



# Provision of mental health services to individuals passing through the criminal justice system: A qualitative literature review

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## Abbreviations

ACT	Assertive Community Treatment
AR	Arrest-Referral
ASW	Approved Social Worker
BME	Black and Minority Ethnic
BJA	British Justice Association
CJS	Criminal Justice System
CMHT(s)	Community Mental Health Team(s)
CJLT(s)	Criminal Justice Mental Health Liaison Team(s)
COAG	Council of Australian Governments
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CPI	Centre for Public Innovation
CPS	Crown Prosecution Service
CSIP	Care Services Improvement Partnership
DAT	Drug Action Team
DOH	Department of Health
DTTO	Drug Treatment and Testing Order
CARAT	Counselling, Advice, Referral, Assessment and Throughcare
ECC	Effective Care Co-ordination
HMIP	Her Majesty's Inspectorate of Probation
HMP	Her Majesty's Prison
H-RAMM	Health Risk Assessment and Management Meeting
IPCC	Independent Police Complaints Commission
MAPPA	Multi-Agency Public Protection Arrangements
MAPPP	Multi-Agency Public Protection Panel
MENDOS	Mentally Disordered Offenders Scheme
MDO(s)	Mentally Disordered Offender(s)
MH NSF	Mental Health National Service Framework
MHEP-AC	Mental Health Effective Practice Audit Checklist
MHEP-ACE	Mental Health Effective Practice Audit Checklist Enhanced
MHEP-ACS	Mental Health Effective Practice Audit Checklist Standard
MHT	Mental Health Trust
MPA	Metropolitan Police Authority
NACRO	National Association for the Care and Resettlement of Offenders
NHS	National Health Service
NHT	National Health Trust
NIMHE	National Institute for Mental Health in England
NOMS	National Offender Management Service
NPS	National Probation Service
NSG	National Steering Group
NWW	New Ways of Working
OASYS	Offender Assessment System
OHCS	Offender Health Care Strategies
PCT(s)	Primary Care Trust(s)
PCG	Primary Care Group
RAPt	Rehabilitation for Addicted Prisoners Trust
RCP	Royal College of Psychiatrists
SIFA	Screening Interview for Adolescents

SLA	Service Level Agreement
SQIFA	Screening Questionnaire Interview for Adolescents
SWING	South West Integration
YJB	Youth Justice Board
YOT(s)	Youth Offender Team(s)

## Preamble

This literature review is commissioned by the Office for Criminal Justice Reform as part of the Home Office/Ministry of Justice examination of the way in which individuals with mental health needs are managed throughout the Criminal Justice System (CJS). This review has three primary aims.

1. To identify existing mental health services at different stages of the CJS.
2. To identify effective strategies for the delivery of mental health services in the CJS.
3. To provide recommendations for strengthening effective practice in the provision of mental health services in the CJS.

The review was undertaken in two stages. The first comprised a report on existing mental health services (see Winstone and Pakes, 2007) and, arising from this, a further report was commissioned to identify aspects of effective practice. The findings were peer reviewed and endorsed by two separate Professional Advisory Groups convened at the Home Office (Appendix 1). The findings from both reports appear here in a summarised form for publication

## Executive summary

This qualitative literature review supports the findings of the National Association for the Care and Resettlement of Offenders (NACRO, 2006) that provision of mental health support for individuals in contact with the CJS is notoriously difficult and, at present, patchy and piecemeal. These vulnerable individuals are disproportionately at risk of social exclusion and are likely to have multiple and complex needs, including mental health needs, but also needs in a variety of other areas (Social Exclusion Unit (SEU, 2002). Therefore, implementing practice that maximises the effectiveness of intended outcomes for criminal justice, health and social factors would clearly be of great benefit.

## Effective practice

A single bastion of best practice does not exist. However, areas can be identified which are examples of good practice, both in the UK and elsewhere. Areas of identified effective practice linked to process and structure are as follows.

- Process: (a) information sharing linked to protocols which are based on a shared philosophy and goals linked to multi-agency provision; (b) shared documentation with multi-agency partners; (c) inclusive referral and pro-active screening, assessment and diversion policy linked to training; (d) clear role descriptions and boundaries; and, (e) responsiveness to local needs and the local population profile.
- Structure: (a) effective leadership through the involvement of a Multi-agency Steering (or Project) Group which meets regularly; (b) protocols and training to support s136 MHA (1983) and other interagency arrangements; (c) liaison and diversion linked to secure funding arrangements and good information exchange protocols (or Service Level Agreements (SLAs); (d) adequate staffing and access to appropriate professionals and services; (e) periodic review of practice and multi-agency training to inform continuous professional development; (f) focus upon both direct outcomes, for example, reduction in frequency and seriousness of offending linked to better management of mental health needs, and indirect outcomes, for example, improvement in social exclusion factors, such as housing and community involvement; and, (g) pro-active involvement of Primary Care Trusts which appears to ensure that schemes have a higher likelihood of success and sustainability.

## Policy implications

There are substantial cost and outcome benefits to be gained from an effective mental health support scheme. Reducing prison numbers (including the length of time spent on remand) and the associated burden upon the prison service of providing services for offenders with mental health issues is clearly desirable. In addition, appropriate care will enhance personal well-being, produce positive health outcomes and will reduce re-offending as well as the well-known 'revolving door' syndrome. There is no doubt that effective schemes can achieve such

outcomes (James, Farnham, Moorey, Lloyd, Hill, Blizard and Barnes, 2002). However, the following points should be borne in mind which have implications for current delivery

- Few existing schemes are sustained over the long term; professional uncertainty as to the value, aims and outcomes of schemes is a significant contributory factor to poor sustainability. The short-term nature of existing schemes leads to: financially inefficient investment; fragmented schemes that often fail to deliver a local or nationally coherent and standardised service; a lack of evaluation and thus a poor evidence base for national guidelines on what works in reducing recidivism in this group of offenders.
- Funding difficulties, lack of trained staff, lack of resources such as hospital beds and hostel places, lack of continuity and clear lines of responsibility, appear to undermine many schemes and dishearten many dedicated professionals and volunteers working in this sector. Notwithstanding existing financial and resource constraints, through implementing more effective organisational and liaison structures there could be an improvement in dealing with complex needs.
- On the positive side, good practice does exist and is characterised by multi-agency provision with the following characteristics: (1) financial stability, (2) clear protocols for operation and information sharing, (3) effective leadership, (4) clear role definition, (5) shared philosophy and goals, (6) shared training, and (7) adequate staffing.
- Evidence also suggests that statutory provision may be enhanced by using the expertise and resources of voluntary and community providers. Where PCTs are pro-active, schemes appear to have a higher likelihood of success and sustainability. Consideration might usefully be given to awarding some form of quality 'kite mark' to schemes demonstrating effective arrangements (as with the formal accreditation of probation programme delivery).
- Schemes could benefit from being able to draw on nationally agreed guidelines for both strategic and operational activities. Such guidelines have been successful in establishing and sustaining Multi-Agency Public Protection Arrangements (MAPPA) arrangements. In addition, to facilitate effectiveness, it would be helpful if schemes harmonised what they are called. At present, the naming of schemes and arrangements (other than MAPPA) appears to be somewhat arbitrary and this makes for a very weak base for information sharing, comparison and evaluation.
- In terms of alternative strategies, there are some useful international comparisons that could be explored. The South Australian example of a 'travelling diversion court' may be feasible to consider for adapting for UK purposes and could provide a structured base upon which to develop a national initiative. The Wessex Consortium has shown how a trained mental health team in court can promote significant cost, time and management efficiencies. A similar model, in which Court Diversion was overseen by magistrates dealing solely with offenders with mental health issues, could ensure that intervention was structured and appropriate to complex needs, whilst sending a positive public message that the policy makers were addressing perceived deficiencies in the management of this group in the CJS.

- Criminal justice liaison and diversion schemes need a stronger identity. They need to advertise themselves locally and they need a visible presence both within criminal justice (particularly magistrates' courts and police stations) and within local health provision (PCTs, Community Mental Health). In addition, there needs to be an overarching national framework. Many schemes feel a sense of isolation; the establishment of a national network of schemes could prove valuable.
- On the basis of the literature and research evidence, it is recommended that the effective practice of schemes could be assessed by examining seven areas of practice: screening; assessment; facilitating access to mental health support; liaison; information sharing; multi-agency arrangements; and data collection and analysis.
- It is recommended that six best practice elements be assessed against each of the seven areas, these being: statement of purpose; policy; management; resourcing; practice; and continuous professional development.
- A Mental Health Effective Practice Audit Checklist Enhanced (MHEP-ACE) to assess the seven areas and associated elements has been devised and piloted to identify the strengths of current schemes and to detect those areas where schemes require additional support to ensure that they continue to be viable, sustainable and effective. A Mental Health Effective Practice Audit Checklist Standard (MHEP-ACS) based upon the MHEP-ACE has been developed for national implementation.

# 1. Introduction

Work with Mentally Disordered Offenders (MDOs) has historically suffered from a lack of prioritisation and funding with provision unevenly distributed and accessed. The very term 'MDO' has partly contributed to this. It implies that provision should focus upon those who have been sentenced under the Mental Health Act (1983/2007) rather than the 80% (Singleton, Meltzer and Gatward, 1998) of (imprisoned) offenders who have one or more clinically diagnosed mental health problems but who are sentenced under regular criminal justice provisions. The authors therefore, prefer to use NACRO's definition of MDOs because of its inclusiveness:

*“Those who come into contact with the Criminal Justice System because they have committed, or are suspected of committing, a criminal offence, and who may be acutely or chronically mentally ill....It also includes those in whom a degree of mental disturbance is recognised, even though that may not be severe enough to bring it within the criteria laid down by the Mental Health Act 1983.”*

(NACRO, 2006, p.2)

The working definition that has been devised for 'effective practice' is:

*“protocols and procedures which effectively facilitate the provision of mental health support between the various agencies involved in the management of offenders and within the Criminal Justice System and can lead to intended outcomes”.*

Providing care for those who pass through the CJS whilst suffering from mental health problems has proved difficult. These individuals tend to fall between services; their problems often go unnoticed and availability of services is inconsistent. They furthermore suffer from a high degree of social exclusion. The result is that their multiple and complex needs are insufficiently met. Their exclusion is exacerbated because of resourcing difficulties and weaknesses in multi-agency collaboration so that services regularly fail to take 'ownership' of these individuals.

This review will examine the literature available on the provision of care for these individuals that are referred to here as mentally disordered offenders. The authors firstly assess information exchange, which arguably is the glue that holds multi-agency provision together (NACRO, 2004). After that we examine Section 136 MHA that allows a police officer to remove a person seemingly suffering from a mental disorder from a public place to a place of safety. Crisis Intervention Teams operating in the US which deal with similar situations will also be explored.

Key to quality provision is early identification of mental health needs. Mental health screening and assessment in police stations but also in other parts of the CJS such as prisons will be reviewed. Just as important as screening and assessment is what happens next. The authors therefore look at diversion and liaison as ways of effectively addressing individuals' needs outside prison or outside criminal justice altogether. After that they evaluate difficulties in obtaining further assessments such as via court ordered psychiatric reports. Finally, they discuss collaborative and multi-agency arrangements. There is no doubt that individuals' needs, often complex and multifaceted, require a multi-agency approach. This goes well beyond the provision capability of MAPPAs which effectively capture the few dangerous individuals but do not apply to most individuals with mental health needs passing through the CJS. Multi-agency work is fraught with difficulties but there are some promising examples to consider.

This summary report is intended as a review and not a full evaluation; however, it demonstrates that effective practice in this area of meeting the mental health and complex needs of this vulnerable group is possible and does occur, but in a patchy and piecemeal fashion. In addition, there is method in what constitutes effective and sustainable provision and this report will highlight what the effective ingredients of best practice are.

## 2. Information sharing

### Introduction

The research evidence demonstrates that information sharing is critical to a range of activities that support the provision of services to individuals with mental health needs. Most notably, referral, assessment and all aspects of multi-agency work rely upon information sharing which is accurate, timely and serves the purpose for which it is intended (NACRO, 2004). Information exchange can serve as the glue that holds effective provision together.

Effective information exchange refers to the protocols and procedures which facilitate the flow of information between the various agencies. A weakness in information exchange (OCHS, 2005) appears to be at the point of an individual moving from one service or setting to another, for example between prison and the community.

There is no single 'right' way to facilitate information exchange; the literature abounds with ineffective examples. However, what is cited here are some examples of effective strategies where designated co-ordinators and/or agreed protocols support the task. Two main areas are identified: information exchange to facilitate risk management and public protection and information exchange to facilitate better provision and continuity for care purposes.

### Key findings: risk management and public protection

The schemes that offer the most promising information exchange strategies to promote risk management and public protection had the following features.

- Multi-agency teams with an integrated organisational structure, roles and a point of authority, linked to multi-agency training and secure stream of funding. Good examples include the Cornwall Peninsular Strategy and the Wolverhampton City PCT cross-agency community mental health service arrangements (OCHS, 2005).
- Regional projects and joint training. Good examples are the West Midlands region reducing re-offending regional action plan (2005/06) and the South West Integration (SWING) regional prison/probation resettlement project spanning 14 prisons and 5 probation areas (OCHS, 2005).
- Multi-agency teams which work holistically. Good examples are, firstly, the Holloway Resettlement Unit which demonstrates the ways in which a shared philosophical approach can strengthen multi-agency work and promote good information exchange across the prison/probation sector (CSIP, 2006) and, secondly, the National Health Service (NHS) Forensic Catchment Group Yorkshire, forensic services for women, which are delivered against a local strategy (NHS Forensic Catchment Group Yorkshire NHS-Strategy Document 2004-08; CSIP, 2006).

## Key findings: continuity of care and better care provision

Information exchange to promote continuity of care and better care provision relies in part upon the quality and timeliness of information passing between agencies. The schemes which offered the most promising information exchange strategies to promote risk management and public protection had the following features.

- Strategies to promote prompt sharing of discharge information, for example West Cheshire PCT who have a framework of information exchange based on cross-agency communication, agreed information exchange policies and processes for identifying offenders at the point of engagement (OCHS, 2005). Also, Bronzefield Prison Healthcare Department which has developed its own notification document. This discharge notification document is used for all women who are seen by primary care and accompanies women if they are transferred to another establishment and is also sent to their GP on release (OCHS, 2005).
- Multi-agency delivery with features of training, clear line management and role clarity to overcome traditional professional boundaries, for example, The Surgery, which was established in 2000 under the auspices of Exeter PCT to respond through a multi-agency delivery to the relatively high numbers of homeless people in the Exeter area, including delivery to those living in probation or drug hostels. Discharge information is faxed between Exeter Prison and The Surgery and the small geographical area has enabled good networking (OCHS, 2005). Also: the Offenders' Healthy Living Project with a cohesive multi-agency team, which crosses traditional boundaries, supported by clear information exchange processes and agreements (OCHS, 2005); New Hall Prison/Young Offender In-Reach Team led by a full time co-ordinator, and Send Prison Healthcare which promotes good partnership work and information exchange by developing services based on Needs Assessment Training for Staff (CSIP, 2006).
- Protocols (including SLAs) across agencies based on knowledge and understanding of the theoretical and organisational issues, for example, a joint protocol aimed at a specific area of need has been produced by Northumbria Probation Service. Known as the HARP Protocol, it is a framework to reduce homelessness amongst people returning from custody which lays out an accommodation 'pathway' for effective resettlement of ex-prisoners.

“The key to the effectiveness of the HARP protocol lies in clear communication, jointly understood risk assessment and trust between the agencies involved”  
(Allender, Brown, Bailey, Colombo, Poole and Saldana, 2006, p 6).

A further example is the new approach to local service delivery with 21 pilot local area SLAs established in March 2005 by Wolverhampton City PCT. These are intended to promote communication and access to partner agencies ([www.wolverhamptonhealth.nhs.uk](http://www.wolverhamptonhealth.nhs.uk)).

- Accurate assessment shared by Multi-Agency Groups. A good example is the Stockport Prison Resettlement Group (Stockport NHS PCT, 2006) which demonstrates how accurate assessment shared in a multi-agency arrangement can support the identification and meeting of complex needs.

## Barriers to effective information exchange

The **Offender Mental Health Care Pathway** (DOH 2005) sets out the existing mental health services available for adult offenders. Reviews of the effectiveness of this pathway (Department of Health (DOH) 2005; Winstone and Pakes, 2007) stated that at all points there were deficiencies in communication and information exchange to facilitate ongoing care both within the prison and post-release. Wing-based mental health liaison officers trained to identify mental health problems and to co-ordinate in-reach services would certainly appear to be a positive strategy, but the only current report on the effectiveness of this (HM Chief Inspector of Prisons, Manchester 2001) suggests that the role is overwhelmed by other difficulties in accessing mental health services for offenders in prison.

NACRO (2005) conducted a survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for MDOs. One hundred and forty-three contacts associated with court diversion work were made. Almost a quarter felt that mentally disordered offenders were a low priority for agencies in their area with 36% of schemes failing to have a policy on information sharing. Contributory factors were a lack of clarity in multi-agency arrangements as to which agency is responsible for the funding of provision, lack of leadership and a lack of clarity with regards to aims and ethos.

Even where promising strategies are being adopted there are barriers to success in the form of, for example, limited shared understanding of what constitutes 'confidentiality', limited engagement by participants who are key to the ongoing success of the scheme, limited resources and lack of pro-active involvement by PCTs. Whilst PCTs claim to have the most developed models of multi-disciplinary working, which includes information exchange to promote harm reduction and quality of care (Aitken and Tylee, 2001), very little evidence to support this assertion has been identified.

## Summary

There is evidence of pockets of local practice of excellence linked to good information exchange – these tend to be small scale, multi-agency, linked to training, have a coherent ethos, protocols and/or SLAs with clear resource and funding arrangements and are often identified with a particular level of interest and enthusiasm of key individuals. Across the literature it appears that whilst key individuals often provide the enthusiasm to initiate schemes, over the long term, multi-agency work is frequently undermined by a lack of commitment and conflict in professional roles and philosophy. When the resource stream is uncertain, lack of clarity in the ownership of funding responsibilities may also impede the effective communication which underpins access to care (OCHS, 2005).

For these reasons it is important to establish the good practice and good working relationships that make a scheme viable by putting a model into place at the outset which contains the strategies and structures which can be identified as sustaining team and multi-agency working over the long term.

The schemes which had the most success at sustaining information exchange strategies to promote continuity of assessment and care had features such as:

- being part of a regional project;
- multi-agency delivery with clear line management, a point of authority and role clarity to overcome traditional professional boundaries;
- multi-agency teams which work holistically;
- multi-agency training;
- multi-agency teams with an integrated organisational structure linked to a secure stream of funding;
- accurate assessment shared by a Multi-Agency Group with a recognition of the complexity of the needs provision;
- processes for identifying offenders and previous links with other agencies at the point of engagement;
- protocols (including SLA's) across agencies based on knowledge and understanding of the theoretical and organisational issues, including a shared understanding of the legal and practice issues around confidentiality;
- strategies to promote prompt sharing of discharge information including:
  - cross agency communication;
  - agreed information exchange policies.

## 3 Crisis intervention and section 136 MHA1983

### Introduction

Section 136 MHA 1983 reads as follows.

a) If a constable finds in a place to which the public have access a person who appears to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of others person, remove that person to a place of safety [...].

b) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approval social worker and of making any necessary arrangements for his treatment or care.

Section 136 MHA 1983 (as amended by section 44 MHA 2007) is an important tool as it avoids utilising powers of arrest. Essential for the effectiveness of section 136 is good working relationships between police and local health, probation and social services (Stone, 2003, p6).

### Key findings: current practice in implementing s136 (MHA)

The arrangements to support s136 (MHA) can be formalised via agreed protocols and it is claimed (Wall, Churchill and Hotopf, 1999), that in London, where s136 is most frequently used, this usually is the case. London arrangements regarding s136 have recently been jointly reviewed by the Metropolitan Police Authority (MPA) and NHS (MPA, 2005).

The MPA joint review is unequivocal and it states: “Despite the existence of protocols, current arrangements are not working effectively, many boroughs do not have formal agreements and those that are in place do not work well. The project board agrees that the use of police cells in these situations is wholly inappropriate, but also recognises that there are drawbacks to the other options currently available” (MPA, 2005, p7).

Places of safety are often locally determined within a designated acute mental health unit, or specific units within acute hospitals. The MPA review suggests that mental health units with designated s136 rooms would appear to be the most appropriate accommodation. However, there is limited availability in London. Users reported to the MPA that while they were often better than police cells, they were often poor environments to spend considerable amounts of time in.

A report by the Royal College of Psychiatrists working group (RCP, 1997) defined standards in three areas: the physical facilities which constitute a place of safety; staffing in the place of safety; and policy in relation to the use of the place of safety.

As a result of considering these standards and applying them to all the available locations, a local decision should normally be made to designate a preferred place of safety, to which most people detained under s136 will be taken. An alternative place of safety should be nominated for those whose behaviour makes them unsuitable for the preferred place of safety. The preferred place of safety would not usually be an Accident and Emergency (A&E) department or a local police station, but a specialised assessment unit closely linked to, or at least very accessible to, a psychiatric facility.

## Protocols

In investigating this issue, the MPA looked for examples of good practice, such as the emergency assessment unit at Chase Farm Hospital in Enfield; however, these are not widespread, and have required considerable investment. The Chase Farm Hospital is the designated place of safety. A comprehensive operational protocol has been put together jointly by the London Boroughs of Barnet, Enfield and Haringey, the Barnet, Enfield and Haringey Mental Health NHS Trust, the London Ambulance Service and the Metropolitan Police. Its level of detail and the explicitness of the responsibilities of the various actors and agencies involved do make this an example that might deserve wider following.

Despite the existence of protocols as described above, the Independent Police Complaints Commission (IPCC, 2006a, 2006b) recognises the wide diversity and the lack of a national picture concerning practice under s136, and is currently carrying out a nationwide research project.

## Crisis Intervention Teams in the US

From the US, a promising development appears to be the so-called Crisis Intervention Teams (MPA, 2005). The idea originated in Memphis, Tennessee. Evaluations show highly positive results (Vickers, 2000). In Memphis, about ten per cent of the police force is trained to be part of a Crisis Intervention Team and they provide a specialist 24-hour response to mental health emergency calls. There is an agreement with the University of Tennessee Hospital who admit all individuals that cannot be allocated elsewhere. The results of the Steadman, Williams Deane, Borum and Morrissey (2001) study show low arrest rates and high rates of transfer to specialist units. The programme is reported to be a success on several other measures as well, for example, officer injury decreased seven-fold, arrest rates decreased for the mentally ill, use of force decreased, violence and use of restraints decreased in the emergency room, and the rate of mental illness in the jail decreased significantly (Steadman, *et al*, 2001).

The Memphis model requires further study for four reasons: (i) to establish exactly the extent of its success, (ii) to identify the key ingredients of its success, (iii) to establish to what extent the model is transferable to locations within the UK, and (iv) to establish whether a Memphis-style police training programme would be suitable to the UK. The fact that the University

of Tennessee Hospital has the capacity to take any individual brought to them is probably instrumental in achieving positive outcomes; the other factor is probably that individual police officers have volunteered for the role and have been quite extensively trained.

## Summary

From the evidence, the following implications for effective practice in crisis intervention emerge:

- Minimum standards of a place of safety require a shared definition with those agencies involved in the provision and management.
- Where possible the place of safety should be designated section 136 rooms within specialised mental health units. In that regard the Barnet, Enfield and Haringey model is worthy of further scrutiny.
- Any locality, but most particularly metropolitan inner cities, would benefit from a single health institution with a 'no refusal' policy within its boundaries, as in place at the University of Tennessee Hospital in Memphis, US.
- The Memphis model requires further study for the reasons listed above.

## 4 Mental health screening

### Introduction

Once within the CJS it is essential that any mental health needs are identified quickly. The means by which that occurs is often referred to as 'screening'. The concept of screening requires some elaboration as it is regularly confused with a 'quick scan diagnosis' of mental illness. It is not. As posited by the Youth Justice Board (YJB, 2003), screening programmes should aim to identify either common or severe and treatable mental illness within a population. This is not to decide whether an individual is actually diagnosable but to support timely decision making regarding those individuals who test 'positive', i.e. with whom at first sight something is wrong. In addition, protocols should be in place, to decide what should happen in relation to individuals who test positive.

As James, Farnham, Moorey, Lloyd, Hill, Blizzard and Barnes (2002) noted, whether screening forms part of the work of any scheme has repercussions for both the size of its caseload and the type of cases involved. "In a screening system, all cases passing through a given location (police station custody suite, or magistrates' court cell area) are examined in order to establish whether they have evidence of disorder or healthcare need. The ability of the screening procedure to identify cases will depend in part upon the intensity of the screening procedure adopted" (James *et al*, 2002, p. 100).

### Key findings

Langley (2005) recently commented: "police stations need to be given a checklist of factors to aid mental health screening". Unless mental health problems are obvious and severe, such as when s136 MHA has come into play, mental health issues at police stations are easily overlooked.

Birmingham, Gray, Mason and Grubin (2000) argue that many mental disorders remain undetected by prison reception health screening. Their study suggests that diagnostic problems are frequent and serious, as psychotic problems were no less likely to be overlooked than milder mental health problems. Singleton *et al*'s (1998) survey found that over three-quarters of the men on remand, nearly two-thirds of the males sentenced, and half of the women sentenced fitted a diagnosis of personality disorder (Singleton *et al*, 1998) but it seems that often these are not detected upon entering prison.

The Youth Justice Board commissioned a report (Harrington, Bailey, Chitsabesan, Kroll, Macdonald, Sneider, Kenning, Taylor, Byford and Barrett, 2005) with a brief to identify the gaps in provision in the delivery of mental health to young offenders. It concluded that over secure and community sites there were several shortcomings. It identified significant evidence of unmet mental health needs and for these the single most important factor appeared to be inadequate screening and, therefore, under-recognition of these needs. This was also linked to identified gaps in mental health services for 16- to 18-year-olds and continuity of care overall.

The DOH (2005) and Harrington *et al* (2005) further identify a wide range of disenablers to accessing treatment, including actuarial and clinical assessment processes, in both adult and youth settings. This confirms the literature which states that these processes are weak, potentially introduce bias and do not effectively identify mental health needs (see Bhui, Stansfeld, Hull, Priebe, Mole, Feder [2003] for an overview regarding Black and Minority Ethnic (BME) groups). Additionally, Grubin, *et al* (2002) argue that different screening tools should exist for male, female and juvenile inmates and that it also makes sense to have a tool in place for prisoners whose circumstances change.

## Research evidence

The quality of screening instruments is usually psychometrically established and the tools in place score satisfactory or even very high. However, the research evidence suggests that although the screening tools should identify those with mental health needs, there is a consistent picture that individuals with mild or even serious mental health problems are not picked up. The considerations that require close scrutiny to account for this are, firstly, the context in which screening occurs (for example, in reception at police stations and prisons) and secondly, the training for those using screening tools (to ensure the accuracy and consistency of use and interpretation of the tool) with a further key to the success of the screening process being what happens on the basis of it, and in that regard, diversion is of key importance.

## Barriers to effective practice

Different screening tools are in place in different contexts and their aims differ, so like is not being compared with like when assessing their statistical properties. The requirement for training and continuous professional development in the use of screening tools for all staff involved in their implementation appears to underpin lack of effectiveness. In addition, screening by police officers at police stations does not seem to happen consistently. This may be linked to lack of training but also to weak or ineffective liaison with mental health services provided in police stations. Proactive screening by a mental health professional would enable a more effective identification of mental health needs than is currently the case.

A further difficulty is that identified by Harrington *et al* (2005) in their report for the Youth Justice Board. This states that there is a paucity of data on all aspects of mental health delivery in the youth justice sector, including no clear national data on follow-up procedures; thus it is difficult to identify whether there has been effective diversion based upon the use of screening and assessment tools.

## Summary

The findings can be summarised as follows.

- Within police stations, prisons, youth justice and adult community settings, reliable and easy-to-use screening tools are in place, but in prisons, youth justice and police stations there is an identified skill deficit in using these to produce information which will lead

to appropriate treatment and management. In other words, screening and assessment tools developed for predictive consistency are not being used consistently. This skill deficit is linked to access to training and continuous professional development in this area.

- When considering proactively operating schemes, screening is a vital component. It allows the scheme to deliver both to those who are referred to them but also to identify and intervene with their own clientele. This enhances a scheme's accessibility and makes it more likely that existing needs are properly addressed.
- Key factors in evaluating quality health care through the screening process being:
  - the skilful use of the screening instrument to ensure mental health needs are identified
  - assessment, screening and referral outcome should be part of routine data collection, but often are not (James, *et al*, 2002)
  - clear national data on follow up procedures (particularly relevant to the youth justice sector)
  - the ways in which screening translates into diversion activities.

## 5 Diversion and liaison

### Introduction

NACRO (2004) describes diversion as a process of decision making, which results in MDOs being diverted away from the Criminal Justice System towards health and social care. Diversion may occur at any stage of the criminal justice process: before arrest; after proceedings have been instigated; in place of prosecution; or when a case is being considered by the courts. If a prosecution is initiated, the Crown Prosecution Service (CPS) might decide to discontinue or, if the offender is prosecuted because prosecution is appropriate, the court might opt for a relevant disposal under the Mental Health Act 1983/2007, such as a hospital order, in place of a criminal justice disposal, such as imprisonment. However, the process of diverting individuals away from prison but not out of the Criminal Justice System altogether can be termed diversion as well. The key to diversion is the understanding that prison is not conducive to the successful treatment of mental health problems (see Home Office Circular 66/90). Liaison includes brokering, linking and advocating for appropriate (continuity of) care inside prison and in the community (Centre for Public Innovation, 2005).

### Key findings

Examples of effective practice and funding for liaison and diversion have been identified as follows.

The Centre for Public Innovation (CPI) (2005) has looked at a number of schemes that operate up and down the country. Several types have been identified. They include:

- community based psychiatric nurse based in the court;
- psychiatric assessment teams operating in police stations or courts;
- panel schemes;
- community mental health teams linked to the court;
- consultant-led teams.

There are about 135 such schemes operating in England and Wales. The services provided were broadly: screening; mental health assessment (but not in a uniform fashion across schemes); communication with other services; advocacy; report writing and making recommendations to the courts; referral; and linking of CJS with other agencies. Investment in the schemes varied from some £30,000 per year for single staffed schemes with one part time community psychiatric nurse, to over £200,000 per annum for a team consisting of seven people. On average they deal with about 150-200 assessments per year. However the CPI (2005) found in terms of overall arrangements:

- no standard approach to commissioning or funding (most were 'health-led');
- little clarity about the expectation of the funding and commissioning body;

- little or no monitoring of the schemes;
- little evidence for joint funding, 'pooling' of budgets or joint commissioning;
- where joint funding and commissioning were absent, there was no integrated responsibility for clients between providers.

There is no national performance management network in place. Many schemes do not work to targets and data collection is not uniform. That makes it, according to CPI, very difficult to decide whether these services offer value for money, and which (type of) services work better than others. Schemes did not tend to measure outcomes. A lot is dependent on the energy and commitment of individual professionals involved. Very few schemes actively 'market' themselves via leaflets or otherwise.

What does emerge as a finding is that good links with courts are essential. In addition, good working relationships with a variety of services, such as police, probation, primary care, housing agencies, bail hostels, social services, escort security staff etc, were of vital importance.

## **Mental Health Courts in the US and Australia**

In relation to diversion, Mental Health Courts in the US deserve consideration. There are over 100 Mental Health Courts in the US. Because there is no formal definition of a Mental Health Court, the following criteria might be helpful for labelling a court as such. First, all persons with mental illness identified for referral to community-based services on initial booking are managed on a single court docket. Second, a courtroom team approach is used to arrive at recommended treatment and supervision plans with a person specifically designated as a 'boundary spanner' (link worker) to ensure actual linkage. Third, assurance of existing appropriate treatment slots is necessary before the judge rules. Fourth, appropriate monitoring occurs under court aegis with possible criminal sanctions for non-compliance, such as reinstating continued charges or sentences. On the basis of these criteria, a Mental Health Court may be a diversion programme with all staff and services circulating around a single judge, or it could simply be the court of jurisdiction within a broader jail diversion programme (Steadman *et al*, 2001).

Current evaluation studies on Mental Health Courts include Trupin, Richards, Wertheimer and Bruschi (2001); and Christy, Poythress, Boothroyd, Petrila, and Shabnam Mehra, (2005). These demonstrate that Mental Health Courts come in various shapes and sizes (Erickson, Campbell and Lamberti, 2006) and Erickson, *et al* (2006) lament the fact that the Mental Health Courts share no underlying philosophy concerning whom they are for and what their aims should be. The variety in their arrangements and characteristics and the fact that there has been no study, as yet, which focuses upon whether there are successful long-term outcomes, lead Erickson *et al* to cautiously conclude that Mental Health Courts hold "potential promise for improved integrated care" (Erickson *et al*, 2006, p336). In addition, there is the view (Steadman *et al*, 2001) that Mental Health Courts are no more than a hub

and that it remains the case that the available community-based mental health services will make or break the success of these courts.

Australia is set for a major overhaul of the provision of service to mentally disordered offenders. The Council of Australian Governments (COAG) recently announced a reform of mental health services in Australia (COAG, 2006a; 2006b). In April 2006, the Prime Minister confirmed that the Australian Government would commit \$1.8 billion over five years to this. Of particular interest in the Australian reform are so-called diversion courts, which could be thought of as the Australian version of US Mental Health Courts. They have been in operation in one Australian state, South Australia, since 1999. This has been referred to as a Mental Impairment Court, but is referred to by the South Australian authorities as a Diversion Court. These courts are part of a diversionary programme.

The Australian programme provides an opportunity for eligible individuals to voluntarily address their mental health and/or disability needs and any offending behaviours, while legal proceedings are adjourned. It facilitates a range of health and other appropriate services to assist individuals with the aim of participants addressing any perceived link between their offending and impaired intellectual or mental functioning.

The programme's central feature, the Diversion Court, sits on a regular basis in different courthouses around the State. It considers only summary or certain minor indictable offences and the Magistrate has the authority to refuse any person entry to the programme. Following consent, each person undergoes a preliminary assessment by one of the clinical advisors employed by the court specifically to make preliminary psychological assessments. The person's involvement and progress through the treatment programme is reported back to the court and the Magistrate; police and defence lawyers may use this information in dealing further with the case.

At the final hearing, the Magistrate makes a determination taking into account the participant's involvement in the programme. This may include the withdrawal of minor matters by the prosecution as a result of the participant's successful completion of the programme. This arrangement has been positively evaluated (Court Administration Authority South Australia, 2006) although a cost-benefit analysis was not part of this.

Transposing such a scheme to the UK would be a lower key initiative than introducing the more significant changes required for establishing Mental Health Courts. The ownership by a Magistrate of the process might be helpful for the programme as it would be seen to be under the umbrella of the criminal justice system whilst avoiding the negative exclusionary and/or punitive side effects associated with the sentencing of offenders with a mental health problem. It is, therefore, certainly worth investigating further, as its introduction in the UK may well be beneficial and more 'seamless' than US-style Mental Health Courts.

## Summary

There are good local examples of Mental Health Assessment and Diversion schemes, linked to courts or police stations that qualify to be termed best practice. These have secure funding arrangements, good information exchange, clear role boundaries, strong management lead, inclusive referral and proactive screening policies.

Mental Health Courts seem to adopt a more imaginative approach to mental health problems in the Criminal Justice System, as the courts put these problems at the very heart of its interventions in a non-adversarial consensus-based fashion. That said, the proliferation of such courts in the US seems to be a rather 'wild growth', and the risk is that the diversity in arrangements will make it difficult to identify the most promising examples.

## 6 Psychiatric and court reports

### Introduction

NPS (2005) states that psychiatrists reporting to the court should be approved by the Secretary of State under s12 of the Mental Health Act 1983 by virtue of their special experience in the diagnosis and treatment of mental disorder. Approval, however, is not limited to consultants and psychiatrists; some GPs may be s12 approved.

For the purposes of this section of the literature review, effectiveness is defined as providing timely and appropriate reports to the court to facilitate the sentencing process. There are a number of features which support the effective arrangements of providing such reports. These are as follows.

- Clarity from the court in terms of what is required  
NPS (2005) states that it is always helpful if the court specifies what is required in any psychiatric report, for example: the existence of a mental disorder; the relationship between the disorder and offending behaviour; any risk the offender poses to self or others; and an opinion on what disposals would both address the offender's disorder and reduce offending. It would be very useful if the court could consider requiring the psychiatric report to include an assessment of the risk to the public of serious harm by the commission of further such offences (NPS, 2005)
- Appropriate expertise  
NPS (2005) states that the court will be best served if the report is provided by a general or forensic psychiatrist and that appropriate expertise in providing a clinical opinion is important in assisting the court in determining the sentence to be passed. However, there is also evidence that a well-structured protocol, implemented by trained personnel, can be used to screen individuals to provide prompt information to the Court as to whether a specialist psychiatric report is required or whether an alternative medical report will equally serve the purposes of the Court.
- Relevant content  
The Code of Practice to the Mental Health Act 1983 (DOH & Welsh Office, 1999) states that psychiatric reports should include data on which the report is based, how this relates to the opinion given, factors relating to presence of mental disorder that may affect the risk the offender poses to himself/herself or others, factors relating to the presence of mental disorder that may affect the risk of re-offending, where relevant, how the opinion may relate to any medical condition, defence or other trial issues, if admission to hospital is recommended, what, if any, special treatment or security is required and how this would be addressed, and, where no medical proposal is made, advice on management may be appropriate.

- Coherence of commissioning reports with linked resources  
Best results will generally be obtained from commissioning reports from the offender's catchment area services (DOH & Welsh Office, 1999). This allows resources to be matched to proposals and ensures delivery of the service is the responsibility of the reporting doctor. Funding is available for psychiatric reports in the magistrates' courts but not in the Crown Court. For remands on bail the probation service will act as commissioning agents for the psychiatric report on behalf of the court. For those in custody, including cases in the Crown Court, the prison will be responsible for arranging the report. The NHS is responsible for health care centres in prisons, and arrangements will be in place to assess and report on offenders remanded in custody. The court must send a clear instruction to the prison that a report has been ordered (NPS, 2005).

The following provide detailed examples of arrangements to support timely advice and reports to the courts.

- Structured protocol for the provision of reports and other mental health advice: The Wessex Consortium Forensic Project Team provides an outstanding example of the effectiveness of particular arrangements supported by a structured protocol for the provision of timely and suitable psychiatric and other professional mental health advice to the courts (Wessex Consortium, 2003). It is known as MENDOS (Mentally Disordered Offenders Scheme). MENDOS aims to cut down on the 250 requests made each year for psychiatric opinion on mentally disordered offenders, of which only a handful prove necessary for action by the courts (Wessex Consortium, 2003, p1). The scheme is based on a flow chart of psychiatric support to magistrates' courts supported by prescribed forms for requesting and recording information. This reduces the time-lag between an offender exhibiting a disturbed mental state and the decision as to whether and what additional specialist reports may be required before the judicial process can continue (Vaughan, 2004).
- Integrated Multidisciplinary Team: Bristol PCT Court Assessment and Referral Service (CARS) is an integrated multidisciplinary team which has been set up to provide a specialist mental health service to Bristol Magistrates' Court. The purpose of CARS is to assess those people in custody, awaiting court appearance, who are referred having a suspected or recognised mental health problem (NPS, 2005). The scheme aims to minimise the number of court appearances, reduce waiting time on remand and prevent undue stress to court users. They will also be a conduit for information between courts and prisons and other health care agencies (NPS, 2005).

NACRO (2005) note that services can be accessed more easily where a scheme is made up of staff from a variety of agencies (NACRO, 2005, p8). Of those schemes which were working well, 42% had three members of staff or more. Multi-agency staffing was shown to improve the efficiency of the schemes with eight per cent of those surveyed having a

probation officer as part of their team and four of these had some funding from probation services. Forty seven per cent of schemes had at least 0.5 of an Approved Social Worker (ASW) and 34% had 0.3 or more administrative support. Approximately half the schemes were led by general psychiatry and half by forensic. Three schemes included learning disability workers and three included drug/alcohol workers.

## **Barriers to the effective provision of reports to the court**

It is not uncommon, if the defence is arranging for a report to be prepared out of the catchment area, for difficulties to arise in attempting to realise the proposal due to lack of funding. The lack of clarity in funding specialist reports for the Crown Court may also present difficulties in producing timely results (DOH & Welsh Office, 1999). NACRO's (2005) findings were generally pessimistic, with 30% of schemes surveyed citing reduced staffing levels impacting upon provision to MDOs in the sentencing process, 50% citing no sessional input from either a psychiatrist or a psychologist and 41% reporting difficulties in obtaining psychiatric reports. Seventy-two per cent of the schemes surveyed cited lack of beds as a barrier to their schemes operating successfully (NACRO, 2005, p 9).

## **Summary**

Effective practice in the provision of both psychiatric and other mental health reports to the Court require adequately staffed and trained multi-agency teams working to clear guidelines from the Court. Locally agreed protocols for provision of mental health advice to the Court can be very successful in enhancing the service to the Court.

The survey evidence is strong (NACRO, 2005), and shows that many Criminal Justice Mental Health Liaison Teams struggle to provide a good service to the courts. On the other hand the MENDOS developed by the Wessex Consortium, demonstrates that an adequately staffed and trained multi-agency team with a well-structured strategy for delivering mental health reports, information and advice to the courts, has two outstanding strengths by being:

- 1) cost-effective through reducing both the number of unnecessary psychiatric reports ordered; and,
- 2) reducing delays in the judicial process, in particular with an individual on remand.

## 7 Collaborative and multi-agency arrangements

### Introduction

For the purposes of this section, effective collaborative arrangements are understood to be those which draw on personnel from several statutory, voluntary and community sectors with the aim of identifying and delivering support to meet complex and mental health needs.

It is difficult to ascertain how widespread the effectiveness of multi-agency collaboration is in the prison, through-care and community settings and the ways in which the resources that support community-based intervention are readily accessible (DOH 2005; Harrington, *et al* 2005). The literature continues to suggest that collaborative arrangements, when they work well, are the most effective way of delivering a service to meet complex needs, (Stone, 2003). This holds true for both interagency and multi-agency collaboration but, with the caveat that this is most likely to occur when the individuals involved have developed good working relationships and as Stone (2003) points out, many multi-agency initiatives founder on festering, unresolved disputes.

The voluntary and community sectors have long been valued by many service users and carers as offering greater choice, flexibility and services which meet local need, independent of statutory providers. Organisations are usually commissioned by local authorities and PCTs where they are direct service providers, but are also funded by charitable donations, grants and trusts. Increasingly, the voluntary sector is a major provider of mental health services through national organisations such as Together – Working for Wellbeing (formerly MACA), MIND and Rethink, and smaller, local organisations – working to limited-term contracts. Most voluntary organisations involve service users and carers in governance, planning and management, and some are entirely user-led (RCP, 2005, p23).

### Key features of effective collaborative arrangements

Many of the schemes reported in the detailed findings in this qualitative review have provided evidence of effective collaborative arrangements both within and between the CJS, the community and voluntary services. The following examples also demonstrate innovative approaches initiated by the Royal College of Psychiatrists (RCP) and Liverpool Mersey Care Trust.

RCP: New Ways of Working (NWW) was set up in response to a groundswell of opinion that there was a need for new and changing roles for psychiatrists (RCP, 2005). NWW is about supporting and enabling consultant psychiatrists, among others, to deliver effective and person-centred care across services for children, adults and older people with mental health problems. RCP (2005, p3) reports that “this is about a big culture change; it is not just tinkering at the edges of service improvement”. In essence, NWW is about using the skills, knowledge and experience of consultant psychiatrists “to best effect by concentrating on service users with the most complex needs, acting as a consultant to multi-disciplinary teams, and promoting

distributed responsibility and leadership across teams to achieve a cultural shift in services. It encompasses a willingness to embrace change and to work flexibly with all stakeholders to achieve a motivated workforce offering a high quality service” (RCP, 2005, p4).

The NWW has inspired key organisations to review their working arrangements which has included NIMHE (the National Institute for Mental Health in England, see NIMHE 2004, 2005) becoming part of the Care Services Improvement Partnership (CSIP). The shared contributions of practitioners in multi-agency and multidisciplinary teams are being debated with a focus on the Care Programme Approach (CPA) and the role of the care co-ordinator. Experience to date (RCP, 2005, p19) suggests that psychiatrists, and frequently clinical psychologists, have not undertaken this role, sometimes causing friction in teams.

Finally of interest are H-RAMM arrangements as operating in Liverpool. An H-RAMM is a Health Risk Assessment and Management Meeting. H-RAMM is a health co-ordinated risk assessment and management framework for those high-risk service users at risk of dangerousness, across Mersey Care Trust, who do not fit the MAPPA criteria or who are subject to ECC (Effective Care Co-ordination) but are experiencing complicating factors which are causing increased concern. The process involves multi-agency partnerships with the aim of sharing reasonable and proportionate information identifying risks and co-ordinating a multi-agency action plan (Bullivant and Sergeant, 2005). An H-RAMM can, therefore, be both an alternative to, as well as a gateway into, MAPPA.

H-RAMM meetings occur frequently and are seemingly highly effective. They can, therefore, serve as an example of effective practice.

## **Barriers to effective collaborative arrangements**

There is a pessimistic catalogue of failed initiatives in multi-agency and multi-disciplinary working (see, for example, HM Chief Inspector of Prisons, 2001; DOH 2005; Harrington, *et al*, 2005; Stone, 2003; RCP, 2005; NACRO, 2005; Winstone and Pakes, 2005; 2007), of which the most frequently cited fall into two main categories.

- 1) Professional relationships: including lack of commitment of key personnel; clash in philosophies, aims and goals; weak leadership and role confusion; lack of clarity about where responsibility for resourcing lies between different agencies.
- 2) Organisational structures: including lack of secure funding; lack of adequately trained staff; weak protocols for information sharing; weak leadership.

The above two lists are not mutually exclusive. Weak organisational structures give rise to the potential for philosophical and role clashes between personnel, including that of where money will come from to fund the time and input of professionals and which organisation

takes responsibility for funding specific activities. These problems can be complicated by uncertainty as to what information about service-users can be shared between agencies, who have different views on confidentiality. In addition, how to incorporate service-users' views can come into conflict with the aims and goals of the different agencies, for example, statutory agencies must work to clearly defined organisational goals and aims and these may not be coherent service-users' views and the views of voluntary and community agencies who may be working with conflicting agendas and philosophies (RCP, 2005).

## Summary

The evidence from effective multi-agency and multi-disciplinary work suggests that the way forward in the long term is to put into place those practices which militate against the barriers to effective practice emerging. The active involvement of service-users and carers has been shown to enhance the levels of satisfaction levels with service delivery (RCP, 2005). The caveat to this is that service-user involvement needs to be structured within a framework of protocols which are understood and agreed by all parties concerned.

It is generally agreed that MAPPA overcomes many issues associated with multi-agency work because it is highly regulated (Wood and Kemshall, 2007). Clearer agreements for multi-agency work with MDOs along MAPPA lines are likely to enhance multi-agency arrangements in mental health delivery for offenders who do not meet MAPPA criteria, because the offender is disordered rather than dangerous. With the intention of the National Offender Management Service (NOMS) to promote Public Value Partnerships (embracing the principle of contestability) it will be essential for the CJS to continue to modernise its attitude towards partnerships with the community and the voluntary sector and to seek out models to do this based on the evidence of existing effective practice.

Much good practice relies on personal zeal and informal interpersonal relationships. Sadly, that makes for effective yet fragile arrangements without safeguards to enhance their sustainability. The work of schemes and providers must be examined and supported with reference to their sustainability. Such audit and support processes need to be ongoing, centrally funded and monitored.

## 8 Conclusion: effective practice and evaluation

There seems renewed interest in diversion and other forms of care for mentally disordered offenders, not least evidenced by the review currently being undertaken by Lord Bradley who is expected to report his findings in November 2008 to the Department of Health and the Ministry of Justice. With the subject higher up the political agenda, it is important to utilise the opportunities that this may afford.

Provision to offer mental health support for individuals with mental health needs who pass through the criminal justice system needs to perform well in a number of key areas. These can be summarised as: screening and assessment; facilitating access to mental health support; other liaison; information sharing and multi-agency arrangements and should include data collection and analysis. In order to get them right, these areas need to be governed by the following elements: statement of purpose; policy; management; resourcing; practice continuous professional development.

In order to achieve that, the Mental Health Effective Practice Audit Checklist Enhanced (MHEP-ACE) has been developed to evaluate schemes across these parameters and has been piloted across nine schemes with a report submitted to the Office for Criminal Justice Reform. In consultation with stakeholders a standard version (MHEP-ACS) has been finalised for national implementation.

Currently, few arrangements will perform outstandingly over all these variables. However, best practice does exist and at present is insufficiently recognised and shared. An effort must, therefore, be made to uncover and implement best practice more systematically.

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## Appendix 1

### PROFESSIONAL ADVISORY GROUP ON EFFECTIVE PRACTICE ON MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM

Those present at meeting on 5 March 2007

Dr Tony Munton	Head of Criminal Justice Evidence and Analysis, OCJR (Chair)
Dr Lawrence Singer	Research Development and Statistics, OCJR
Robert Ritchie	CJS Mental Health Issues, OCJR (Secretary)
Jane Winstone	Principal Lecturer: Institute of Criminal Justice Studies, University of Portsmouth
Dr Francis Pakes	Principal Lecturer: Institute of Criminal Justice Studies, University of Portsmouth
Dr John O'Grady	Chair, Forensic Faculty, Royal College of Psychiatrists
Dr David Pevalin	ESRC Placement Fellow, Research Development and Statistics, OCJR
Anne Richardson	Policy Lead, Offender Mental Health, Health and Offender Partnerships
Professor Sir Michael Rutter	Institute of Psychiatry, King's College London
Enver Solomon	Centre for Crime and Justice Studies, King's College London

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Jane Winstone	Principal Lecturer: Institute of Criminal Justice Studies, University of Portsmouth
Dr Francis Pakes	Principal Lecturer: Institute of Criminal Justice Studies, University of Portsmouth
Sean Duggan	Director, Prisons & Criminal Justice Programme, Sainsbury Centre for Mental Health
Dr Kimmett Edgar	Head of Research Prison Reform Trust
Kathryn Harney	Programme Manager, National Programme on Forensic Mental Health R&D
Lucy Smith	Senior Research and Information Officer, Mental Health Unit, Nacro
Dr Julie Wilkinson	National Offender Management Service, Research & Evaluation

## **Office for Criminal Justice Reform Practice Review 1/09**

### **Provision of mental health services to individuals passing through the criminal justice system: A qualitative literature review**

The provision of mental health services to individuals passing through the criminal justice system is fraught with difficulty. Most individuals who suffer from mental health difficulties whilst detained or prosecuted have complex needs that are not only medical but also social, financial and, not least, practical. Their needs cross organisational boundaries and require a co-ordinated multi-disciplinary approach. Such approaches are notoriously difficult to establish and sustain.

This literature review has three primary aims.

- 1) To identify existing mental health services at different stages of the CJS.
- 2) To identify effective strategies for the delivery of mental health services in the CJS.
- 3) To provide recommendations for strengthening effective practice in the provision of mental health services in the CJS.

In addition to multi-agency arrangements and information exchange, this review assesses practice in the areas of mental health screening, assessment, liaison and diversion. It also examines issues in obtaining appropriate and timely psychiatric reports. Throughout it highlights barriers to and key indicators of, effective practice. The review concludes that whilst there is no single bastion of best practice, good practice does exist and is identified with multi-agency provision with the following characteristics: (1) financial stability; (2) clear protocols for operation and information sharing; (3) effective leadership; (4) shared philosophy and goals; (5) shared training; and, (6) adequate staffing. These are the key ingredients for sustainable arrangements to provide services in this complex area.

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