select Committee on Health (2000a):

“The evidence we received [from witnesses] on the Government’s proposals was remarkable in its uniformity. The first point made to us by many witnesses related to what they saw as the highly dubious nature of the definition ‘dangerous people with severe personality disorder’ or ‘DSPD individuals’” (2000a, para. 154).

Dr Mike Shooter of the Royal College of Psychiatrists had made this point to the Committee in oral evidence:

“Dangerous severe personality disorder is a very difficult one and fraught with disaster. The link between severe personality disorder and dangerousness is extremely tenuous and poorly researched. We will find that most people with a severe personality disorder are not dangerous and most people who are dangerous in the Government sense will not have a severe personality disorder” (2000a, para. 154).

The Government, however, argued that DSPD was not meant to be a medical diagnosis, but was the remit of criminal justice and not health. The then Home Office Minister, Paul Boateng MP, told the Committee that the Government:

“Have quite deliberately chosen this term (DSPD) in order to avoid the confusion that would otherwise arise if we were to adopt a clinical or medical approach to this issue ... I think it is only fair to share with the Committee at the outset that the Government’s proposals on dangerous people with severe personality disorder are first and foremost a criminal justice measure and they should not be confused with the issue of mental health” (2000a, para. 155).

The Committee expressed concern over such ‘quasi-medical’ definitions, and unease that the Home Office was dominating what they believed should be a health issue. The Chairman, David Hinchliffe MP, remarked to ministers that, although there was clearly some joint ownership of The Proposals, the Home Office was taking precedence over the Department of Health, resulting in some overtly damaging inter-departmental tensions:

“You have both referred to the inevitable tensions between the Home Office and the Department of Health and these are legendary over the years and we have picked them up on numerous issues ... The picture we have got, and certainly I have got from a number of people is that, in areas of health care ... the Home Office has taken over and is in the driving seat with a law and order message behind what is being put forward ... That in a sense [Health] have been hijacked by the Home Office in this area of policy” (House of Commons Select Committee on Health 2000b, Question 715).

The then health minister Alan Milburn MP replied that a matter such as DSPD is:

“A problem for the Government as a whole, it is not just a problem for the Home Office but a problem for the Department [of Health], for the Prison Service, for mental health services, and somehow or other we have to find a solution to that problem. The truth is we can only do that together. Paul [Boateng MP] has alluded to the fact that we have pilot work going on in HMP Whitemoor at the moment, we have work going on in the National Health Service too to try and crack this problem, and in the end it will only be cracked on the basis, one, of cross-governmental co-operation, which there is, and, two, on the basis, as he says, of multidisciplinary team work because the range of interventions which will be required here will be deeply complex” (2000b, Question 715).

As part of the Committee’s investigation, many memoranda were submitted by experts, the majority expressing deep reservations about the Proposals. Among the most fervent was the submission from the Department of Forensic Psychiatry at King’s College London, which was primarily concerned that DSPD was not a medical diagnosis but a political construct:

“A medical term ‘personality disorder’ has been borrowed for political and legal purposes. Personality disorder is a contentious medical term which is used in different ways by different people and in this document it has been made more difficult to comprehend by the addition of ‘severe’ and ‘dangerous’. The term ‘dangerous severe personality disorder’ in spite of its apparent medical flavour is not a recognised diagnosis nor is it used anywhere else in the world” (House of Commons Select Committee on Health 2000c).

They also expressed grave reservations that the acronym (DSPD) was unhelpful and stigmatising:

“The acronym ‘DSPD’ is even worse than the term ‘dangerous severe personality disorder’ because abstract letters such as these are rapidly detached from any clinical meaning. In psychiatry it is all too easy for people with problems to become a something, something which is less than human. The new acronym has already been used by some of the very professionals this document aims to recruit as a new pejorative term ‘DSPD-ed’ with all the overtones of moral judgement and rejection that the term ‘psychopath’ has carried for so many years” (2000c).

Finally, they stated that:

“Most fundamentally we are surprised and shocked by the remarkable lack of evidence underlying the proposals in this document ... The evidence that is available seems to have been ignored” (2000c).

One forensic psychiatrist expressed fears that psychiatry’s own problems with defining personality disorder may have blurred the issue for politicians:

“What in this context does this term ‘dangerous severe personality disorder’ mean? What Mr Straw may well mean is patients who give him the biggest political problem ... These groups of patients are better described in simple criminal terms ... Psychiatry is confused and illogical in its approach to the concepts embodied under the broad umbrella of personality disorder. Has our philosophical muddle about terminology and the concepts behind the terminology handed politicians new devices for social control?” (Gunn 2000, p. 336).

The Health Select Committee’s final report concluded that it was “Unable to support either Option A or Option B in the Home Office / Department of Health discussion document [on DSPD]” (House of Commons Select Committee on Health 2000a, para. 165).

Limitations of risk-based interventions

Several commentators have also noted the significant limitations of risk-based interventions. Seddon (2008) identified the high profile given to the concept of ‘risk’ in the Proposals noting that ‘risk’ is mentioned 124 times in its 76 pages (2008, p. 307).

Farnham and James (2001) warned that:

“Would-be clairvoyants engaged in this form of assessment exercise will make use of ‘tools’ in the form of actuarially-based checklists, which gave spurious scientific value estimations that perform less well than chance” (2001, p. 1926).

Moran (2002) noted the perils of attempting to predict ‘dangerousness’, which he argued is unreliable and often leads to over-prediction:

“The prediction of dangerous behaviour is fraught with difficulty. Two approaches have been advocated by psychiatrists, although neither are wholly satisfactory: First, the actuarial approach, which incorporates statistical concepts of likelihood, and secondly, clinical prediction ... Because of the worrying ramifications of failing to predict dangerous behaviour, psychiatrists usually err on the side of caution and over-predict” (2002, p. 7).

Moran (2002) was also concerned that DSPD changed the role of the doctor from one of “treating the sick, to social control”. In addition he asked: “In the absence of good evidence to show that treatment actually works, how ethical is it to impose such treatments?” (2002, p. 8). He questioned whether the public would be any more protected by DSPD, concluding that there were:

“Strong indications that the cost to both patient and the profession of this new responsibility on psychiatry would be considerable. British doctors have been justifiably critical of the abuse of psychiatry in other countries. It is now time to face the uncomfortable truth that we are not immune from such problems in the UK” (2002, p. 9).

Corbett and Westwood (2005) were concerned about the ‘actuarial’ nature of DSPD, comparing it to concepts described in Beck’s *Risk Society* (Beck 1992), and likening DSPD to Philip K. Dick’s 1956 fictional idea of ‘pre-crime’ in his short story *Minority Report* (Dick 1956). The authors noted that DSPD:

“Appears to be driven more by the political appeasement of an electorate in relation to poorly defined notions of ‘public safety’ and sensational exposes of violence committed by discharged patients, rather than by attention to any evidence. It is this manifestation of the late modern risk society, with its political underpinnings, which we argue is of potential concern for human rights” (2005, p. 131).

Manipulation of the law

One consultant forensic psychiatrist, writing in 1999, warned that DSPD could be an attempt to enable ‘preventive detention’ through the guise of a health intervention (Chiswick 1999). He noted that:

“The folly of equating high risk with a dubious psychiatric diagnosis to the exclusion of other relevant factors cannot be over-emphasised. It arises because Mr Straw’s policy is not based on clinical or academic knowledge, but on caricature. It is a populist measure drawn up in response to alarmist fears, some of them generated by government ministers. The proposals serve to demonise mental disorder and to fuel the stigmatisation of the mentally ill. Notwithstanding the presentational spin, this consultation paper is about the exhumation and enhancement of preventive detention, a measure that suffered a slow death before burial in 1967. Resuscitation of this particular corpse depends entirely on the connivance of psychiatrists. Now the profession must decide where it stands” (1999, p. 704).

In 2006, Rutherford noted that:

“The incoming government embraced a legal moralism that sought to blur distinctions between criminal and civil remedies and to side-step or neutralise traditional checks and balances. From this standpoint, when the criminal law is conceived as a mere instrument of social engineering, the significance of the offence condition may disappear almost to vanishing point. In like manner, within the realm of mental health law, the offer of treatment as a condition for detention becomes a bothersome legacy of a rights-obsessed era” (2006, pp. 51–2).

Maden (2007) went as far to describe DSPD as an agent of ‘political theatre’, in which:

“The true motivation [for DSPD] was ... a longstanding frustration within government at the refusal of psychiatrists to address the problem of high-risk offenders with personality disorder” (s. 8).

International views

In 2008, Seddon argued that DSPD was part of “a long line of initiatives and legislation” to converge mental health and criminal justice in the UK and elsewhere, citing as examples Section 45a of the Mental Health Act 1983 (as discussed previously), the TBS (‘Terbesschikkingstelling’) Order (in use in the Netherlands since 1928), US ‘sexual psychopath’ laws (now ‘sexually violent predator’ laws in 17 states, first introduced as a concept in the 1930s), and initiatives and laws in several other nations including Australia and Canada.

Maden (2007) also noted that there are some “antecedents” of DSPD, particularly from the Netherlands and TBS, and that although “the DSPD diagnosis and service appeared suddenly, [it was] not out of nowhere” (2007, s. 8). However, he also observed that:

“The civil servants who created the DSPD Programme were obviously impressed by the TBS system so it is remarkable how little of it they chose to adopt. No new legislation was introduced so the criminal courts play no role in sending offenders to DSPD units ... The DSPD Programme developed as a high-security inpatient service with no clear pathway to the community. The most important difference may be that the DSPD Programme lacks the legitimacy that the Dutch courts give to TBS” (2007, ss. 9–10).

Mullen (2007) remarked that the DSPD programme has gained an international profile and that:

“The DSPD initiative is being watched by forensic mental health professionals, and by governments, around the world. Will it become the model or a warning?” (2007, s. 3)

Peay (2007), by contrast, countered Seddon's view that DSPD is similar to models found internationally, reflecting that no other country has gone so far in the direction of DSPD:

“The DSPD initiative does not bode well. It shocked our North American counterparts, who have observed that, even there, such proposals had not been countenanced” (2007, p. 518).

DSPD research findings

There are now a number of research findings for DSPD. Very few positive outcomes have been identified, and research has for the most part been critical.

■ DSPD requires the detention of six people to prevent one crime.

One of the first studies on DSPD was by Buchanan and Leese (2001), who assessed 23 international studies related to interventions for violent offenders with personality disorders. Their results demonstrated that under the Government's DSPD proposals, “six people would have to be detained to prevent one violent act” (2001, p. 1955). Farnham and James (2001) remarked that this sort of rate was only to be expected from risk-based interventions:

“This finding should not come as a surprise. The forecasting of dangerousness remains like that of the weather – accurate over a few days, but impotent to state longer-term outcomes with any certainty” (2001, p. 1926).

■ DSPD started badly, but may yet prove useful

Mullen, a one-time critic of DSPD, had somewhat changed his views by 2007 arguing that, while the original Proposals were significantly flawed, there are signs that the DSPD Programme may now be performing a useful function:

“The programme was born out of an ill-conceived attempt to hide the imposition of preventive detention and indefinite sentences behind the veneer of respectability. However, just as good intentions can pave the road to hell so cynical calculation can occasionally lead, if not to heaven, at least to progress for the good” (2007, s. 3).

Mullen's primary argument for maintaining what he calls “the DSPD juggernaut” is that DSPD directs money and attention towards mentally disordered offenders, which might otherwise disappear:

“If [DSPD] fails, I doubt there will be any further money for initiatives directed at offenders with mental illness for some considerable time” (2007, s. 3).

“To succeed, the DSPD initiative will need to continue to alter its approaches in response to scientific progress and the results of evaluations of its own practices. Above all it must remain self-critical and in constant evolution. Predicting the future of the DSPD initiative is a task as difficult and dubious as guessing whether any particular offender will re-offend” (2007, s. 6).

■ DSPD must be cost-effective

In the current economic climate, value for money is increasingly a key driver in shaping public policy. Some (e.g. Mullen 2007) stated that DSPD will be judged a success or failure in relation to the financial worth assigned to reducing re-offending:

“How the DSPD units will be judged, at least by government, is obvious: a decrease in violent recidivism among those who are managed by these services. How large a decrease? For the money

they are spending it will have to be substantial, but whether this amounts to expectations of 20, 50, 80 or even 100% is not yet clear” (2007, s. 3).

However, others have remarked that the complexity of DSPD interventions, the challenging nature of interviewing DSPD service users, and the practical difficulties in carrying out research in secure facilities, all make value for money analyses of DSPD very challenging. Barrett and Byford (2007) proposed a model “capable of capturing services” and measuring their economic performance, which they subsequently tested (Barrett *et al.* 2009).

The latter study, however, which compared prisoners from high security prisons in DSPD assessment and those who were not in assessment, found that the group of prisoners undergoing DSPD assessment had higher costs and worse outcomes:

“The DSPD group cost £3,500 more on average than those in the control over six months. There were no significant differences in outcome, although there was a consistent trend for the DSPD assessment group to have worse outcomes than controls” (2009, p. 120).

The authors concluded that “given the substantially higher costs and observed deterioration in outcome among those in [DSPD] assessment compared to those who remain in a high security prison, the additional benefit of assessment is unclear and needs further exploration” (2009, p. 129).

■ ‘Bowdlerisation’ of research

In January 2009, the *British Journal of Forensic Psychiatry and Psychology* published an exchange between government funded researchers and the DSPD Programme research unit. Tyrer and colleagues (2009) described the results of a project funded by the DSPD Programme.

They reported that prisoners arrived both ‘disgruntled’ and with raised expectations [at the DSPD unit]; discipline on the unit was criticised; prisoners who were discharged, or were not accepted for the treatment programme, returned demoralised to their original prisons having lost their jobs, cells and privileges; and Black prisoners as a group were unlikely to engage with a hybrid of two services – mental health and the criminal justice system – which have clearly discriminated against the Black population (Tyrer *et al.* 2009).

The paper concluded with criticism of the ongoing lack of evidence for DSPD interventions:

“The DSPD programme will ultimately be judged on the success of its treatment arm – yet to date there is no evidence that any treatment is of proven, or even presumptive, efficacy in those with severe personality disorder, and the planned evaluations of the programme are not aimed at testing the efficacy of the many interventions currently employed. There is also very limited evidence of the efficacy of interventions aimed at reducing aggression and violence, so the portents for the success of this and similar programmes are not particularly good. Our findings, together with concerns about treatability, raise more fundamental concerns about whether medical management of people with these problems is a justifiable use of resources and ethically appropriate” (2009, pp. 143–4).

The DSPD Programme research unit (Ramsey *et al.* 2009) responded that the “official’ version of Tyrer *et al.*’s report to the DSPD Programme ‘gives a more rounded picture than the article’” (2009, p. 147), and suggested that the authors changed their findings between writing the official report and writing the independent academic paper.

Tyrer *et al.* countered (Tyrer *et al.* 2009b), rejecting this response and claiming that their ‘official’ report was subject to ‘Bowdlerisation’ by the government. They argued that:

“A scientific publication in a learned journal has the merit of independent peer review and differs from a report written for an organisation such as the Home Office. Such reports are constrained by the insistence on internal as well as external scrutiny, and the final version is an amalgam of the two that is not completely free of Bowdlerisation” (2009b, p. 151).

They go on to state that their research found that many prisoners detained in the DSPD units for assessment had “little in the way of severe personality disorder” (2009b, p.152), and even accused the Home Office of violating the research process:

“Protocol violations occurred frequently during the course of our randomised trial and all attempts by us to have these corrected or prevented were ignored or over-ruled. We think the Home Office might have been more forceful in ensuring the success of an evaluation that we believe could have been of greater value to the assessment programme. Indeed, there is a general point to be made here: This lack of will has led to a failure to conduct randomised trials in prisons, thereby severely compromising the identification of effective interventions for an especially disadvantaged group” (2009b, p. 152).

The paper concludes:

“We are sad that, with the large resources at its disposal, the Home Office is not able to support a proper randomised controlled trial of the interventions that are available ... We must still point out that in view of the absence of evidence from any source for most of the interventions currently used in the programme, it would be unwise for anyone to imply that because treatment was available it is therefore effective” (2009b, p. 153).

Current status of DSPD Programme

To say that implementation of DSPD proposals “did not run smoothly” (Seddon 2008, p. 306) is rather an understatement. Attempts to introduce DSPD into legislation have repeatedly failed, and legislative efforts were shelved in 2006 after a long and difficult battle in Parliament, leaving DSPD in pilot form rather than in law.

Seddon notes that, by remaining a pilot programme, the operational legality of DSPD is complex:

“Confinement in the DSPD units is currently governed by a rather patchwork legislative framework. The two units based in high secure Special Hospitals operate within the existing mental health legislation, which authorises detention, inter alia, for the protection of others. The two prison-based units, on the other hand, derive their authority to confine from the general sentencing powers of the criminal courts” (2008, p. 306).

Since 2005, more than 350 DSPD places have been available in a mixture of high security prisons and hospitals. Yet the DSPD service has never been fully occupied despite claims by the Government that there would be massive over-demand for DSPD places (Ministry of Justice and Department of Health 2008).

The question of whether someone detained in DSPD services should go to a prison unit or a hospital unit, and whether they are a prisoner or a patient, has always been somewhat unclear as “each of the units will broadly be taking similar groups of people based on the admission criteria” (Ministry of Justice and Department of Health (2008, p. 10).

The DSPD programme's *Planning and Delivery Guide* (Ministry of Justice and Department of Health 2008) attempted to clarify this matter. Hospitals should be used primarily where a prisoner is near the end of their sentence, and therefore needs to be detained under another auspice. The guide notes that this decision should be based on the following considerations:

- “[Whether] the individual has mental health treatment needs that can be best met in a hospital environment; and
- [Whether] an individual is near the end of their sentence and is likely to require continued detention under mental health legislation in order to complete treatment” (2008, p. 10).

“Every effort should be made to identify the prisoner as early on as possible within the course of their prison term [and] as a general guideline, anyone with less than 12 months to serve of their sentence should be referred directly to one of the hospital units for assessment” (2008, p. 10).

Pressure for evidence on the effectiveness of DSPD has been consistently high, and is increasing. Responding to questions from parliamentarians, the Government announced in July 2009 that the DSPD programme has two linked evaluations that will be published by early 2010, one focusing on treatment offered and responses to treatment, the other concerned with staffing and organisation, which will provide a preliminary assessment of effectiveness and cost-effectiveness of the DSPD programme. It is intended that they will also assess the health of those subject to the programme and the potential implications for public safety (Eagle 2009a).

Peay (2007), however, has questioned whether the DSPD programme can ever provide robust evidence of its effectiveness due to several fundamental problems:

“[DSPD] is not an evidence-based programme. How could it be? If there is no agreed definition, no clear diagnosis, no agreed treatment, no means of assessing when the predicted risk may have been reduced, and no obvious link between the alleged underlying condition and the behaviour, how could outcome measures be agreed and then evaluated?” (2007, pp. 518–9).

Assessment

The DSPD programme is a ten year government pilot project that has cost nearly half a billion pounds. Positive outcomes have been very limited, and a host of ethical concerns have been raised since its creation in 1999.

Personality disorder (without the ‘D’ and ‘S’) is now a recognised clinical and psychiatric condition, included under the new definition of mental disorder in the Mental Health Act 2007. This change to the Act, as well as relaxing the ‘treatability’ criterion, adds further uncertainty to the need for a ‘DS’-PD service as opposed to mainstream personality disorder treatment in prisons, or in secure forensic settings where required.

The evidence suggests that it is now time for the DSPD programme to be phased out in favour of a prison-based personality disorder service. Reinvesting the DSPD Programme’s operational costs of £60 million per year, for example on mainstream prison-based interventions, would have a substantial impact on the current level of need in mainstream prisons, where up to 70% of prisoners have a form of personality disorder.

It is probably the issue of cost that is likely to determine the future for DSPD, as Maden (2007) suggests:

“The architects of the DSPD service took some major strategic risks when they decided to go down a different road. They took those risks in a high-stakes game, and the most important risk may turn out to be financial. The average cost of DSPD treatment is more than £200,000 per patient per year (and nearly £300,000 in the high security hospitals), a sum that can buy a lot of risk management in other settings. People who work in the DSPD programmes already feel their practice is subject to close examination, but it may be worth nothing compared with the scrutiny heading their way from the accountants.”

The Bradley Report called for a full assessment of services available for offenders with personality disorder, and specifically ‘an evaluation of the DSPD programme to ensure it is able to address the level of need’ (Bradley 2009, p. 109).

The Government’s National Delivery Plan stated that, within a year, it would:

“Develop, through stakeholder engagement and consultation, an interdepartmental forensic personality disorder strategy. This will set out policies and a delivery framework for a systemic approach to effectively managing and treating this population. This work will involve improvement in all stages of the offender pathway for those with a personality disorder in the criminal justice system” (HM Government 2009a, p. 48).

The Government confirmed that it would also deliver an “overarching, cross-departmental strategy for the management of people with personality disorders, by October 2010” (HM Government 2009a, p. 41).

Critical to the future of the DSPD Programme is the Government’s plan to fully review all spending on the DSPD services, and the promise to “agree a revised plan for NOMS and the NHS of investment in the DSPD programme, by July 2010” (HM Government 2009a, p. 41).



Systems convergence

Chapters eight to eleven summarise further examples of convergence, and draw specifically from written submissions from twenty-three invited experts working in the field of mental health and criminal justice. The experts included individuals and organisations working in central and regional government departments, academics, practitioners and clinicians.

This chapter demonstrates convergence by presenting several examples that have significantly affected the operation of the mental health and criminal justice systems.

Large hospital closures

Although robust evidence is limited, some experts reflected the commonly held belief that there is a correlation between the closure of the large psychiatric hospitals in the 1970s and 1980s (and the introduction of care in the community) with the rise in the number of people with mental illness now in prisons (a trend sometimes referred to as ‘Penrose Law’):

“Many prison staff have a strong belief that since the closing of the large mental health institutions and the introduction of community care, the criminal justice system has been used by society to deal with the presentation of mental health on the streets. Rather than address need through a mental health system these people are now housed in prison.”

“It has frequently been stated that prisons and criminal justice have to some extent replaced the large residential mental hospitals as places in which to hold the troubled and the troublesome. Recent legislation, which is likely to pull in individuals displaying risky or anti-social behaviour, has exacerbated this.”

“There appears to be an enduring relationship between falling capacity of the mental health institutions and a burgeoning criminal justice population... With [this] comes a much more vulnerable prisoner population, many of whom will have mental health problems.”

“The implementation of care in the community led to a significant number of people becoming more visible in the community, having more contact with other members of the public and more ‘opportunity’ to be arrested.”

Introduction of prison in-reach services

A major achievement of policy makers in the last decade was the transfer of commissioning responsibility for prison health care from the Prison Service to the NHS. This transition was completed in 2006, and £20 million is now spent each year on prison mental health services. These services are

based on the community mental health team model, and are commonly referred to as ‘in-reach’ services.

Although current investment is some way short of achieving the Government’s policy of ‘equivalence’ (in access to, and quality of, treatment between prison and community; Sainsbury Centre 2008a), the introduction of prison in-reach teams was a significant milestone.

Several experts highlighted the introduction of prison in-reach as a key example of convergence, and some noted that there has been a knock-on effect on other elements of offender health care:

“The transfer of commissioning of health services to the NHS from the prison service has been the catalyst for a whole scale shift in culture and attitude within health care in jails. The requirement of prison health care to meet the same standards as other NHS services is another example of convergence that is attempting to drive up quality. Investment in prison health and mental health in particular has risen as consequence. A wider range of services are now available and convergence in delivery is clear to see. One example of this is the development of mental health in-reach teams. These teams, which are in essence CMHTs in the prisons, are an example of the convergence of policy and service development between health, social care and the prison service.”

A common statement was that the introduction of NHS in-reach teams has led to improved working and collaboration between mental health and criminal justice practitioners in prisons.

The use of CPA in prisons

The Care Programme Approach (CPA) was introduced in England in 1990 by The Department of Health in a circular to health and social services (Department of Health 1990), and implemented on 1 April 1991 (see Box 3). CPA requires health and social care services to work together to put in place specified arrangements for the care and treatment of mentally ill people in the community. CPA was modernised in 1999 as a result of the introduction of the National Service Framework for Mental Health (Department of Health, 1999).

Offenders in prison and serving sentences in the community are eligible for CPA if they have a severe mental illness. However, CPA is generally used in a limited and disjointed way with offenders. Despite this, a number of experts highlighted CPA in prisons as an example of convergence:

“CPA being followed in prison, and care co-ordinators needing to communicate to prison in-reach and health care centres, is a good thing. Sadly we still find examples of care teams discharging people from care when sent to prison but this is generally easily challenged and changed.”

Another noted that local health care providers must remain accountable for patients on CPA who are sent to prison, and should re-engage when a prisoner on CPA is released. It should be affirmed that CPA is the responsibility of local health agencies, and not prison health care staff:

“Mental health providers [should] accept their responsibility where appropriate in meeting the guidance on providing CPA to the clients when in criminal justice services. It is not the responsibility of prison mental health teams to provide care co-ordination [outside of prison].”

Box 3: The Care Programme Approach

“CPA ensures that there is communication between everyone involved in the assessment of the patient’s care needs. Social care needs will be assessed as part of this process. There will be a formal written care plan, which outlines any risks and includes details of what should happen in an emergency or crisis.

“A CPA care co-ordinator should be appointed to co-ordinate the assessment and planning process. The co-ordinator is usually a nurse, social worker or occupational therapist. You and the person you’re looking after will be given their name and contact details. A formal review is made at least once a year. This may include consideration as to whether CPA support is still needed.

“It’s recommended that the person who needs CPA support is involved in the assessment of their own needs and in the development of the plan to meet those needs. The person should be informed about the different choices for care and support available to them, and they should be treated with dignity and respect.”

(NHS Choices 2009).



9

The rise of forensic mental health

Several experts identified the rise of forensic psychiatry as a clinical profession, and the rapid capacity increases in forensic psychiatric hospitals in the last twenty years, as examples of convergence.

At the end of 2008 there were:

- 3,937 patients detained in forensic mental health services, compared to 1998 when the forensic mental health service population was 2,749;
- 937 forensic patients detained as a result of transfer from prison (either once sentenced, or while on remand awaiting sentencing);
- 1,501 admissions to hospital in 2008, including 926 prison transfers;
- 1,255 discharges/disposals of restricted patients, of whom 499 (or 40%) were discharged into the community (Ministry of Justice 2010).

As one expert noted:

“The development of the field of forensic psychiatry embodies the close association for some elements of mental health with the criminal justice sector.”

A number of experts expressed concern that the convergence seen in the rise of forensic psychiatry, and the increased numbers of offenders transferred to hospitals from prison, has resulted in hospitals increasingly becoming more like prisons. One noted that this is seen particularly in terms of hospital security with an emphasis on public protection:

“A form of convergence has occurred in the more specialist mental health services in that government consistently seeks to impose prison standards of perimeter security on specialist hospitals; this started with Tilt recommendations for the special hospitals, but has extended to medium security too.”

Fundamental differences between prisons and hospitals

There are a number of fundamental differences between hospitals and prisons. One expert who agreed to have his comments attributed (John Gunn, Emeritus Professor of Forensic Psychiatry, King's College London) argued that these differences should remain intact:

■ Purpose

“The primary purpose of a prison is punishment and deterrence together with an important secondary purpose of social control. Social control is also a secondary purpose for a secure hospital but its primary purpose is treatment and rehabilitation.

■ Staffing

“Prison staff are trained to be security staff first and to regard their charges as competent adults. They may well be assisted by therapeutic staff but major policy decisions are always taken in terms of security. Secure hospital staff are also trained in security but they are almost exclusively recruited from the therapeutic professions and have therapeutic skills which can be deployed even in highly dangerous situations. Staffing ratios are also different between prisons and hospitals which is one of the factors that make prisons cheaper per inmate than secure hospitals.

■ Treatment

“Treatment can be given in a prison but it is only in specialised prisons that the environment itself is designed to be therapeutic. For most prisons treatment in any meaningful sense is given during episodes of time away from the main institution e.g. a group session or a psychological programme. Prisons have regimes, hospitals do not.

“Hospitals should be and often are designed to be therapeutic in themselves. Treatment is not given primarily in ‘programmes’ but is individually designed for each patient. Patients are regularly assessed by therapeutic teams, usually led by a psychiatrist. These meetings or ward rounds are held monthly or more frequently and regular adjustments to patients’ programmes are made on a day-to-day basis.

“This is totally different from a prison sentence plan which may only occur once a year and which does not always include staff trained in mental therapeutics. Even the administrative staff in a secure hospital include executives who are clinically trained, such as the chief nurse or the medical director. This is almost unthinkable in a prison.

■ Length of stay

“Length of stay in prison is governed by strict laws and usually determined during the sentencing phase of a criminal hearing. Indefinite sentences have a compulsory tariff period and after that the length of stay is determined by an outside body (the Parole Board) who have no ongoing responsibility for the person concerned and who are dependent upon one formal, tense interview, and information supplied by prison staff. If a decision to release is made then neither prison staff nor the Parole Board have any further interest in the case or control over it. The prisoner is simply handed over to people who may have taken an interest during his sentence but who may be complete strangers; readmission if necessary is a legal process which is seen by all parties as re-imprisonment.

“Length of stay in hospital is driven primarily by medical need, the decisions are taken by the professionals who know the patient well and usually involve the professionals who will continue to manage the case after discharge. For dangerous cases there are extra safeguards via mental health review tribunals, the Ministry of Justice, and the Parole Board, but even then there is usually continuity of care between the inpatient phase and care in the community. If the patient’s management requires readmission to hospital this is easily affected and its duration is once again dependent on clinical need rather than legal niceties.

■ Rehabilitation

“Many prisoners and many secure hospital patients have psychiatric conditions that are life-long. Being based on a punitive model prisons are focused on a prescribed period in prison followed by something or nothing in the community provided entirely separately and necessarily disconnected from imprisonment. In forensic psychiatry institutions rehabilitation is an integral part of patient care and there is an expectation of long-term management by a team that has responsibilities for both

inpatients and outpatients. In a well-designed forensic psychiatry service there are also places in hostels which are managed by the same team.

Gunn concludes:

“If prisons become hospitals and hospitals disappear the advantages of hospitals will disappear, to the detriment of the health of individuals and to the safety of the public. Furthermore the punitive and deterrence aspects of imprisonment would be diluted.”

Another expert made a similar point:

“Prisons are not, and never should be, substitutes for hospitals. If people who must be imprisoned have any kind of disorder of health for which they need treatment as an outpatient and that treatment is available in prison, then it is reasonable for them to receive that treatment in prison; if they need treatment as an inpatient, then that must be in a hospital.

“Equally, hospitals are not and never should be mere prisons. The security needs of someone who offended because of a mental disorder may have some features in common with any person who needs security, but there are also substantial differences, and it is unsafe as well as unfair simply to impose prison standards of perimeter security on hospitals.”



Legislative convergence

One expert described the three ways in which legislative convergence has occurred as “deliberate, accidental and implied”. Almost all of the written submissions gave an example of legislative convergence, and each could fit into one of the three categories.

A number of experts cited IPP sentences, Hospital and Limitation Directions, and Mental Health Treatment Requirements (which one expert referred to as ‘psychiatric probation’), as explicit examples of legislative convergence (these are all described in chapters four, five and six). There were also many other examples given of legislative convergence, outlined in this chapter.

Mental Health Act 2007

A general view from the experts was that the amendments introduced by the Mental Health Act 2007 were more an intention to expand the application of mental health legislation to a wider population, and less an attempt to improve clinical care and rehabilitation. One expert noted that:

“The removal of the categories of mental disorder within the amended Mental Health Act broadened the powers of mental health services to formally detain those suffering with mental disorders.”

The changes to the treatability criterion in the Mental Health Act 2007 were also given as an example of convergence:

“Replacing treatability criteria with ‘available appropriate treatment’ paves the way for the long term incarceration of mentally disordered offenders whether they choose to engage in treatment or not.”

It was also asserted that there is increasing pressure for professionals to use the Mental Health Act for public protection:

“[There is] anecdotal evidence of an increased focus upon public protection as a reason for detention [and] pressure from other agencies to utilise the Mental Health Act when viable risk management is not available.”

Community Treatment Orders

One manifestation of the increasing emphasis on public protection can be seen through the introduction and use of Community Treatment Orders (CTOs). It is important that CTOs are not to be confused with Community Orders, the community sentence available under the Criminal Justice Act 2003.

CTOs were one of the most controversial elements of the Mental Health Act 2007, and were implemented in November 2008. They provide the statutory mechanism for enforced Supervised Community Treatment (SCT, under Section 17a of the Mental Health Act).

The NHS has described the purpose of SCT as “to allow patients to continue their treatment in the community following a period of detention in hospital” (NHS 2009, p. 6), and added that they essentially replace the now abolished ‘supervised discharge’ that was previously available.

Community Care magazine (Dunning 2009) summarised the purpose of CTOs as follows:

“CTOs must be agreed with an approved mental health professional – typically a social worker. Under a CTO, patients must take their medication or face being returned to a psychiatric unit. CTOs have always been controversial, with an Institute of Psychiatry review in 2007 finding no evidence from other countries of their worth.

“The report, which examined 72 studies into the use of CTOs in six countries, found it was not possible to state whether they were beneficial or harmful to patients” (Dunning 2009).

The Government expected the use of Supervised Community Treatment to be no more than 350–450 in its first year. However, Table 2 illustrates a much higher take up in the five months between 3 November 2008 and 31 March 2009 (NHS 2009, p. 30).

Some 2,109 CTOs were issued in this six month period alone, eight times the expected rate, with 207 recalls to hospital, 143 revocations and only 33 discharges from SCT.

Table 2: Uses of Supervised Community Treatment (under Section 17A)

Total number of SCTs	2,109
Section 3 to SCT	1,581
Section 37 to SCT	52
Section 47 to SCT	2
Section 48 to SCT	0
Other sections to SCT*	474

*Other sections are mostly those who were previously under a section of the Mental Health Act related to Supervised Discharge.

While there is some credence in the claim that the use of CTOs is primarily to enable discharge of a patient from a restrictive inpatient setting to a community based treatment, there are a number of concerns that the CTO is being issued as standard practice by increasingly risk-averse psychiatric professionals who wish to ‘cover themselves’ for any future incidents or non-compliance.

It has also been claimed that CTOs are being used as a means to create bed space in hospitals, and that patients are being discharged too soon and therefore inevitably are likely to fail to meet the requirements of the Order when discharged in the community (Dunning 2009).

Some of the experts highlighted CTOs as an example of convergence. One described their potential as a favourable development:

“The development of CTOs is one such example [of community-based approaches in mental health legislation]. If this can be coupled to approaches in probation then there is real opportunity to support offenders with mental health problems with a joint legal framework that will enable organisations to work together more effectively.”

However, another described a common concern that CTOs may result in premature hospital discharge:

“It is feared that the pressure to empty beds may lead to patients with severe mental illness being displaced. The new Community Treatment Order under the Mental Health Act may provide the gateway for this displacement as it provides a mechanism by which people can be released early. Resources may end up being diverted from voluntary patients in hospital and in the community to patients under compulsion. This may in turn increase the numbers of people with mental disorder entering the criminal justice system.”

Sections 135 and 136 of the Mental Health Act

The police are commonly a first point of contact for a person in a mental health crisis. Up to 15% of incidents with which the police deal are thought to have some kind of mental health dimension (Sainsbury Centre 2008c).

Yet police stations are rarely used by mental health services as places from which to divert offenders to appropriate care and support, and relationships between police forces and health and social services can be difficult.

‘Places of safety’

Every year 11,000 people are taken to a police station as a ‘place of safety’ under the Mental Health Act (Sainsbury Centre 2008c).

Where an individual is suspected of having a mental health problem and is in need of immediate care or control, the police can use Section 136 of the Mental Health Act 1983 to take the person from a ‘public place’ to a ‘place of safety’ for up to 72 hours. Where the person is not in a public place, the police may use Section 135 of the Mental Health Act to gain access to a person’s home or property by force following the granting of a court warrant.

Under the 2007 Mental Health Act, once an individual has been taken to a ‘place of safety’, they should be assessed by an approved clinician (formerly a registered medical practitioner), one ideally approved by Section 12 of the Act, and by an Approved Mental Health Practitioner (AMHP; formerly an Approved Social Worker).

Recent guidance from the Department of Health (Department of Health 2008b) made changes to the use of Section 136 when Section 44 of the new Mental Health Act 2007 came into effect on 30 April 2008. The new legislation allows a person to be taken from one place of safety to one or more different places of safety during the 72 hour maximum period. They may be taken between places of safety by a police officer, an AMHP, or someone authorised by either of these.

The Department of Health guidance also states that police stations should only be used as ‘places of safety’ in ‘exceptional circumstances’ (2008b). This is particularly important in relation to the contingency plan (known as Operation Safeguard) for using police cells in response to the prison population reaching its operational capacity.

However, many police forces say they have no alternative to using police stations as places of safety due to the absence of appropriate facilities within health settings (Sainsbury Centre 2008c). Ideally, a

‘place of safety’ should be a hospital rather than a police station yet just 6,400 people are detained in this way in hospitals each year. Police stations are often crowded and chaotic places and station cells are often a far cry from a place of safety.

The Department of Health has noted the concern that holding a person with a severe mental illness in a police cell for an assessment may create a feeling of criminalisation and incite instability. However, often hospitals feel that they are ill equipped to cope with mentally unstable people who need to be held securely for assessment at the request of the police. While the Department of Health noted that “NHS bodies and local social services authorities will need to ensure that their staff are aware of the change and that it is reflected in local policies”, there has been as yet no central provision of funding or guidance on transposing places of safety away from police stations to other localities.

One expert noted that the police are increasingly involved in incidents related to mental health:

“Convergence is increasing as more mental health patients are being supported within community settings and therefore come into contact with their local police. The police are most often the primary response to incidents involving or centred around people suffering with mental health issues, as victims or offenders, and [the police] are often faced with problematic and limited options to resolve any highlighted issues.”

The use of police stations as a ‘place of safety’ is problematic. The expert stated that it is both a consequence and an example of convergence:

“The police often find themselves detaining a person under the Mental Health Act and transporting them to a custody suite as a ‘place of safety’: this is not ideal and whilst custody suites should only be used in exceptional circumstances, this practice cannot be avoided in many locations across the country where designated places of safety do not exist. Once there, access to diversion or referral options is limited and detention can be often costly to police services through officer’s time and the need to remain with any detainee until and during any subsequent assessment.”

Lord Bradley was concerned by the use of police stations as a ‘place of safety’, and recommended that:

“All partner organisations involved in the use of Section 136 of the Mental Health Act 2007 should work together to develop an agreed protocol on its use”; and

“Discussions should immediately commence to identify suitable local mental health facilities as the place of safety, ensuring that the police station is no longer used for this purpose” (Bradley 2009 p. 47).

The Government’s National Delivery Plan responded:

“We will introduce a national template and guidance on the application of Section 135 and 136 of the Mental Health Act 2007 by October 2010” (HM Government 2009a, p. 38).



Managing ‘dangerous’ and ‘anti-social’ people

This chapter highlights three examples of convergence that each relate to recent measures introduced to aid the management of ‘dangerous’ or ‘anti-social’ people in the community.

Multi-Agency Public Protection Arrangements

Several experts identified the statutory Multi-Agency Public Protection Arrangements (MAPPA) as an example of convergence. The Government has stated that:

“MAPPA Guidance is issued by the Secretary of State under Section 325(8) Criminal Justice Act (2003). This Guidance is therefore statutory. All Responsible Authorities and ‘co-operating bodies’, being public bodies, have a duty imposed by public law to have regard to this Guidance in exercising their functions under the Multi-Agency Public Protection Arrangements (MAPPA). If they choose to depart from the Guidance they will need to demonstrate, and record, good reasons for doing so” (NOMS 2009, p. 31).

This guidance also notes that:

“MAPPA are the statutory arrangements for managing sexual and violent offenders. MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner. Agencies at all times retain their full statutory responsibilities and obligations.

“The Responsible Authority (RA) consists of the Police, Prison and Probation Services. They are charged with the duty and responsibility to ensure that MAPPA is established in their area and for the assessment and management of risk of all identified MAPPA offenders. Other agencies under Section 325(3) of the Criminal Justice Act (2003) have a ‘duty to co-operate’ with the RA” (2009, p. 31).

These agencies are:

- Local Authority Social Care Services;
- Primary Care Trusts, other NHS Trusts and Strategic Health Authorities;
- Jobcentre Plus;
- Youth Offending Teams;
- Registered Social Landlords which accommodate MAPPA offenders;
- Local Housing Authorities;
- Local Education Authorities; and
- Electronic Monitoring Providers.

On the ‘purpose’ of MAPPA, the guidance notes that:

“The purpose of MAPPA is to help to reduce the re-offending behaviour of sexual and violent offenders in order to protect the public, including previous victims, from serious harm. It aims to do this by ensuring that all relevant agencies work together effectively to:

- Identify all relevant offenders;
- Complete comprehensive risk assessments that take advantage of co-ordinated information sharing across the agencies;
- Devise, implement and review robust Risk Management Plans;
- Focus the available resources in a way which best protects the public from serious harm” (NOMS 2009, p. 31–2).

Mental health agencies are increasingly likely to play a key role in MAPPA, and mental health clinicians regularly attend MAPPA Panels.

The Guidance notes that:

“Relevant offenders for Mental Health [services and care] are MAPPA eligible offenders:

- Who are subject to a conditional discharge from a restricted hospital order made under Section 37 of the Mental Health Act (1983) (as amended) or under the Insanity legislation or under the Criminal Procedure (Insanity) Act (1964) as amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act (1991) or the Domestic Violence, Crime and Victims Act (2004); or
- Who are discharged by a responsible clinician under a community treatment order made under Section 17A of the Mental Health Act (1983); or
- Whose conditional discharge is planned within the next 6 months; or
- Who are required to register with the police and whose discharge from any hospital order or guardianship order (including those transferred prisoners being treated as notionally subject to Section 37 hospital orders), or from an admission under part 2 of the Mental Health Act (1983) is planned within the next 6 months” (NOMS 2009, p. 48).

One expert noted that:

“Perhaps the principal visible convergence has come in the form of Multi-Agency Public Protection panels. These affect a fairly small number of the most serious offenders, whether from criminal justice or health care settings, but require full co-operation according to explicit guidance on the management of individuals liable to these arrangements between health and criminal justice.

“Multi-Agency Public Protection Arrangements that have statutory backing are in an early phase and will mature and strengthen over time, engendering partnership and driving convergence.

“At various times during the last twenty years there have been attempts to join up the criminal justice system and mental health services. The most successful ones have included ... good involvement in MAPPA.”

‘Potentially Dangerous Persons’ provisions

MAPPA is only available for people convicted of a criminal offence. Yet experts noted that the MAPPA model is one that could be replicated (under appropriate ethical and clinical scrutiny) to those with chaotic lives and multiple needs, who are not formally involved in the criminal justice system:

“Clearly operational practice between criminal justice and mental health has become more ‘joined-up’ and legislative change may need to reflect this to allow it to happen more fully. For example, currently only those people convicted of a criminal offence can be subject to Multi-Agency Public Protection

Arrangements (MAPPA) even though some people well known to mental health services, but not having been convicted of an offence, may also benefit from such arrangements. Usually, agencies get around this by holding “informal MAPPAs” and it may be sensible to make these arrangements subject to proper scrutiny and safeguards.”

This is currently already available in the form of Potentially Dangerous Persons (PDP) meetings, which often take place immediately after MAPPA panels have met. The Association of Chief Police Officers (ACPO) defines a ‘Potentially Dangerous Person’ (PDP) as:

“A person who has not been convicted of, or cautioned for, any offence placing them in one of the three MAPPA Categories, but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm” (ACPO 2007).

The MAPPA Guidance notes that:

“MAPPA legislation does not provide the lawful authority for exchanging information on non-MAPPA persons. However, many police forces have taken steps to agree local protocols with partner agencies for providing risk assessment and management of these individuals outside of MAPPA” (NOMS 2009, p. 40).

The guidance cautions that “the branding of someone as a PDP does not itself reduce the risks of offending” and reminds practitioners that the Human Rights Act 1998 and the Data Protection Act 1998 must be applicable to any information sharing at a PDP meeting (NOMS 2009, p. 41).

Further work is required to assess the benefits of PDP provisions. However, there are a number of ethical concerns that arise from the use of such non-statutory preventive risk-management measures, and these should be carefully weighed against any perceived benefits to public protection.

Anti-Social Behaviour Orders

Anti-Social Behaviour Orders (ASBOs) were implemented in April 1999 as part of the Crime and Disorder Act 1998, aimed at targeting behaviour that “caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as himself”.

Originally, ASBOs were intended to be used as part of housing legislation to help social housing landlords evict ‘problem families’, but ASBOs have made their name in behaviour prevention. ASBOs are issued under civil law, and are designed to pre-empt activity that may in the future lead to further ‘harassment, alarm or distress’ but that is not itself ‘criminal’.

The powers conferred by an ASBO and their consequences are significant. They are normally issued by a magistrate’s court and must last for at least 2 years with no requirement for a maximum length. Under civil law, hearsay evidence is permitted in court, but the activity in question must be proven to criminal burden of proof. The broad definition of anti-social behaviour (ASB) has meant ASBOs are used in response to a range of problems such as speeding traffic, loud music, ‘marauding youths’, fly-tipping and graffiti.

Breach of an ASBO, however, is an offence under criminal law, and can result in a sentence of up to five years in prison. When ASBOs were introduced in 1998, the Government expected that 5,000 would be issued each year (Straw 1998).

When initial uptake by the courts was slower than expected (only 1,017 ASBOs had been issued by the end of 2002), further legislation (including the 2002 Police Reform Act, the 2003 Anti-Social Behaviour Act, the Criminal Justice Act 2003, the Serious Organised Crime and Police Act 2005, and the Drugs Act 2005) was passed to facilitate the application of ASBOs to a wider range of circumstances.

- Use of ASBOs reached a peak in 2005, when 4,122 were issued;
- 14,972 ASBOs had been issued by the end of 2007, half of which had been breached;
- 13% of ASBOs had been issued to women (2,012);
- 40% to children aged 10–17 (6,028);
- 7,981 people had breached their order by the end of 2007, 53% of all ASBOs issued;
- 4,228 people received a custodial sentence for breach of their ASBO (28% of the total). Some of these people were sentenced to custody for breach of ASBOs alone. In other cases, they were convicted for other offences at the same time;
- 1,142 children received a custodial sentence for breach of their ASBO, and 44 children were given a sentence of more than 12 months in custody.

(NB data about the use of ASBOs are not available beyond the end of 2007; see <http://www.crimereduction.homeoffice.gov.uk/asbos/asbos2.htm>).

Guidelines for sentencers and practitioners have repeatedly stated that careful consideration should be given to issuing an ASBO if the individual has a mental health problem.

The Sentencing Guidelines Council, which provides advice and delivers guidelines for magistrates and judges on sentencing practices, has noted that:

“Some factors may indicate that an offender’s culpability is unusually low, or that the harm caused by an offence is less than usually serious ... Factors indicating significantly lower culpability [include] ... Mental illness or disability, ...youth or age, where it affects the responsibility of the individual defendant” (Sentencing Guidelines Council 2004, p. 7).

The Justices’ Clerks’ Society has stated that:

“The court should be cautious when considering applications that relate to offenders with defined medical/mental problems that give rise to the anti-social behaviour” (Justices’ Clerks’ Society 2006, s. 4.4h).

A Home Office guide to ASBOs states that “If there is any evidence to suggest that the person against whom the order is being sought may be suffering from drug, alcohol or mental health problems or an autistic spectrum disorder, the necessary support should be provided by social services or other support agencies. Such support should run parallel with the collection of evidence and application for an order, where an application for an order is deemed necessary. This ensures that the court can balance the needs of the community with the needs of any alleged perpetrator” (Home Office 2006b, p. 21).

Despite these guidelines, a Home Office review of ASBOs found that for 60% of those issued an ASBO there was a mitigating factor such as mental distress, addiction or learning difficulties (Home Office 2002). This would equate to nearly 9,000 of the people who had received ASBOs by the end of 2007 (Sainsbury Centre 2007).

In early 2007, a British Institute for Brain Injured Children (BIBIC) report stated that over 30% of young people who receive ASBOs have a diagnosed mental health disorder or learning disability. The report went on to describe how ASBOs were frequently issued without any assessment for mental health

problems or learning difficulties, and wide prevalence of case by case variation in the weight attached to mental health problems as a mitigating factor (BIBIC 2007). This would mean that around 1,800 children with mental health disorders or learning disabilities had received ASBOs by 2007.

A number of experts were concerned about the use ASBOs on people with mental health problems, and argued that ASBOs are a clear example of convergence.

“Although an amalgam of civil and criminal law, the powers of an ASBO and the consequences of breach are considerable. There is now evidence of their use in attempts to control or manage, for example para-suicidal behaviour. Practice evidence from colleagues at the Elmore Anti Social Behaviour Service indicates that many of their clients who receive ASBOs have been diagnosed with mental health problems which have led directly or indirectly to their anti social behaviour. A resultant ASBO breach can draw people further into the criminal justice system. We are concerned by the conflation of responses to mental distress and behaviour and would see this as a concerning aspect of convergence.”

“The use of anti-social behaviour orders, whose breach can and does lead to criminal sanctions, also brings into criminal justice a disproportionate number of those with mental health and learning difficulties.”



12

Examples of non-convergence

While this report has so far highlighted many examples of convergence, there are also many instances where convergence has not occurred. These examples of ‘non-convergence’, as highlighted by the experts, are presented here.

‘Silo-working’

A number of experts gave detailed accounts of a lack of joined-up working between health and criminal justice professionals, and a tendency for agencies to work in ‘silos’.

One expert noted that this was still the norm in prisons, and that the lack of joined-up working and poor continuity of care became particularly apparent when a prisoner was released:

“Despite the increased range and scope of services within our prisons, there remains a siloed approach ... The resultant hiatus can be aggravated by the lack of join up between community and prison services. A striking example of this is the current failure to provide resettlement support or offender management supervision to those serving less than one year in prison despite the demonstrable need and high re-offending rates amongst this cohort.”

Inconsistent application of national policy and legislation

Several experts noted that, while there has been a considerable amount of national policy, legislation and guidance related to offender health, there has been inconsistent and often patchy local application, which has led to variation and disparity in services where “current legislation is inconsistently applied and open to manipulation”.

One expert noted that this is not just an adult-services problem, but was equally the case with young people’s criminal justice and health services:

“On a local level [policy] documents have been translated and interpreted according to local governing strategy, which means that delivery is patchy and historically there has been a lack of understanding around the assessment and treatment of young people who offend and who should take responsibility.”

Divergent professional attitudes

A number of experts reflected that convergence of policy and practice has gone some way to change attitudes within services, both in terms of professionals' understanding of their own responsibilities and increasing their appreciation of the jobs that others have to do. In one expert's opinion, however, a lack of national prescription based on 'what works' evidence has led to inconsistent approaches at a local level:

"Currently there seems to be little evidence to suggest what works with this group [offenders with mental health problems] and how health can make a valuable contribution. This has resulted in a generalisation in services and no scope, guidance or quality on service models that could be potentially transferred nationally ... Often the language and cultures of differing organisations get in the way of developing [person] centered services. To date, policy has not assisted in changing attitudes or culture; this change transformation can only come from partnership from the top down."

Pressure on services to prioritise security and risk

Many experts highlighted the increasing pressure on services to be risk-averse and security focused, often at the expense of best clinical care and treatment, as an example of where convergence was not happening, or happening in favour of the criminal justice system.

One noted that the two systems have very different goals and emphases, that convergence was a cause of increased risk aversion in clinical practice, as mental health services become increasingly aligned to the needs and practices of criminal justice agencies, pressured by political and populist influences, and that this means that convergence has been more limited than it might have been.

Another noted that the application of the National Service Framework for Mental Health has been hampered in prisons by security needs:

"The main impediment remaining to the delivery of the NSF in this setting is the need the prison service has to give the highest priority to the security of the prisoner. I find this understandable and I suspect this is a position that a majority of the population would support. Nevertheless it was a real or frequently offered reason for slow or no progress. However, the practical issues arising from this, and the effect on the ability to deliver the best of new models of care in the CJ system, are well recognised."

Gaps in provision

One of the most common comments was that there are many gaps between health, social care and criminal justice agencies in the provision of services to offenders with complex needs. The default position is for an offender to have a mixture of complex problems. Many of these needs, however, are 'sub-threshold' to get access to services, where a drug or mental health problem is not quite serious enough to qualify for support from mainstream services. Nevertheless, as a package, this mixture makes the offender a very disabled individual whose needs are often missed by services (Durcan 2008).

Experts noted that gaps in provision occur throughout the criminal justice pathway, from police to courts to prison to resettlement. This frequently has the result of creating a ‘revolving door’ scenario, where the cycle of offending and release remains unbroken by services.

One noted that the shortfalls found in prison services are likely to be in part due to the current weakness of interventions before and after custody:

“There were too many gaps in provision and too much unmet and sometimes unrecognised need in prisons. The need will always remain greater than the capacity, unless mental health and community services outside prison are improved and people are appropriately directed to them: before, instead of, and after custody.”

Inadequate services for dual diagnosis

One of the most common problems faced by offenders is a dual diagnosis (or co-morbidity) of mental health problems and drug or alcohol addiction.

A number of experts noted the difficulty offenders with dual diagnosis of this kind have in accessing appropriate services, and how there is “inadequate recognition of the ‘dual diagnosis’ of many offenders with mental health problems”.

One noted that this was particularly apparent in prisons:

“Gaps remain in addressing both primary mental health care and multiplicity of need within the prison context. Despite the increased range and scope of services within our prisons, there remains a siloed approach. Services for those with a dual diagnosis and complex or multiple needs remain a vexed issue from both a commissioning and service delivery perspective.”

Another noted that often, in cases of dual diagnosis, mental health problems are overlooked because of the apparently more pressing drug problem and that “mental health problems are both obscured by and exacerbated by drug-taking”.

The Government, in response to concerns expressed by Lord Bradley in relation to dual diagnosis, promised that:

“We will identify a model for the management of offenders with a dual diagnosis, to inform how dual diagnosis issues may be best addressed and fit within the court process, by September 2010” (HM Government 2009a, p. 39).

Limited mental health awareness among police

A lack of mental health awareness training for police and a “lack of effective liaison between police and mental health staff” were identified as two current areas of non-convergence:

“Two of the key problems for officers have to be the limited training received to enable and equip them to identify a mental health issue as well as the lack of availability of mental health specialists on a 24–7 basis.”

Patchy resettlement planning and support

Resettlement services that attempt to reintegrate offenders back into the community, to reduce re-offending, and ensure continuity of care, are often under-resourced and have limited success (Sainsbury Centre 2008d).

One expert was especially concerned with resettlement support for prisoners who are moved to 'Approved Premises' as part of their licence conditions, noting that there is:

“Poor planning on release from prison [where] prisoners are being moved into Approved Premises on release, often without a full medical history going with them. Therefore, the Probation services managing this are not aware of their full needs or risks. GPs, who are responsible for these Hostels, are sometimes having to ask patients what medication they are on ... [There is] risk associated with not having full history on release, and also issues about access to services for people living in Approved Premises as [there is currently] no clarity on Responsible Commissioner.”

Another stated that mental ill health will always be commonplace in prisons:

“Prisons can provide better and more focused care for those who need to be there; but they will only do so effectively if there is ... effective community support for those who leave prison. Unless those gaps are filled, mentally ill people will continue to fall through them, and into our overcrowded, increasingly pressurised prisons. This illustrates the lack of a joined-up approach to this issue by the services and departments between which those with mental illness will bounce, or else fall through.”

One noted that there has been a lot of focus on prison-based services, but that more needs to be done to achieve good resettlement:

“The focus [of services] has rightly been on prisons, but it is my judgement that there is more to do in relation to resettlement and community provision for offenders with mental health problems.”

Lord Bradley placed great emphasis on the importance of resettlement, particularly for those who do not receive any form of Probation supervision, recommending that:

“The National Offender Management Service, in partnership with the Department of Health and the NHS, should develop a national strategy for rehabilitation services for those leaving prison with mental health problems or learning disabilities who are not subject to supervision from the Probation Service” (Bradley 2009, p. 113).

The Government noted in reply that:

“Working with NOMS, we will scope and develop a model rehabilitation service for individuals with mental health or learning disability problems who are not subject to supervision from probation on release. The initial report is to be completed by July 2010” (HM Government 2009a, pp. 41–42).

Delays within and between the systems

Several experts reflected that there are many delays in the system that reduce efficiency in the criminal justice and health systems and highlight a lack of convergence.

Some focused on the delays in obtaining psychiatric court reports for offenders to inform sentencing, which is “leading to offenders with mental health problems being detained for unnecessarily long periods in custody on remand”.

Lord Bradley recognised this problem, and recommended that:

“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”; and

“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” (Bradley 2009, p. 73).

The Government accepted this was a problem and set as a key deliverable the aim to:

“Reduce the current delay in producing court psychiatric reports by supporting implementation of service level agreements between PCTs and HM Courts service for the provision of court psychiatric reports. We will devise a national template and issue guidance by April 2010, supporting delivery throughout 2011” (HM Government 2009a, pp 38–39).

Another delay highlighted was the long waits that prisoners with severe mental illness often face before they can be transferred out of prison to a secure forensic mental health hospital. Lord Bradley found a number of barriers causing this delay:

- Communication breakdowns within and between prisons and hospitals;
- Difficulties in obtaining the required paperwork held within different departments across the criminal justice system;
- Lack of administrative support in prisons;
- Lack of bed availability and, on closer inspection, lack of through-care/step-down facilities to provide fluidity and movement between different levels of security;
- Problems establishing responsible PCT commissioners and getting PCTs to accept responsibility for payment for prisoners’ treatment;
- Disputes over the level of security required for the prisoner; and
- Different attitudes and perceptions of prison and hospital staff towards mental illness and offenders (Bradley 2009, p. 105).

The Government previously attempted to reduce transfer waiting times to no more than 14 days in two pilot studies conducted in 2007. These had mixed success, but Lord Bradley recommended that:

“The Department of Health should develop a new minimum target for the NHS of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate health care setting” (Bradley 2009, p. 106).

The Government responded that:

“We will improve transfers between prison and appropriate NHS facilities. We aim to achieve a 14-day standard for the transfer of mentally ill prisoners under Sections 47 and 48 of the Mental Health Act

1983. We know that this standard has been met in many areas of the country and we believe that through focused activity it should be achievable everywhere. We will work with NOMS, government agencies and the NHS to identify by April 2010 the structural, procedural and service changes required to underpin delivery, with a phased implementation thereafter” (HM Government 2009a, p. 41).

One expert suggested that the overarching reason for these problems is that the pathways offenders take through the criminal justice system are not sufficiently related to their needs:

“An individual’s pathway through the system does not appear to be related to need, or the appropriateness of a particular intervention at a particular time, but rather to chance, geography, or the point at which they come into contact with either therapeutic or criminal justice systems.”

Commissioning

Strategic commissioning of offender mental health services is vitally important to ensure that effective services are provided to offenders with complex needs. Most experts identified commissioning as essential to the process, but many noted that joint commissioning between health, social care and criminal justice agencies is generally poor, despite a number of good practice examples locally.

One expert noted that many of the current shortfalls in provision are not related to a lack of law or policy and that:

“Current legislative powers are, in general, sufficient to support the effective diversion of offenders with mental health problems. [Rather, the] current difficulties reflect issues of practice and commissioning.”

Lord Bradley made a key recommendation related to commissioning:

“Primary care trusts (PCTs) and partners should jointly plan services for offenders to ensure effective commissioning and delivery of services” (Bradley 2009, p. 146).

In its National Delivery Plan, the Government placed great importance on commissioning to improve services across the offender pathway:

“Effective commissioning will be the key driver to achieving the necessary changes. This will rely on the approach set out in World Class Commissioning (WCC) ... This plan can only be delivered through effective partnerships between health and criminal justice commissioners. The police, DOMS and Probation trusts (as the key regional and local commissioners for offenders) will have a particularly important role. World Class Commissioning provides the context in which offender health commissioning must be developed and the associated competencies are critical to success. In particular, partners will need to focus on:

- Improved local leadership in all the partnership agencies, building where appropriate on lead commissioning arrangements in the NHS;
- Improved services – outcomes to match those achieved in the wider community;
- Improved information – for continuity of care and performance management; and
- Partnership working and commissioning – to drive forward improvement, effectiveness and productivity” (HM Government 2009a, pp. 26–7).



13

The future of convergence

Expert opinion was divided on the question of whether convergence will occur increasingly over the forthcoming decade. The majority, however, believed that more convergence would be seen.

Some experts believed that convergence would increase but stated that it was likely to occur ‘very slowly’ due to ‘a lack of resources’.

One expert noted that the recent attention on this area generated by the Bradley Report and the resultant government National Delivery Plan would see an increase of convergence, and another that:

“Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice systems adds further to weight to this view. If implemented the Bradley recommendations would create major momentum for greater convergence between the criminal justice and mental health systems.”

Another was encouraged by the Government’s response to the Bradley Report:

“The Government has accepted the Bradley Report recommendations, and I am cautiously hopeful that the next ten years will see an increase in the rate and value of convergence.”

Several experts believed that the reference to offenders in the New Horizons strategy, which succeeds the National Service Framework for Mental Health, “should have a profound impact”.

One expert stated that future convergence would be dependent on the approach of the government of the day:

“Significant work has been done in converging mental health and criminal justice in the last few years ... However, as to whether there will be greater convergence over the next 10 years we believe depends on the government at that time’s strategy for health and criminal justice.”

Another disagreed, stating that if convergence were to increase “it will be incremental rather than a sudden step change, and not by political or policy design”.

One expert believed that future convergence would be largely dependent on the advancing development of CJLD services, and another stated that “there will need to be a redefining of what the role of mental health services is within the criminal justice system”.

Two experts believed that pressure on prison and hospital places will drive convergence forward by necessity:

“It is likely that the inability of prisons to cope with prisoners in crisis will add to the pressure.”

“The drivers of reducing incarceration rates, prisoner numbers and improving mental health standards must surely result in a more effective response from the criminal justice system in diverting and more humanely managing offenders with mental health, learning difficulties, and addiction problems.”

One expert gave a more optimistic reason for a future increase in convergence:

“Criminal justice and health care systems can work together to commission and deliver high quality services ... Convergence is and will continue to be a positive element of policy and service development. It will bring with it the need to establish and maintain a skilled and capable workforce, both in terms of commissioning and provision. It will require an improved cultural understanding on both sides and will need policy makers to set out a clear framework that emphasises the imperatives to successful convergence over the coming decade.

“Further convergence is necessary and in my view, inevitable. Every policy and guideline suggests that inter agency working will be promoted and expected. Only by creating convergence and clear linkage at a policy, legislative and service delivery, can further improvements be made in breaking down barriers, streamlining pathways and promoting engagement.”

While most of the experts predicted that convergence would increase in the future, a minority of experts took the opposite view. Most attributed their view (that convergence would not occur increasingly) to a lack of resources in the public sector, which they perceived as the key to further convergence:

“The overcrowding in prisons and the Bradley review has re-kindled interest that was around in the early 1990s. However, without proper resourcing and clear governance arrangements similar to those guiding prison health care, it is likely that PCTs will still view services to defendants going through criminal justice agencies as low priority.”

Similarly:

“Mental Health costs fall to PCTs – for some PCTs this group is seen as a low priority for investment.”

“Budgetary pressures, which are inevitable in the next few years, will stifle or defer innovation and collaborative working as all agencies limit their provision to the highest priority areas.”

Another stated that:

“[A] brake [to an increase of convergence] will be in resources. Many of the developments have been backed by significant injections of resource. The area of forensic mental illness and poor mental wellbeing amongst deprived communities remains one of substantial unmet health need, and any constraint on resource in this area may harm progress towards convergence.”

Professional attitudes were identified as another reason why convergence may not increase in the future:

“There is an attitudinal culture in mental health services that is not conducive to convergence. Often health service staff view offenders as ‘knife wielding maniacs’ ... [while] some also see the criminal justice system as making inappropriate demands on them, [for example] not seeing court appearances as of relevance to their treatment of a patient.”

It was also stated that the criminal justice system’s ambition for ‘simple, speedy, summary justice’ is contrary to the needs of health services and offenders with mental health problems. Competing requirements on professionals can discourage joint working and reduce convergence:

“Each criminal justice agency has its own targets or restrictions that impact on convergence. Courts and police are increasingly being encouraged to carry out ‘speedy justice’, avoiding adjournments and lengthy delays so want mental health assessments on the day, yet the defence lawyers do not get paid for ‘waiting time’ under the legal aid rules, so [they] often want the case adjourned. Probation cannot carry out Fast Delivery Reports if there is a question around mental health and therefore may not meet

their targets without a quick mental health assessment. All have different needs and demands that do not necessarily encourage partnership working with mental health service providers who have their own targets and limited resources.”

Similarly, another expert noted that agencies often have different and sometimes conflicting protocols in relation to offenders with mental health problems:

“There will always be tensions between the accountabilities of people in differing sectors, whether it is their role within a management structure, or their role as autonomous professionals within self-regulating groups, each with their codes of practice and confidentiality, etc. Matters of governance need to be reconciled in an environment of mutual respect, but also, perhaps, creative tension. We have much more to understand about emerging and modern governance, and how it may come to play a larger part, hopefully a supportive and facilitatory part, in improved convergence between mental health and criminal justice.”

Linked to this point, another expert noted that increased concern about information sharing may also hamper convergence:

“There have been times when health services can paralyse themselves through confidentiality protocols, not necessarily looking at what might be best for the patient.”

Several experts noted that many services are currently positioned with a greater emphasis on security and risk management, than on care and treatment:

“The need to control and manage risk on a micro and macro level is an issue for governments and strong governments are less likely to listen to more libertarian points of view.”

Another expert was pessimistic about future convergence:

“It is likely that political factors will combine with economic ones to preserve and reinforce the current convergence of criminal justice and mental health with an emphasis on public protection rather than individual need.”



The benefits of convergence

This report has highlighted a large number of examples of convergence between mental health and criminal justice legislation, policy, systems and practice. Several examples of non-convergence have also been identified, and experts are divided as to whether convergence will increase in the next decade.

In chapters fourteen and fifteen, the benefits of, and concerns about, convergence are considered, to inform policy-makers and practitioners about where convergence can be useful and where caution is required. These are drawn in part from a meeting held at the end of 2009 with a small group of national experts who were brought together to consider the implications of convergence.

Multi-agency working

Convergence has significantly increased multi-agency provision of services for offenders with mental health problems, and substantially raised levels of understanding across disciplines.

Joint commissioning

'Co-operative convergence' has seen the green shoots of 'World Class Commissioning' between criminal justice and health agencies. This should improve services, increase accountability and involvement, and reduce 'silo working'.

Joint needs assessments

Convergence has highlighted the importance of local agencies conducting Joint Strategic Needs Assessments that include offenders and pay specific attention to the health and social care needs of this group.

Prison in-reach services

Convergence has resulted in an improvement to mental health treatment and care in prison through the introduction of in-reach services. Although under-resourced, these services have driven up standards in prisons and, in some cases, they now provide high-quality mental health care.

Criminal Justice Liaison and Diversion services

Substantial benefits could be gained if a national network of criminal justice liaison and diversion services were fully implemented. It is very encouraging that this was the central recommendation in Lord Bradley's report, and that the Government has now set a five year timetable for full implementation. Current best practice examples from the limited provision available have shown that these teams would go a long way to ensuring comprehensive diversion nationally, and to delivering consistency of treatment and equivalence at all stages of the criminal justice system.

Police involvement

Engaging the police with health services, so that they can become partners in diversion and early intervention, would be of great benefit to both individuals and services. Bradley's recommendation and the Government's delivery plan state that police-based health services should be commissioned by the NHS. This would be a major step and could substantially improve services.

Changing attitudes

As services develop in this way, attitudes may shift for the better, and offenders with mental health problems may be brought into the mainstream as a priority group. Convergence has also brought a recognition that personality disorder is an important diagnosis and should not be one 'of exclusion' from mainstream services.

Workforce improvements

While some blurring of responsibility is inevitable, convergence is creating a stronger, more skilled, better trained workforce in the field of criminal justice and mental health.

Information sharing

Information-sharing is improving between health and criminal justice agencies, and there are now effective models (like MAPPA) for sharing information in partnership to the benefit of both the individual and society.

Measuring what works

Convergence is leading to the first collections of minimum data sets, which with time will aid research and create a strong evidence base for mental health interventions with offenders.

More flexible sentencing

The introduction of community sentences with mental health treatment requirements enables robust diversion under probation supervision, and shared ownership of offenders with mental health problems. Although not often used, the Mental Health Treatment Requirement of community sentences may prove to be a vital tool. In addition, the Hospital and Limitation Direction, if used appropriately and without an avalanche effect, may provide judges with an alternative to the dilemma of treatment or custody by allowing them to order both options.

Cross-governmental working

Convergence is evidenced in the creation of a cross-government, multi-department National Delivery Plan to implement the Bradley Report. This is the most substantial and significant example of policy convergence in twenty years. The newly established National Programme Board brings together (among others) director general level Health, Justice and Home Office policy-makers, which should act as a major driving force from central government in improving services. The Board should also be seen as a high-profile leadership example for regional and local replication.

Linking offenders to broader health reform

Convergence does not just bring mental health to criminal justice agendas, but also brings offenders into mainstream health reforms. Convergence is seen in the inclusion of offenders in critical health policy developments such as the CPA guidance, the Darzi Report and New Horizons. This will ensure that offenders are very much part of the discussions and reforms around the patient-centred approach, now starting to be delivered in mainstream health services.



15

Concerns about convergence

In this chapter we consider the concerns about convergence. These are drawn in part from a meeting held at the end of 2009 with a small group of national experts.

Constructing ‘prison hospitals’

It is vital that the lines between prisons and hospitals do not become overly blurred – prisons should never become a substitute for hospitals, and hospitals should not be designed to be like prisons. There are fundamental differences between the two, and it is untherapeutic and counter-productive to combine long-term psychiatric care with penal custody. The rise of forensic medium secure services is a sign of this, and efforts should be made to curb its exponential expansion.

Widening the use of preventive detention

Criminal sanctions and punitive interventions that are based on risk profiling rather than on actual events are dangerous therapeutically, ethically and financially. IPP sentences and the DSPD programme are two examples of risk-based interventions with a dramatic impact on offenders with mental health problems. And while each is having minimal success in terms of demonstrating reduced re-offending or health improvement, both are costing a great deal in public money.

Increasing stigma

There is a danger that convergence will increase stigma for offenders with mental health problems, who may receive a dual labelling of ‘criminal’ and ‘mentally ill’. It is essential that services, such as mental health courts, are acutely aware of this, as it may have a massive impact on resettlement and reintegration into society.

Cementing a punitive discourse

Convergence may lead to an increase in the current punitive consensus dominating the criminal justice political discourse – ‘popular punitivism’. In this environment, offenders with mental health problems may suffer under the current associations between mental illness and dangerousness.

Establishing competing aims and objectives between professionals

It is inevitable that criminal justice and health agencies have different aims and objectives, but there is a risk that these will, on occasion, clash or compete, to the detriment of service users. For this reason, it is important to recognise that convergence can never be total, and that there will always be a mixture of values, purposes and lines of accountability for services aimed at offenders with mental health problems.

Pitching Health vs. Justice

It is important that this is a healthy balance, and that one side does not dominate the other. At present, and in recent years, there is a danger that health services who aim to deliver treatment and care are bullied or subordinated by justice agencies with a mandate to punish and risk-manage. It is also vital that mental health problems are not criminalised as a result of health and criminal justice professionals adopting converged agendas, and that the criminal justice system should not be seen as a means to manage people with a mental illness.

De-professionalising workforces

There is a risk that convergence may de-professionalise workforces and that practitioner roles will become increasingly blurred. It is important that health and criminal justice staff retain their individual identities, and in particular that clinical and ethical principles are not eroded by the risk aversion. This should not be an inevitable consequence of multi-agency working and shared understanding.

Impact on BME groups

It is widely recognised that Black and Minority Ethnic (BME) groups are over-represented in both the criminal justice system and the secure forensic mental health services. It is critical that this is recognised, and that convergence does not lead to further increases in this problem, but that it is a means to seek rebalancing of representation through better joint and strategic commissioning and service planning for BME groups.



Final remarks

It is clear from the evidence in this report that convergence between mental health and criminal justice (policy, legislation, systems and practice) has occurred significantly in the last twenty years, and that the Bradley Report and the Government's National Delivery Plan are likely to lead to some further convergence in the future. There have been a number of improvements to services and benefits for offenders with mental health problems as a result of convergence. There are also examples where convergence has not occurred, where a number of major improvements can still be made.

There have also been positive and negative implications to convergence. The latter have most prominently been seen when the fundamental differences between the objectives of health and criminal justice agencies are brought to the fore. These differences will undoubtedly remain, but convergence may offer some answers in how to bridge this divide, to share best practice, to replicate what works, to commission strategically, to work across agencies and professions, to strengthen workforces, to spend effectively, to enhance skills and, fundamentally, to improve services.

Ultimately, if managed correctly and with the necessary ethical checks and balances in place and correctly observed, convergence can be a process that raises the standards of mental health services for offenders to the level that our post-Bradley expectations now demand.



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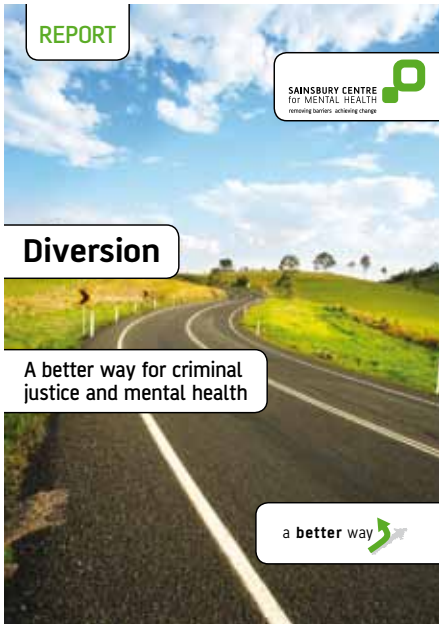
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