

Developing a service specification for court liaison schemes in the West Midlands

Report for NHS West Midlands



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Sept 2009

This report is prepared by Nacro's Mental Health Unit for NHS West Midlands to assist in the development of a service specification for Court Diversion Schemes (CDS), Criminal Justice Mental Health Liaison Schemes (CJLS), and similar arrangements including those at police stations and probation centres. It is written in light of the Bradley Review to take full advantage of its findings and recommendations and to meet the requirements for world class commissioning.

The report looks at schemes operating both at the court stage and police custody.

Nacro is the leading crime reduction charity in England and Wales and was established in 1966. The organisation's prime purpose is to make society safer through the development of effective approaches to crime prevention and through the promotion and delivery of constructive interventions with offenders, which emphasises social inclusion and community involvement.

Nacro's Mental Health Unit has been working since 1990 with the aim of providing a co-ordinated range of development, information and consultancy services to the various agencies that may have dealings with offenders with mental health needs across the criminal justice, health and social care sectors. The key aim is to help them develop effective policy and practice. The Unit has worked in over 30 local authority areas in England and Wales offering a range of services including; consultancy and development work; reviewing existing arrangements; assisting with the development of policies and protocols; and, developing and delivering training programmes.

The Unit has its own dedicated website (www.nacromentalhealth.org.uk), distributes a monthly Digest to over 500 subscribers, and runs an Information Service available to practitioners, service users and carers. In 2008 the Mental Health Unit's website regularly received over 17,000 hits each month. Enquiries to the Information Service helpline focus, in the main, on resettlement and diversion advice and average over 3 enquiries per week.

Nacro would like to thank the commissioners and providers who responded to requests for information. Nacro would also like to thank the members of the virtual reference group for their input and expertise.

CONTENTS

Executive Summary	4
How the work was done	5
Background	6
Prevalence	6
Public Service Agreements	6
Role of schemes	7
History of schemes	8
National Service Framework	10
Social Exclusion	10
Offender Mental Healthcare Pathway	11
Current Position	12
Bradley Review	12
Audit of Court Liaison and Diversion Schemes	12
Developments in the West Midlands	14
Criminal Justice Schemes	14
Meeting the Needs of All	15
Women	15
Black and Minority Ethnic Service Users	17
Learning Disability	18
Personality Disorder	19
Other Courts	20
Youth Courts	20
Civil Courts	20
Community Justice Centres	21
Findings	23
Commissioners	23
Providers	24
Commissioning Template/Service Specification	27

EXECUTIVE SUMMARY

The key findings from the report are:

- ❑ a significant number of the offender population have mental health needs
- ❑ court diversion and criminal justice mental health liaison schemes can be effective in facilitating the transition across the interface of the criminal justice system and mental health and social care sector
- ❑ there is a good coverage of such schemes across the West Midlands working to different models
- ❑ there is a lack of clarity of the commissioning process including an absence of Service Level Agreements (SLA) and commissioning specification
- ❑ health should be the key commissioners of such schemes working in partnership with other relevant agencies and organisations
- ❑ all schemes should be commissioned to a clear commissioning specification incorporating the elements of world class commissioning and should reflect local need
- ❑ a health needs analysis should be carried out prior to the commissioning of services
- ❑ there should be an agreed SLA between the commissioner and provider which includes performance indicators
- ❑ there should be clear governance arrangements for schemes with input from commissioners and stakeholders
- ❑ schemes should cover as many points of intervention within the criminal justice process as identified on the Offender Healthcare pathway as is practicable
- ❑ schemes should operate both pro-active screening and take referrals from a wide range of sources
- ❑ schemes should proactively develop a network of referrers and providers
- ❑ staffing should be both multi-agency and multi-disciplinary to ensure that holistic assessments can be completed and diverse to reflect local populations. The assessment process should take full account of the individual's specific needs including their gender, and their cultural and faith background
- ❑ schemes should be integrated with mainstream mental health services
- ❑ schemes should record and monitor their activity and regularly feed this back to commissioners and stakeholders. Recording and monitoring should include the recording of unmet need. It should include ethnic and gender monitoring to ensure that disadvantaged groups access services appropriately that meet their needs

- ❑ schemes should develop agreed protocols with stakeholders and relevant agencies on information sharing and exchange
- ❑ staff should be encouraged to attend training to develop the necessary skills for this area of work.

HOW THE WORK WAS DONE

To assist with the development of a service specification for CDS, CJLS, and similar arrangements including those at police stations and probation centres information was gathered both about the current position in the West Midlands and the views of commissioners and providers sought on what such a model would look like. Commissioners were from PCTs, local authorities and specialised commissioning.

A questionnaire was developed for commissioners of services (Appendix A) and providers (Appendix B). Although some of the information requested was the same, these differed to take account of different areas of responsibility. The questionnaire for commissioners was sent with a covering letter (Appendix C) by David Williams, Programme Director for Offender Health and Social Care, CSIP West Midlands (now NHS West Midlands) to all West Midlands by email. The questionnaire to providers (ie, existing schemes) was sent with a covering letter (Appendix D) by Nacro to those schemes identified both by the Rethink Auditⁱ and by Nacro's directory of schemesⁱⁱ. These were sent by email and post. In both cases, commissioners and providers were asked to respond within a set timescale.

One further scheme (Walsall) was contacted when they, coincidentally, sent their contact details to be included in a revised copy of the Nacro directory. This is a new scheme that had not been included in either the Rethink audit – although reference was made to it – or the directory.

Follow up phone calls were made and emails sent to those commissioners and providers who did not respond within the timescale.

To ensure that the proposed model meets recommendations made by other reports, a range of publications and evaluations were checked.

To ensure that the needs of specific groups who are often disadvantaged by both the CJS and health and social care system, a number of reports and publications – for example, the Corston Report and No-one Knows - were also checked.

The report and its findings were considered by a virtual reference group consisting of commissioners and providers in the West Midlands.

BACKGROUND

Prevalence

It is difficult to be certain about the numbers of people in contact with the criminal justice system who have a mental health need. Two major prevalence studies (ONSⁱⁱⁱ & Professor John Gunn^{iv}) have highlighted the numbers of prisoners with significant mental health needs. However, in relation to police custody and courts there have only been a limited number of studies often based on a single court or a single custody centre. A report for the Office for Criminal Justice Reform (OCJR) looking at arrests in London and Devon and Cornwall estimated that 269,000 offenders are routinely identified with mental disorder at arrest (12% of all arrested offenders) with 40% of this group (108,000) going on to be charged, accounting for 14.7% of the charged offender population. It further estimated that 33% of all those serving community sentences (56,000) have identified mental disorder.

An unpublished study of courts in the South West found that 25% of all defendants at Bath Magistrates' Court had previous or current contact with mental health services. Further, 70% of defendants at a specialised Domestic Violence court had previous or current contact.

A report by Booker et al^v found that offenders being supervised in the community have significantly worse health than the general population and that their health needs are different in a number of respects to those of prisoners. 27% of the sample had been seen formally by mental health services at some time. The health of female offenders was both worse than that of the general population and their male counterparts.

Public Service Agreements

Cross government Public Service Agreement (PSA) targets encourage joined-up working to address health inequalities and the health and social care needs of socially excluded adults including offenders. Joint Strategic Needs Assessments and the inclusion of indicators relevant to offender health and reducing re-offending in Local Area Agreements (LAA) will further challenge local partnership working.

PSA targets relevant to offender health include:

- PSA 15 Address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief
- PSA 16 Increase the proportion of socially excluded adults in settled accommodation and employment, education or training

Proportion of offenders under probation supervision living in settled and suitable accommodation at the end of their order or licence

Proportion of offenders under probation supervision living in employment at the end of their order or licence

- PSA 23 Make communities safer

Priority Action 1 Reduce the most serious violence, including tackling serious sexual offences and domestic violence

Indicator 1 The level of most serious violent crimes

Priority Action 2 Continue to make progress on serious acquisitive crime through a focus on the issues of greatest priority in each locality and the most harmful offenders – particularly drug-misusing offenders

Indicator 2 The level of serious acquisitive crime

Priority Action 3 Tackle the crime, disorder and antisocial behaviour issues of greatest importance in each locality, increasing public confidence in local agencies involved in dealing with these issues

Indicator 3 Public confidence in local agencies involved in tackling crime and antisocial behaviour (ASB)

Indicator 4 The percentage of people perceiving ASB as a problem

Priority Action 4 Reduce re-offending through the improved management of offenders

Indicator 5 The level of proven re-offending by young and adult offenders

Indicator 6 The level of serious re-offending

- PSA Delivery Agreement 24 Deliver a more effective, transparent and responsive Criminal Justice System for victims and the public

Indicator 1 Effectiveness and efficiency of the CJS in bringing offenders to justice

Indicator 2 Public confidence in the fairness and effectiveness of the CJS

Indicator 3 Experience of the CJS for victims and witnesses

Indicator 4 Understanding and addressing race disproportionality at key stages of the CJS

- PSA 25 Reduce the harm caused by Alcohol and Drugs

Indicator 1 The number of drug users recorded as being in effective treatment

Indicator 2 The rate of alcohol-related hospital admissions

Indicator 3 The rate of drug-related offending

Indicator 4 & 5 The percentage of the public who perceive drug use or dealing/drank and rowdy behaviour to be a problem in their area.

For many of these PSAs, CJLS and CDS could help in meeting the required targets through ensuring that many offenders access appropriate services including settled accommodation which, in turn, makes community safer.

Role of Schemes

Offenders are amongst the least healthy groups in society. Tackling the health inequalities they face can have a significant impact on both their re-offending and

social exclusion. CDS and CJLS or similar can play a vital role by facilitating the transition across the interface between the criminal justice system (CJS) and the health and social care sectors. They can:

- ❑ facilitate the early detection of people with mental health problems in the criminal justice system and ensure appropriate and effective outcomes;
- ❑ ensure that all people with mental health problems who come into contact with the criminal justice system receive speedy and appropriate assessments;
- ❑ facilitate a multi-agency approach from all relevant agencies working with offenders with mental health problems.
- ❑ provide advice and information to criminal justice agencies including making appropriate recommendations;
- ❑ undertake mental health assessments and facilitate requests for further assessments;
- ❑ liaise with a range of service providers including the voluntary sector and community-based providers;
- ❑ assist with obtaining court reports;
- ❑ and, assist with and facilitate disposal options.

A number of studies have demonstrated that such schemes offer significant benefits because they reduce the need for remands in custody^{vi}; reduce re-offending^{vii}, re-engage people with services^{ix}; reduce, or even abolish, delays^x, and, meet the needs of victims^{xi}.

In a recent study by the Sainsbury Centre for Mental Health^{xii}, the authors argue that well-designed arrangements for diversion have the potential to yield multiple benefits including:

- ❑ cost and efficiency savings with the criminal justice system;
- ❑ reductions in re-offending;
- ❑ improvements in mental health.

The report concludes that, even on conservative assumptions, diverting offenders away from short sentences in prison towards effective treatment in the community will lead to savings in crime-related costs of over £20,00 per case including savings for the criminal justice system of up to £8,000 and benefits from reduced re-offending valued at around £16,000. Among a series of recommendations is the call for the establishment of a Diversion and Liaison Team in every PCT area in England commissioned on the basis of joint funding from mental health and criminal justice budgets.

History of schemes

The first recent scheme in England and Wales was set up by Dr Philip Joseph at Horseferry Road Magistrates' Court. This supported Government policy aimed at achieving care and treatment for mentally disordered offenders, rather than

punishment through the criminal justice system, formally articulated in Home Office Circular 66/90: Provision for Mentally Disordered Offenders^{xiii}.

The majority of early schemes saw their main role as being one way by which the policy of diversion could be made more effective and efficient i.e. the policy of transferring offenders with mental health problems to health and social care – and very often admission to hospital – rather than imposing criminal justice outcomes, in particular prison.

While activities for diversion were mainly focused on magistrates' courts as the most cost-effective and efficient means of filtering mentally disordered people out of the criminal justice system, a number of initiatives started to develop at the police station. In late 1991/early 1992 a Diversion at the Point of Arrest (DAPA) scheme started at Hereford Police Station screening people for mental health problems both pre- and post-charge. This was followed by the DAPA scheme at Bournville Lane Police Station, South Birmingham and by schemes at police stations in London and other major cities.

These [both court and police station] developments were further encouraged by the Reed Review^{xiv} which called for “a nationwide provision of properly resourced court assessment and diversion schemes”. It added that, “experience increasingly suggests that, where diversion schemes become established, these come to provide a broader multi-agency focus which, of itself, can make effective disposals easier”. This was to be complemented by “closer working between the police, health and social services to avoid unnecessary prosecution of mentally disordered suspects”^{xv} and “the development of the probation service to help divert from custodial disposals mentally disordered people who have to be prosecuted”^{xvi}.

Following Home Office Circular 12/95, Mentally Disordered Offenders: Inter-Agency Working, there was a change in the role of schemes with many now seeing their function extending more to a liaison role with other agencies in order to ensure an individual receives an appropriate package of care rather than just diversion from the criminal justice system alone. For some, liaison schemes complemented diversion schemes whereas for others they replaced the notion of diversion by extending their area of operation and by taking a more multi-agency approach.

While the initial schemes were, in the main, psychiatrist-led, this second-wave was now staffed, and led by, Community Psychiatric Nurses (CPNs) with or without sessional input from psychiatrists. As such, few of the new schemes had direct access to beds or responsibility for carrying out formal assessments. A number of the more ambitious schemes started to link with prisons as well as police stations and courts. As well as providing a conduit for the exchange of information, the main role was to assist with linking prisoners with mental health needs back into community-based services on release in line with Care Programme Approach (CPA) or similar arrangements.

One of the biggest challenges to face diversion and liaison schemes was – and still is in many cases – one of integration, both strategic and operational. Such schemes – whether operated by psychiatrists or CPNs – were often ad hoc arrangements, added-on to other services. There was little or no direct link to strategic planning or commissioning structures. Not all schemes had any operational governance in terms of a steering group or links to a county-wide mentally disordered offender group. As such, they often became seen as specialist provision and not mainstream and/or the preserve of forensic services with subsequent problems of being able to access

mainstream services whether that was acute beds or Community Mental Health Teams (CMHTs).

The need for an integrated approach had been picked up much earlier by Reed who noted that, without the agreement of a local framework for inter-agency co-operation, “services are likely to develop haphazardly, if at all, and will certainly fail a number of users”^{xvii}.

Despite these promptings the development of schemes has been patchy and piecemeal. Reasons advanced for this include: the absence of a centralised strategy including the setting of targets; the large number of police stations, courts, and prisons which exist and require some sort of provision; the lack of enthusiasm among some clinicians to engage with such initiatives; and, the lack of resources, including dedicated funding. Where schemes do exist they work to different models and configurations from a range of providers including the voluntary sector. The one thing they may have in common is the commitment and enthusiasm of their practitioners.

National Service Framework

The National Service Framework for Mental Health^{xviii} (NSF) recognised that some service users access mental health services via the criminal justice system through “for example, court diversion schemes or directly from a police station or from a prison” and that people who self-harm “commonly have multiple problems including a history of contact with the criminal justice system”. As well as there needing to be improved partnership working, the report called for “court diversion schemes ... to be linked into local mental health services” and for community mental health teams to work with “other specialist teams covering.....mentally disordered offenders”. However, the NSF stopped short of setting targets in relation to work with offenders with mental health needs and/or the agencies working with them.

The main standard associated with access to mental health is standard 4 relating to severe mental illness which states that those with severe mental health problems should, “*be able to access services 24 hours a day, 365 days a year*”.

In addition, Standard 3 states that any individual with a common mental health problem should:

- *be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care*

Although these don't specifically operate in respect of people in police custody or at court it should be assumed – in the absence of any direct standards for these scenarios - that any standards expected in the community equally apply to those held in police custody.

Social Exclusion

The Social Exclusion Unit^{xix} (SEU) 2004 report highlighted the needs of mentally disordered offenders and also called for closer working between health and social care services with the criminal justice system. In particular, it called for the National Institute for Mental Health for England (NIMHE) and the Home Office to develop a model, by 2006, to address “coercive and complex pathways into and out of care for some ethnic minority groups” to ensure that these service users are dealt with appropriately and responsively (Action 11). In addition, the Home Office and Department of Health, by the end of 2005, should develop a “pathways approach that can be used at a local level” to ensure that offenders with mental health needs can access treatment at the earliest possible opportunity (Action 11).

The SEU believed that the development of the National Offender Management Service (NOMS), which brings together prison and probation services, and the introduction of offender management systems should “help improve offenders’ access to mainstream mental health services”. However, while the report quoted research which found diversion schemes to be successful, it acknowledged that there is “no requirement for health or criminal justice agencies to provide diversion schemes and they can be subject to local funding pressures”.

Offender Mental Health Care Pathway

The Home Office and Department of Health developed the Offender Mental Health Care Pathway, which aims at preventing people with acute severe mental illness being sent to prison and to ensure that prisons are “safe places for people with mental health problems and that suicides should be increasingly prevented”^{xx}. As well as detailing the elements of and key objectives of intervention at different points in the criminal justice system, it highlights a number of best practice examples.

CURRENT POSITION

Bradley Review

Lord Keith Bradley was asked by the Justice Secretary, Jack Straw, to lead a review of people with mental health problems or learning disabilities in the criminal justice system. Working closely with the Department of Health and the Ministry of Justice the main aim of the report is to find ways in which more offenders with mental health problems can be diverted away from custody, where appropriate, to a range of alternative options including community options.

His report, published on 30th April 2009, was accompanied by a cross-departmental government response that which accepted either wholly or in principle all 82 recommendations contained in the report. The key recommendations focus on early intervention, better information sharing between agencies and ensuring a more joined-up approach between the criminal justice system and community-based agencies and organisations. They include:

- ❑ the creation of a National Programme Board and National Advisory Group with an independent chair to oversee the implementation of the report within a reasonable timeframe;
- ❑ a system of regional partnerships to ensure improved consistency between local structures and national governance arrangements;
- ❑ new Criminal Justice Mental Health Teams to facilitate improved assessments and information sharing across the offender healthcare pathway;
- ❑ the commissioning and budgetary responsibility of healthcare services in police custody suites should move from individual police forces to the NHS at the earliest opportunity;
- ❑ improved training at every stage of the criminal justice system from points of initial contact such as police officers right through to those sentencing people with a mental health problem or learning disability.

Now that Lord Bradley has reported, the Offender Health and Social Care Strategy will be finalised and published. This will set out a 5-year strategy to ensure that offenders with mental health needs get access to appropriate care and treatment along the offender healthcare pathway including those offenders supervised in the community. The strategy will build on the consultation document 'Improving Health, Supporting Justice' (March 2008).

It is also expected that a health and social care strategy will be developed for young offenders.

The Association of Chief Police Officers (ACPO) is also expected to issue guidance on training and working with offenders with mental health needs.

Audit of Court Liaison and Diversion Schemes

To assist the Bradley Review, each of the 8 Regions in England were requested to participate in an audit of court liaison and diversion schemes using the Mental Health Effective Practice-Audit Checklist (MHEP-AC) developed by Francis Pakes and Jane Winstone at the University of Portsmouth for the Office for Criminal Justice Reform (OCJR).

MHEP-AC aims to identify best practice in assessment/liaison/diversion/referral schemes for those who come into contact with the criminal justice system and have – or are suspected of having – mental health problems. It has 2 components. The first is the Participant Profile, which establishes the nature of the scheme, its organisational context, staffing, operations, and number of service users seen. The second is the actual audit checklist, which tests 7 areas of practice – screening, assessment, facilitating access to mental health support, liaison, information exchange, multi-agency arrangements, and data collection and analysis. Each area is assessed separately against excellent evidence, good evidence, moderate evidence, limited evidence, and weak evidence.

The evaluation in the West Midlands was completed by Rethink. Their report, 'Audit of Court Liaison and Diversion Schemes using a Structured Assessment Tool' (<http://www.westmidlands.csip.org.uk/silo/files/courts-report-pdf.pdf>) found that:

- ❑ only 2 of the 11 schemes evaluated hold current Service Level Agreements (SLA);
- ❑ none had secured long-term funding;
- ❑ funding was mainly from PCTs;
- ❑ 1 scheme has a 0.5 wte post, 4 schemes operate with just 1 team member, 1 scheme had 2 staff members, 3 schemes have 3 staff members, and 2 schemes have 5 members of the team;
- ❑ only 1 scheme was pro-active in obtaining feedback;
- ❑ all scheme liaised with at least 3 core agencies – police, courts and probation;
- ❑ information exchange was the strongest aspect of the audit;
- ❑ 7 schemes showed moderate or limited evidence for data collection and analysis;
- ❑ larger teams scored higher due to 'role specialist' tasks;
- ❑ there was no 'out of hours' specific service.

DEVELOPMENT IN WEST MIDLANDS

The West Midlands region covers an area of 12,998 sq. km and accounts for a population of 5.27 million (9% of the UK total). More than half of the region's population live in large conurbation areas including Birmingham, Wolverhampton, Stoke-on-Trent, and Coventry, while over 2 million reside in the region's rural counties, which cover three-quarters of the region's area.

There are 38 local authorities in the West Midlands region, 7 Metropolitan, 4 County, 3 Unitary and 24 District Councils. There are ** Primary Care Trusts (PCTs).

Within the age structure of the population, 19.5% are aged 0-14 years, 64.5% aged 15-64 and 16.0% aged over 65. Approximately 11.3% of the region's total population belong to ethnic minorities. Of these 7.7% are of Asian, Pakistani or Bangladeshi origin.

Despite a recent decline, manufacturing remains an important element in the economy, accounting for 20.4% of all regional employment. The service sector has expanded and now represents nearly 70% of the region's employment. The West Midlands is a major exporting region, accounting for approximately 8% of the national total by value. It has also proved successful in attracting foreign direct investment – attracting nearly 2000 overseas companies to set up facilities here, with the main centres being Birmingham, Coventry and Telford.

Overall health levels in the Region continue to improve. However, on many indicators the health of the Region's population falls slightly below the average for England. For example, while life expectancy rose in the West Midlands, it is still about 0.5 years less than the national average. Health inequalities across the Region are a major challenge. The gap in life expectancy between the worst and best local authorities is 5.0 years for men and 3.7 years for women. Within local authorities the gaps are even more striking. Similar differences are evident for most health indicators.

Crime rates are relatively low and falling. In the British Crime Survey comparator, crime over the past 4 years reduced by 24.5% compared with a fall of 20.1% across England and Wales for the same period. The West Midlands has a total recorded crime rate of 85 per 1,000 population compared with 91 per 1,000 population in England and Wales. Although crime is higher in major cities in the Region, rates are lower than in most other comparable studies. The West Mercia police force area, which covers Shropshire, Herefordshire, and Worcestershire has one of the lowest crimes rates in the country at 68 per 1,000 population.

Criminal Justice Schemes

There are 13 schemes in the West Midlands covering 21 magistrates' courts, 2 crown courts, 12 police stations, and liaising with 7 prisons. There are no schemes attached to youth courts (2 schemes have contacts with the youth court), family courts, civil courts or the Birmingham Community Court. As with other areas of England and Wales, these schemes vary in their staffing, the way they operate and their governance and strategic links.

Most of the schemes have been in existence for over 10 years. The Birmingham, Dudley and Coventry Court Liaison Scheme - operational from 1990 - was one of the first court-based schemes in England. The Diversion at the Point of Arrest (DAPA) scheme started at Hereford Police Station – now FACT Team – in 1991/92 was the first police station based scheme followed closely by a scheme in South Birmingham.

MEETING THE NEEDS OF ALL

Not only should schemes ensure that they are able to meet the needs of offenders with mental health problems they must also meet the needs of specific groups who may face discrimination and disadvantage from both the CJS and mental health system. These groups would include: women; people from Black and Minority Ethnic (BME) communities; children and young people; people with a learning disability; and, people with a diagnosis of personality disorder.

Women

The Corston Report

In response to a series of suicides in prison the government asked Baroness Corston to carry out a 'Review of Women with Particular Vulnerabilities in the Criminal Justice System'. Her report (March 2007) concluded that women are disadvantaged in the criminal justice system because policies and practice are based primarily on meeting the needs of male offenders. Corston highlighted that it was necessary to adopt different approaches that were more appropriate to women's needs and characteristics to achieve improved and equal outcomes for women.

The report added that there was a need to look more broadly at the reasons and circumstances that can lead women to the point where they are in custody and at risk of harming themselves. This raised further questions about whether prison was having a disproportionate impact on some women, bearing in mind the increased likelihood that they would have particular vulnerabilities, such as mental health problems, drug misuse or histories of violent and sexual abuse. The review was commissioned to examine women's pathways through the criminal justice process and the interventions and services available at each stage. It sought to identify what more could be done to tackle problems at an earlier point, so as to avoid if possible the situation whereby women with vulnerabilities end up in prison.

The Corston Report made 43 recommendations for improving the approaches, services and interventions for women in the criminal justice system and women at risk of offending and called for a greater focus and gender specific approach to women in the Criminal Justice System and those at risk of re-offending. These included:

- every agency within the criminal justice system must prioritise and accelerate preparations to implement the gender equality duty and radically transform the way they deliver services for women;
- all magistrates' courts, police stations, prisons and probation offices should have access to a court diversion/Criminal Justice Liaison and Diversion Scheme in order to access timely psychiatric assessment for women offenders suspected of having a mental disorder. These schemes should be integrated into mainstream services and have access to mental health care provision. Funding for the creation and maintenance of schemes should be ring-fenced;
- the NHS should provide health care services to police custody suites; in busy areas this will require a 24-hour presence and ideally be a registered mental health worker;

- ❑ and, women’s centres should also be used as court and police diversions; as part of a package of measures for community sentences; and for the delivery of probation and other programmes.

The Government Response to the Corston Report was to accept 40 out of the 43 recommendations and develop a National Service Framework for Women Offenders which provides the context within which NOMS, and their partners should work. This builds on the work achieved by the Women’s Offending Reduction Programme, launched in 2004 and followed in 2005 by the announcement of £9.15 million for the Together Women Programme to demonstrate how a multi-agency approach in the community could address women’s complex needs more effectively.

The framework is intended to deliver the Government’s high-level vision for how services should be delivered to women offenders. The headline aim is to ensure that women who come into contact with the criminal justice system are treated appropriately so as to protect the public and reduce re-offending, whilst also meeting their specific and individual needs. To achieve this the government intends:

- ❑ to reduce the number of women coming through the criminal justice system
- ❑ for women who are sentenced, ensure that their needs are met in the community wherever possible;
- ❑ and, or women who are sentenced to custody ensure that the facilities are appropriate to their needs.

By fulfilling these aims the following outcomes in support of the Departmental Strategic Objectives for “protecting the public and reducing re-offending” and “improving criminal justice” will result in:

- ❑ fewer women being sentenced;
- ❑ fewer women being held in custody;
- ❑ reduced re-offending;
- ❑ and, improved well-being and a reduction in self-harm for women in contact with the criminal justice system.

To achieve these aims, the document details statutory service requirements for women offenders as they pass through the various stages from arrest to sentence to community supervision or imprisonment to release, and potentially breach or recall to prison. This is categorised as:

- ❑ Phase 1 – pre-court offender assessment (including pre-sentence reports) and potential diversion either from the court process or custodial remand;
- ❑ Phase 2 – sentence planning, for either community or custodial provision;
- ❑ Phase 3 – community interventions;
- ❑ Phase 4 – custodial categorisation and allocation, and interventions;
- ❑ Phase 5 – offender release and subsequent community supervision and interventions;

- Phase 6 – breach and recall.

CJLS and CDS would assist directly impact on Phase 1 and assist with recommendations for Phase 2 and 3.

The NSF has requested that the Bradley Review consider specific recommendations in relation to women offenders with severe mental health problems to assist in their diversion away from prison. Following the publication of the NSF, the Ministry of Justice also published 'The Offender Management Guide to Working with Women Offenders' (May 2008).

Criminal justice liaison and diversion schemes: A focus on women offenders

The positive impact that schemes can have has already been highlighted and Corston called for a comprehensive network to prevent women receiving custodial remands and sentences. This Nacro and Institute for Criminal Policy Research briefing considered:

- the extent to which court diversion and criminal justice liaison schemes were able to contact women offenders with mental health needs;
- the extent to which schemes provided access to support and treatment to enable women to remain in the community rather than receive a custodial sentence;
- the factors that helped or hindered court diversion and criminal justice liaison schemes in their task of identifying and supporting women offenders with mental health needs.

The evaluation found that the delivery of services was patchy and that the specific needs of women were often missed. The paper made a number of general recommendations relating to commissioning, resourcing and performance monitoring. In respect of women it called for:

- informed gender practice including proactive screening to identify women with less obvious mental health needs – unlikely to be picked up by non-specialists eg, women who appear challenging can also be very vulnerable; offering the service user the choice of speaking with a female member of staff; and, training for scheme staff on women's mental health and other needs and the profile of women offenders;
- partnership working including improved relationships between court diversion and criminal justice liaison schemes and arrest-referral workers; improved relationships between court diversion and criminal justice liaison schemes and in-reach teams in female prisons; and links with community-based services including women centres, women-only hostels, supported accommodation and drug projects, crisis centres, and services that engage with sex workers (see Griffin Society's database);
- and, a user strategy to fully engage with service users and effectively consult with.

Black & Minority Ethnic Service Users

A number of reports^{xxi xxii xxiii} have shown that a significant number of service users from Black and Minority Ethnic (BME) communities only access mental health services via aversive pathways, including through the criminal justice system (CJS).

This is likely to result in inappropriate and sometime costly outcomes, which give rise to dissatisfaction about the service received from a range of agencies.

Although Court Diversion Schemes (CDS) and Criminal Justice Mental Health Liaison Schemes (CJLS), or similar arrangements, play a vital role in facilitating the transition across the interface between the CJS and the health and social care sectors, many of these schemes' practitioners – when completing a recent Nacro survey^{xxiv} - felt that:

- ❑ the criminal justice system was discriminatory by nature and so BME service users were being disadvantaged by their involvement in it;
- ❑ the low numbers of BME service users seen by some schemes meant that they 'stood out' and may receive a different service as a result of that;
- ❑ there are limited resources available to meet their specific needs;
- ❑ there are problems when English is not a first language;
- ❑ there is a general lack of understanding of need;
- ❑ there is a lack of mental health service provision – particularly provision that is culturally sensitive;
- ❑ there is a pre-supposition of dangerousness and risk with Black clients. Respondents felt that this applies to mental health staff as much as criminal justice agencies – and means that many service users are perceived as presenting a high risk and, are therefore referred to secure inpatient services inappropriately;
- ❑ and, many areas have a transient population ie, the nature of need changes and resources may be applied to a group that is no longer resident in the area a few months later.

Therefore, even where CDS & CJLS initiatives exist, the specific needs of BME service users may not be properly assessed or met.

A recent good practice guide by Nacro^{xxv} highlights that, if schemes are to properly assess and met the needs of BME service users they should: recruit a diverse workforce; offer assessments by someone from the same or similar minority ethnic group; involve BME service users, carers and providers in the scheme's steering group; consult with BME service users, carers and providers in developing the scheme; ensure that assessments take account of a person's cultural and spiritual needs; guard against misunderstanding or discrimination in the assessment of risk; record, monitor and analyse the scheme's activity in relation to BME service users; develop pro-active links with BME service providers; and, ensure that all staff participate in equality and diversity training.

Learning Disability

A number of studies have been conducted on the prevalence of offenders with learning disabilities with varying results. The variation is due to a number of factors, including differences in the screening and assessment tools used and what is being measured. Recent research suggests that:

- ❑ 7% of prisoners have an IQ of less than 70 and a further 25% have an IQ of less than 80 (Mottram 2007);
- ❑ 23% of prisoners under 18 have an IQ of less than 70 (Harrington, Bailey et al 2005);
- ❑ between 20 and 50% of men in prison have a specific learning disability (Disability Rights Commission 2005 memorandum to the Commons Select Committee on prison education);
- ❑ a quarter of children in contact with the youth justice system have learning disabilities (DH 2007).

There are a number of issues that need to be addressed in relation to offenders with a learning disability. These include: identification; what the learning disability means in relation to charge, acting as a witness etc.; appropriate assessment; accessing support eg, appropriate adult; and, accessing resources – in particular community resources to offer and alternative to custody.

Most criminal justice mental health liaison schemes and court diversion schemes are focused on offenders with mental illness. Although practitioners will claim that they are able to identify people with a learning disability and refer them to the appropriate service, the reality may be very different. There are currently 3 schemes in England and Wales that have active links with or practitioners from learning disability services. None of these exist in the West Midlands although one did operate previously in Wolverhampton.

NOMS has commissioned work to address this issue. 'Positive Practice – Positive Outcomes'^{xxvi} aims to: help criminal justice professionals recognise when a person may have a learning disability; be aware of their communication and support needs; and make links with local learning disability and support services. The handbook draws attention to Community Teams for People with Learning Disabilities (CTLDs), Criminal Justice Liaison Teams and Forensic Learning Disability Teams, which can all potentially help with early detection and assessment of learning difficulties/disabilities.

Both 'Positive Practice – Positive Outcomes' and 'No-one Knows'^{xxvii} theorise that, if there has been effective screening and diversion at the police station, the number of people with learning disabilities appearing in court unidentified as such should decrease. They also call for there to be pro-active and effective diversion schemes to keep people with learning disabilities out of the criminal justice system where appropriate.

Personality Disorder

Personality disorders are one of the most contentious and difficult to define categories of disorder. It is unlikely that any other mental disorder carries a greater stigma. The Government's response, set out in 'Personality disorder: no longer a diagnosis of exclusion'^{xxviii}, is that all Trust's delivering mental health services should consider how to meet the needs of people with a personality disorder.

This multi-agency approach is also taken up by the new NICE guidelines^{xxix} on antisocial personality disorder. It is likely that many people with an antisocial personality disorder will be in contact with the CJS and that schemes will be well-placed to both identify them and refer them to suitable programme providers.

OTHER COURTS

Youth Courts

The youth court is a section of the magistrates' court and can be located in the same building. It deals with almost all cases involving young people under the age of 18. Youth courts are less formal than magistrates' courts, are more open and engage more with the young person appearing in court and their family. Youth courts are essentially private places and members of the public are not allowed in. The victim(s) of the crime, however, has/have the opportunity to attend the hearings of the court if they want to, but they must make a request to the court if they wish to do so. The needs and wishes of victims will always be considered by the court and, through the youth offending team (YOT), they often have the opportunity to have an input into the sentencing process.

Although some CJLS and CDS were attached to youth courts, that no longer seems to be the case. Some schemes do try and develop active links with youth courts and Yots to assist with advice and recommendations.

The Children and Young People Health and Social Care Programme Board, which includes the Department of Health (DH), the Ministry of Justice (MoJ), the Department of Children, Schools and Families (DCSF), the Home Office and The Youth Justice Board is supporting a major national programme of six pilot youth justice liaison and diversion schemes for young people with mental health, learning, communication difficulties or other vulnerabilities affecting their physical and emotional well being.

The pilot schemes are designed to identify and support under 18 year olds (and their families) more systematically into services at the point that they enter youth justice system. Workers will liaise closely with partners in the youth justice system to support decision making at this early stage in the Youth Justice System (YJS) and with local providers of children's services in local areas to improve access to services. The pilots will contribute to the knowledge base on what works, for whom and at what point in the young person's youth justice pathway. Pilot sites will also be part of a national research programme to evaluate their role in improving outcomes for this group and in providing wider benefits.

Findings from these pilots, and recommendations from the Bradley Review and the Offender Health and Social Care Strategy will provide guidance for schemes and commissioners to develop this area of work.

Civil Courts

The Civil Court system of England and Wales is separate from the Criminal Court system. In simple terms, while the role of the criminal court is to decide whether someone is guilty of a criminal offence, the role of the civil court is to resolve disputes between two or more people.

The civil Courts are divided into two main categories: the County Court and the High Court. Judges in the civil courts will hear cases involving for example divorce, child care and adoption, consumer disputes, bankruptcy, contract disputes and compensation claims involving accidents or personal injuries.

Most civil cases will be heard at a local county court. For cases involving very large sums of money or very complex issues, the High Court will usually hear the case.

Most towns have a local county court. Most larger towns and cities have a High Court as well as a County Court – these courts are usually in the same Court building.

It is unlikely that schemes will operate at Civil Courts. One scheme in the South West has attended Civil Courts to support people appearing at the magistrates' court who is also subject to proceedings there. However, unless scheme members carry a case-load it is probably more appropriate that other mental health staff are involved with such cases.

Community Justice Centres

Building on the North Liverpool Community Justice Centre and a similar project in Salford, community courts operate on eight key principles of community justice:

courts connecting to the community

justice is seen to be done

cases handled robustly and speedily

a strong independent judiciary

solving problems, finding solutions

working together

repairing harm, raising confidence

re-integrating offenders, building communities.

They are part of the Government's agenda to tackle anti social behaviour and the crime associated with it by bringing the justice system and the community together to solve problems, reduce crime and build confidence.

One of the new community justice centres is based in Birmingham. The initiative is led by the West Midlands Criminal Justice Board to encourage partnership working between all of the criminal justice agencies as well as the local Judiciary and Magistrates, local authorities, Victim Support, Community Safety Partnerships and many other services such as housing associations, and drug and alcohol services. There is a dedicated courtroom for Community Justice based in Birmingham Magistrates' Court. The court will co-ordinate social services and unpaid work programmes, and will offer support for victims of crime, and advice and help for witnesses. For offenders, it will combine punishment with help to encourage them to address the problems that are at the root of their criminal behaviour, linking them with organisations who can offer advice on drug treatments, health care and education.

The court focuses on crimes like anti-social behaviour, robbery, domestic burglary, vandalism and graffiti, and drug-related crime. It is designed to respond to the specific concerns of individual communities and to address the crimes that affect the community.

The court has new powers under Section 178 of the Criminal Justice Act 2003 which provides the power for the court to review offenders progress as they carry out community orders. This means that when an offender is given a community penalty the court can order that the offender comes back to court on a regular basis and for their behaviour during the sentence to be considered. This increased oversight by

the Judge or Magistrates will bring increased responsibility and encouragement for offenders to comply with the conditions of the sentence. It will also give the court the opportunity to support the offender as they face challenges and adapt the conditions of the sentence if conditions change.

This section of the Act has been enacted exclusively for the community justice courts, helping to inform government decisions about bringing in reviews of community orders more widely across England and Wales. The new Mental Health Court pilot based at Stratford Magistrates' Court is able to use this power – Stratford has a community court – to review sentences including a Community Order with a Mental Health Treatment Requirement.

Neither of the 2 evaluations of North Liverpool^{xxx} or Salford^{xxxi} have flagged up mental health issues although it would be surprising if this was not an issue. The Birmingham Court Scheme does not appear to have any links with the community court but, in light of the Mental Health Court pilot, this might be an area of work that should be pursued.

FINDINGS

Commissioners

Only 5 out of 22 questionnaires – 2 within the timescale and both from Warwickshire – were returned by commissioners despite follow-up 'phone calls and emails. One of these (Staffordshire) was completed by the Mental Health and Criminal Justice Manager although with reference to commissioners. The lack of responses may be indicative of the lack of understanding by commissioners to this area of work.

From these questionnaires 3 commissioning models emerge. The first (Warwickshire) is a jointly commissioned service by the police, health, social care, and probation to provide mental health input at police stations, probation centres and approved premises. While the commissioners are clear this service does not operate at courts, the providers all say that they do also visit magistrates' courts. It is not clear if this is to follow-up clients they have identified at the police station or as a separate service. The service has been commissioned since 1996 and provides for 2.5 wte Community Forensic Psychiatric Nurses (CFPN). The funding for the scheme is unclear. One of the respondents says that this is commissioning for a specific service while the other says that it is part of 'block commissioning' with Coventry and Warwickshire Partnership Trust.

Funding for the service is approximately £180k p.a.

The second model (Shropshire and Telford) is described as Criminal Justice Liaison and is funded as part of block commissioning although, in the case of Shropshire, it is not stated whom this is with. The funding is for 1 Band 7 Nurse. It is not clear whether the service applies to any other point of intervention beyond the court. The provider reports that she attends police stations, magistrates' courts and crown court. For Telford it is with the Foundation Trust with specific activity being monitored.

The final model (Staffordshire) covers the whole of the county. The service in the south of the county is provided by a partnership arrangement between the local authority, probation and mental health trust and between the local authority, probation and 'combined healthcare' in the north. Both teams include CPNs, probation offender, social worker and secretarial support. The North Staffordshire/Stoke-on-Trent team has dedicated input from a psychiatrist. Each has their own team leader with an overall county-wide Mental Health & Criminal Justice Manager.

The service operates at courts – mainly magistrates' but will attend crown when required. There is also a clinic/fast track service to 2 Approved Premises in North Staffordshire and Stoke. Mental health input into police custody suites is not specifically commissioned but is offered on an "as and when basis". This has been identified within the County/Stoke strategy as a priority development.

Services are described as having 'evolved' and have been in place for more than 10 years. It is not clear from the completed questionnaire how these arrangements are commissioned or whether the probation and social work posts are designated by the relevant agencies rather than provided from a jointly commissioned 'pot'. From information supplied by the provider, it would appear that the initial scheme received 'pump-priming' funds from the Home Office in 1994. When this ended, a partnership arrangement was established with some posts being taken from block contracts, and some being provided by an agency. Further posts eg, admin support, team leader, and consultant psychiatrist have resulted from specific funding bids to the PCT or LIT.

Commissioners were asked whether or not they received feedback from schemes and if they did what this involved. 3 respondents said they did and 2 said they didn't. There were 2 replies from Warwickshire but both gave different answers to this question. One possible explanation for this was that the positive response came from the ACO National Probation Service – Warwickshire and both questionnaire responses from the providers said that they send information on recording and monitoring to probation but mentioned no-one else as receiving this information.

Where feedback was sent, this is in the form of statistics with a written report either "as requested" or as part of a "brief commentary on statistics". Identification of unmet need was included to some degree or could "be interpreted from the statistics".

3 respondents (Staffordshire and Warwickshire) say that there is a steering group for the scheme(s) and that they are a member. These responses are supported by replies from providers although 1 of the schemes in Warwickshire says that the scheme had a steering group but that it has "lapsed over the past year or so due to various reorganisations. My understanding is that it will be reinstated in the near future".

In relation to whether or not there is a Service Level Agreement (SLA) or any other documentation with the schemes:

- Shropshire responded that there is a service specification with the scheme (the provider says that there is no SLA or similar);
- Staffordshire says that it is "currently in development with Contractual and Service Specification work being undertaken in JCU (answer supported by the provider);
- Telford has a service specification rather than an SLA. This details: criteria – including catchment area; description of the service including team skill mix and numbers, aims and objectives, and service response targets; what the service does; leadership; and, partnership working;
- Warwickshire has a framework agreement that requires updating.

A copy of the framework agreement for Warwickshire was seen which includes the aims and purpose of the scheme, sets out a commissioning framework, states the referral process and criteria but does not include performance indicators or targets.

Respondents suggested that an SLA should include the following elements: staff skills; range of interventions; service model; numbers diverted at point of arrest; numbers diverted at court; outcomes for those diverted; re-offending rates; numbers admitted to hospital from diversion; training; and, joint working arrangements.

Providers

11 out of 13 questionnaires were returned by providers/schemes. The majority of these were within the timescale. 1 scheme (Rugby) was unable to complete the questionnaire as the worker is away from work on long-term sick and there is no cover or anyone with knowledge of the service. 1 scheme (Solihull) did not return a questionnaire despite prompting.

The questionnaire for Birmingham also covered Coventry and Dudley.

The schemes vary in the way they work, their size, whether they are a specialist service or provide a service to criminal justice agencies within a wider role (eg, as part of a Community Forensic Team), and where they are located (eg, within a Community Mental Health Team).

10 of the schemes operate at more than one point of intervention in the criminal justice process. Most usually this is police station(s), court(s) (both magistrates' court and crown court), and probation centres (sometimes on as a result of a request or a referral). Some schemes also liaise with or work with approved premises and prisons. 2 schemes have links with the Youth Court – Hereford and West Bromwich. The latter through a clinical contact in the Youth Offending Team (Yot). Only 1 scheme - provided by Reaside Medium Secure Unit to the courts at Birmingham, Coventry, and Dudley - operates at only one point (ie, magistrates' court) within the CJS.

A total of 21 magistrates' courts, 2 crown courts, 12 police stations, 15 probation centres, 7 approved premises are worked with and there is liaison with 7 prisons.

4 of the schemes report that funding for the service is through 'block funding' to the mental health trust; 2 (Warwickshire) is through joint funding from police, probation health (not clear if PCT specific or block funding), and social care; 2 schemes (Staffordshire) report that funding is through joint arrangements (probation, health, social care) including specific funding for certain posts; 2 from the PCT specific to the post; and 2 include funding from West Midlands Specialised Commissioning Team (WMSCT). 1 scheme thinks that some funding may be from the safer Borough Partnership and another from the Joint Commissioning Group.

Only 1 scheme (Leamington Spa/Stratford) reported that the scheme had an SLA with its commissioner. 1 scheme (Hereford) said that there is an SLA with the Joint Commissioning Group for its Drug Arrest Referral Work. It also receives funding from the PCT but there is no SLA. 1 scheme (West Bromwich/ Warley) is unsure but thinks this will change as the provider is now part of a Foundation Trust; 1 scheme (Wolverhampton) did not answer this question. All 7 other schemes stated there was no SLA with their commissioner(s).

The key element of Leamington Spa/Stratford's SLA is to "provide assessments/support". The key element of the SLA between Hereford and the JCG re the scheme's Drug Arrest Referral work is to "provide Drug Arrest Referral screening at point of police custody and refer on".

There are no SLAs between any of the schemes and another agency or another organisation.

6 schemes say they have an operational protocol; 3 did not answer this question; and, 2 (Nuneaton and West Bromwich/Warley) say that this is currently under review. Of the 6 schemes that responded positively, all said that the protocols include targets for responding to requests (one of these as part of CPA arrangements) and 5 of these also include reporting mechanisms.

In respect of other protocols which might assist multi-agency working:

- 7 schemes have ones on information – 1 of these (Stafford) via the Trust's CPA policy; 1 (Hereford) relies on that developed by the PCT; 2 (Shrewsbury and West Bromwich/Warley) adhere to the general Trust protocol; and, 1 scheme (Walsall) is currently developing a protocol;

- 4 schemes have a protocol on accessing assessment - 1 of these (Stafford) via the Trust's CPA policy; 2 (Shrewsbury and West Bromwich/Warley) adhere to the general Trust protocol; 1 scheme (Walsall) is currently developing a protocol; 1 (Nuneaton) does not have a protocol; and, 2 (Hereford and Telford) did not answer the question;
- 3 schemes have a protocol on conveying; 3 (Nuneaton, Shrewsbury and West Bromwich/Warley) adhere to the general Trust protocol; 2 (Leamington Spa/Stafford and Walsall) do not have a protocol; and, 3 schemes (Hereford, Stafford and Telford) did not answer the question.

9 of the 10 schemes currently record and monitor the activity of the scheme. 1 scheme (Stafford) is currently setting up a database to record this information. 1 scheme (Wolverhampton) did not answer this question. Information is sent to a range of individuals, groups, agencies and organisations including: line manager; probation mental health trust; multi-agency group; county-wide MDO steering group; and, WMSCT. 1 scheme (Hereford) collects statistics but these are not requested by other agencies so, presumably, are not sent to any.

5 schemes report that they have steering group; 2 (Hereford and Shrewsbury) that there is no steering group; 2 (Nuneaton and Telford) that there is no longer a group; 1 (Walsall) did not answer the question. 1 further scheme (Wolverhampton) said that they have a steering group but it would appear that this is really a Forensic Team meeting.

The groups, where they exist, have representation from a range of relevant criminal justice, health and social agencies and vary in whom provides the Chairs. All 4 meet quarterly and report within the Trust, to the Local Criminal Justice Board, WMSCT, probation, to the local joint commissioning unit, and to the local authority. We did ask whether or not Terms of Reference, work programmes etc exist for these groups.

Staff members from 7 of the schemes receive monthly supervision of their work. 1 scheme (Stafford) weekly supervision. 1 scheme (West Bromwich/Warley) allow staff to decided upon the frequency themselves – although it is usually every 5 – 6 weeks – and 2 schemes (Hereford and Wolverhampton) did not answer this question.

Staff in 5 of the schemes receive monthly clinical supervision; for 1 scheme (Nuneaton) it is monthly from the line manager and quarterly as part of meetings with clinicians from Reaside MSU; 1 scheme (Stafford) quarterly from the team leader; 1 scheme (Leamington Spa/Stafford) when available from consultants at Reaside MSU; 1 scheme (Hereford) via weekly team meetings; and, 1 scheme (West Bromwich/Warley) allows staff to identify their own supervisor but this is proving difficult. Rather staff discuss cases on a daily basis and weekly as part of a formal clinical review. 1 scheme (Wolverhampton) did not answer this question.

Clinical supervision is provided by a range of individuals including: peer support; as part of the team; line manager; senior professional leads from different agencies; clinicians and consultants at Reaside MSU. As well as West Bromwich/Warley, Walsall also flags up difficulties in identifying a suitable clinical supervisor for this line of work.

COMMISSIONING TEMPLATE/SERVICE SPECIFICATION

In order to meet the needs of commissioners, agencies working with offenders with mental health needs, and the individuals themselves and their carers, a service specification needs to be developed to provide a criminal justice mental health liaison service which can achieve effective and appropriate outcomes. This should be consistent with government reports and guidance, build upon existing good practice, meet local need and be based on the principle of world class commissioning.

World class commissioning is a statement of intent aimed at delivering outstanding performance in the way health and social care services are commissioned. This requires taking a strategic and long-term approach to commissioning services with a clear focus on delivering improved health outcomes. It also involves a shift from traditional models of commissioning with a pivotal shift from diagnosis and treatment to prevention and well-being. It includes taking an evidence-based approach.

World class commissioning encourages commissioners to actively shape local services to deliver a wider choice of more personalized high-quality solutions. PCTs will provide the lead through building close relationships with key local partners – including through joint commissioning - to drive dramatic improvements in quality and safety.

Such commissioning should be informed by a health needs analysis.

Aims

The aim of the service should be to provide a clear care pathway for staff working across the interface of criminal justice and health and social care to facilitate effective and appropriate outcomes. This should be an integrated approach linked to mainstream services, which will result in a reduction in the 'revolving door' client, a reduction in re-offending, and a reduction in social exclusion. Other key benefits of such a model include:

- early intervention resulting in the production of timely and appropriate reports for the court, a reduction in requests for expensive and time-consuming psychiatric reports, a reduction in the use of remand, and a reduction in the needs for subsequent expensive prison transfers;
- a reduction in the number of people 'slipping through the net';
- effective information exchange along the care pathway;
- effective multi-agency working;
- and, joint training and support.

The objectives of such a service would be to:

1. Provide a consistent service to those in contact with the CJS who have mental health issues.
2. Identify as early as possible any person in contact with the CJS who has a mental health issue.
3. Undertake an assessment and help facilitate subsequent assessments.

4. Ensure that the appropriate people in the criminal justice system have information about a person's mental health to ensure the most appropriate disposal.
5. Reduce the number of remands in custody awaiting mental health assessment and information.
6. Negotiate and facilitate appropriate level services at an early stage to those with mental health problems who are in contact with the CJS to prevent re-offending and promote public safety.
7. Reduce the number of secure beds needed by mentally ill offenders by offering appropriate level services as early as possible.
8. Re-engage service users who have lost contact with treatment and are at risk.
9. Improve the relationship between mental health providers and criminal justice agencies and increase understanding and information sharing.
10. Offer courts the increased opportunity to use a Community Order with Mental Health Treatment Requirement by providing appropriate information to allow for such decisions.

Funding & Commissioning

For any service to be sustainable and to be able to develop to meet increased demand it requires secure, long-term and protected funding. This should be provided by health through its commissioning process. Where one or more commissioner has responsibility for an area covered by a scheme then one should act as the lead commissioner for the scheme. Equally there should be an agreed provider.

Some in-kind funding (eg, providing an office rather than making a direct grant) could be provided by other agencies to generate a sense of shared ownership and accountability.

If an individual agency has particular service requirements (eg, mental health support to approved premises) then they should be prepared to fund these.

Scheme

Site of operation: For intervention and diversion to be effective and to prevent people falling through the net, the scheme needs to operate at a variety of points of intervention in the criminal justice system. The more sites it covers, the more effective it is likely to be as well as providing a conduit for the exchange of, and passing of, information between these different sites. However, if the scheme is not adequately resourced and staffed to allow this to happen effectively then it might be better to operate at just one point in the criminal justice system.

The earliest point of intervention will be at the police custody suite. The service should look to complement existing health provision by providing specialist mental health assessment and advice. The service should operate five-days per week and look to provide an 'out of hours' either by offering an 'on-call service' or by linking with the Crisis and Home Treatment Team.

The service should provide a full service to the courts. It should not just operate at the magistrates' court but will need to be available to the crown court and to be linked

to the youth court. This should be a five-day provision with consideration being given to covering Saturday morning and Bank Holiday courts.

There should be formal links with the prison in-reach or prison mental health team. There should be agreement on joint working, communication and information sharing, and, referrals to provide a seamless service of care.

Although the scheme will operate at points of intervention in the CJS it should not be seen as either a 'stand alone' or 'add-on' service. Rather it should be fully integrated with mainstream mental health services.

To assist local mental health services and commissioners to track people through the criminal justice system and to plan for service development, the scheme should aim to provide a tracking service where contact and CPA arrangements are supported as service users pass through custodial settings or secure mental health facilities.

In working to achieve the aims of maintaining people in community settings, managing risk and providing community options to courts, the scheme should offer a time-limited co-working service to CMHTs to support and develop confidence in working with this client group and increase the range of community options.

The scheme should also look to co-operate with the probation service to produce appropriate Pre-Sentence Reports (PSRs). One option – developed in Staffordshire and Stoke has been through a designated probation officer being attached to the scheme.

Staffing: schemes should be both multi-agency and multi-disciplinary to allow for a more rounded assessment, and to ensure access to a variety of disposal options. This should, wherever possible, mirror a community mental health team and include or have input from: consultant psychiatrist; psychologist; CPN; social worker; community support workers; and, administrator or secretarial support. Consideration should also be given to attaching a probation officer to the scheme. The role of the administrator is vital providing not only support for the scheme and its workers (eg, collating information, taking messages etc) but also acting as a contact point for other agencies and referrers.

In order to meet the needs of people with a learning disability who come into contact with the criminal justice system, either a practitioner from learning disability services should be recruited or be seconded to the team. Alternatively, discussions should take place with LD services to ensure that an LD practitioner can respond to a request for an assessment or in providing advice to the scheme.

The make-up of the staff team should be diverse both in relation to ethnicity and gender. Not only does this ensure that it reflects the community it serves but also allows a service user to choose whether they wish to be assessed by someone of the same gender and the same – or similar – minority ethnic group. Such an approach fits with the principle and concept of choice but may also mean that the quality of the assessment is better as the service user is more engaged in the process. Where this is not possible, then links need to be made with other teams to allow for this to happen.

The skills needed by scheme staff include:

- mental health assessment skills;
- risk assessment skills;

- ❑ working knowledge of the CJS;
- ❑ working knowledge of the Police and Criminal Evidence Act (PACE) 1984 including the role of the 'approved medical practitioner' and Codes of Practice;
- ❑ knowledge of the Mental Health Act 1983 as amended by the Mental Health Act 2007 and the Codes of Practice;
- ❑ knowledge of local mental health services and how to access them;
- ❑ knowledge of local social care including housing, employment, and support services and how to access them;
- ❑ knowledge and understanding of specialist services eg, for women, for service users from Black and Minority Ethnic communities and how to access them;
- ❑ understanding of the issues surrounding offenders with mental health needs including the appropriateness of charging and diversion.

It is important that schemes are able to access psychiatrists and Approved Mental Health Practitioners (AMHPs) both easily and speedily especially where an assessment is needed prior to possible admission to hospital. If funding does not allow for a psychiatrist to be attached to the team, then there should be agreed arrangements for obtaining psychiatric advice or opinion or for there to be regular, weekly sessional input into the service. This might also apply to input from psychological services and Occupational Therapy (OT) services.

Referrals: the scheme should look to offer a mixture of both pro-active screening (ie, actively attending a police station or court and actively seeking to identify people with a mental health problem including the use of databases to identify people known to mental health services) and responding to referrals from agency staff. The referral form should identify the immediate problems as perceived by the referrer and allow the health professional to prioritise the level of access to the services available. An example of a referral form that achieves both these aspects for is the Threshold Assessment Grid (TAG) produced by Kings College^{xxxii}.

The greater the range of referrers, the more likely an effective intervention will be made. Referrals should be accepted from :Court staff; Magistrates; Probation staff; Crown Prosecutors; Solicitors; Gaolers/custody services; Self-referral; Family & friends; Accommodation providers; Prisons; Police; Forensic Physicians; Arrest-Referral Workers; Appropriate Adults; In-patient units; Community Mental Health Teams; Alcohol & Drug Services; Yots.

Criteria: the scheme should see anyone with a known or suspected mental health problem in contact with the CJS or someone whom a practitioner is concerned about.

Assessments

Assessment describes the process of gathering information on, and knowledge of, an individual for the purpose of identifying needs. This may include an initial screening or triage before a full mental health assessment where necessary. Both processes should include an assessment of risk. There are three elements to the assessment:

the process itself, the gathering of information (and how this is carried out) and the formatting of a care plan.

The staff role in relation to the assessment should be clear. It is to assess the person's mental health needs and develop a plan to have these met. They should also provide advice to criminal justice agencies about management and treatment. However, they are neither aligned with criminal justice agencies nor an advocate on behalf of the service user.

Schemes should aim to provide mental health assessments as speedily as possible for all clients. There should be written agreement, in the form of agreed protocols, between the scheme, criminal justice agencies and health and social care professionals about the purpose of the assessment, how it will be carried out and what outcomes might occur.

The assessment process should take full account of the individual's specific needs including their gender, and their cultural and faith background. During this process it is important that due regard is given to ensuring that someone's cultural norms do not unduly influence the outcome and that their gender, cultural and spiritual needs are met.

The scheme should be clear about what advice – and what form that advice takes – can and should be made available to the police, the courts, prisons, defence solicitors, probation staff, and service users and carers. Advice should be supported by a written record. The advice should include: the person's mental state; any risk of suicide or self-harm; risk of violence to others; drug and alcohol use; and, possible disposals. Finally, a recommendation may be offered as part of that advice.

Information gathering and exchange

In order to ensure that a full understanding of someone's needs is obtained and their needs are met both effectively and appropriately, then information will need to both gathered and exchanged. The informed consent of the individual should be sought before any information is obtained or shared. A consent form should be signed. Ideally, the form should allow the individual to state people and agencies they do not want information obtained from or shared with.

Where consent is not given or where the person lacks capacity to give informed consent or where it is not possible or practical to obtain consent, there should be clear guidelines contained in jointly agreed information sharing protocols about when and how information might still be gathered and shared^{xxxiii}.

Where relevant information is obtained at one point in the criminal justice process there should be a clear mechanism for passing this on – either with consent or by meeting agreed criteria where consent is not given – along the criminal justice pathway.

Protocols

For the day-to-day operation of the scheme to be effective it is necessary for it to be supported by an operational protocol. The protocol details what the process of the service is and not just the elements that make it up. It should be jointly agreed by all key stakeholders to encourage ownership and accountability. Without such a protocol, the scheme has nothing to measure itself against. It also helps guarantee continuation of the scheme if key individuals leave while allowing newly recruited staff to gain an understanding of the scheme's aims and its overall operation.

The operational protocol should include: the aims of the service; what the service offers; who staffs the scheme with their roles and responsibilities; the geographical area the scheme covers; criteria for referral to the scheme; how to make a referral; where the scheme is located; the sites it operates at; hours of operation; contact details; and, its management and reporting structures.

As well as the operational protocol and one on information exchange, schemes should either develop or use their local agency's joint ones on:

- conveying people to hospital from the police station and court;
- risk assessment and risk management;
- partnership working with Arrest-Referral workers and other relevant teams;
- recording and monitoring;
- and, obtaining assessments under the Mental Health Act 1983 as amended by the Mental Health Act 2007.

The scheme should have a written complaints procedure, which can be used by service users and agencies working with offenders with mental health needs. The procedure should contain details of how and in what form complaints should be registered, to whom the complaint should be addressed, and how complaints will be investigated and resolved.

The scheme should also agree, with the relevant agencies, a formal or informal process for resolving disputes that might occur over particular cases or as part of the wider operation of the scheme.

Outcomes

As well as facilitating access to mental health services, schemes should also provide a liaison function to enable individuals to have their social care and other needs met. This includes both signposting to and assisting access to a range of services including accommodation, drug and alcohol services, benefits agencies, training and employment, and specialist services for women and people from BME communities.

Such referral should not on a case-by-case basis. Rather, schemes should develop formal links which includes the criteria for referral and protocols on information sharing etc.

Governance and Reporting

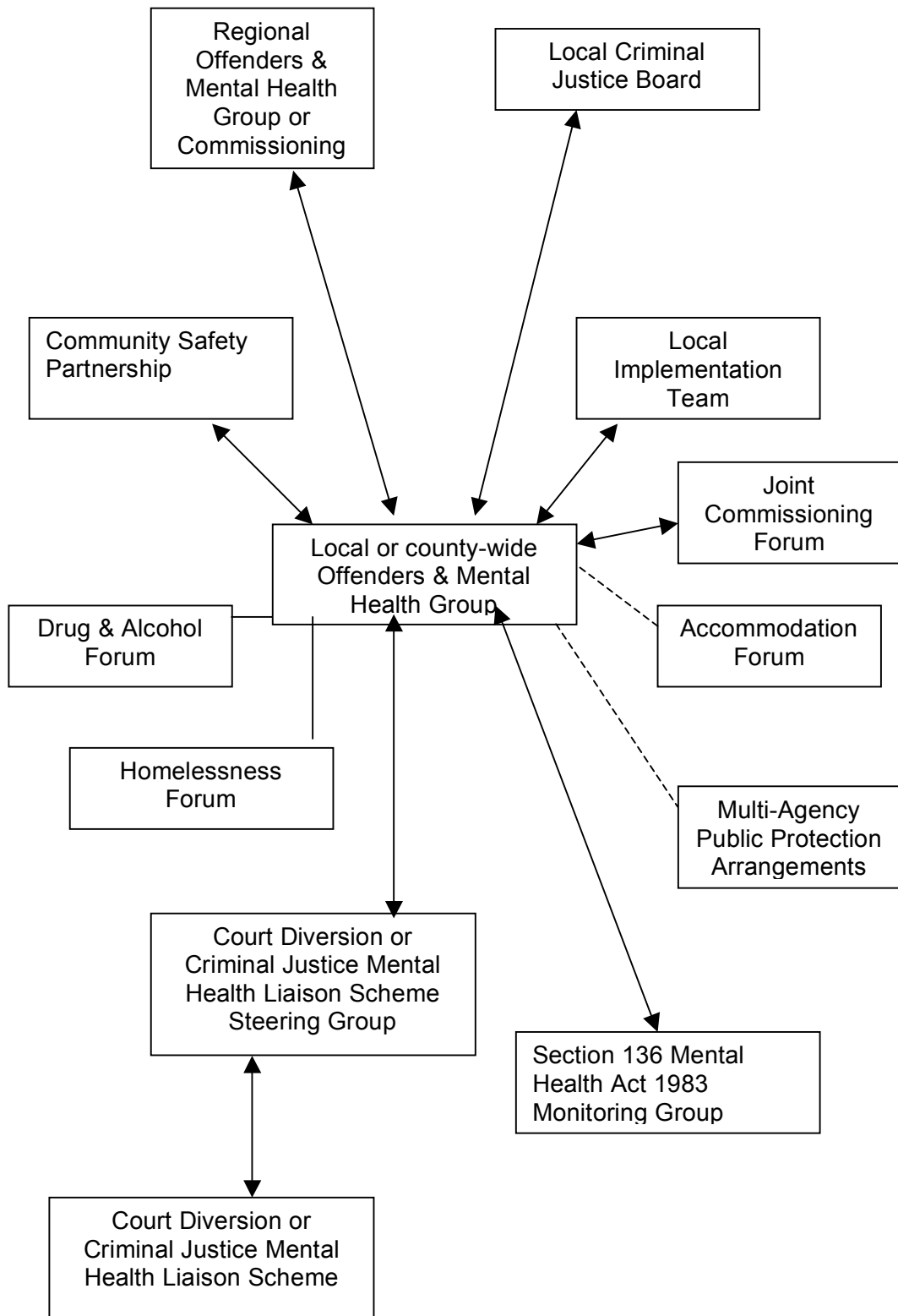
It is vital that robust and co-ordinated arrangements are in place that link schemes with commissioners and managers of services. The scheme should be line-managed by the most appropriate agency. It can exist either in its own entity as a discrete service or as part of another team's function. However, whichever arrangement is chosen it must be fully integrated with mainstream services and not seen as either an *ad hoc* arrangement or an 'add-on' to other services.

The scheme should have its own steering group, which can steer its day-to-day operation and future development. It must meet regularly (at least quarterly), have representatives from all relevant stakeholders (principally from the police, health, social services, probation, CPS, and the courts), have aims, terms of reference, and a work programme. It must also be able to report directly to relevant agencies and other bodies.

The steering group is unlikely to co-ordinate strategy or to be responsible for developing additional services. Ideally, this function will be the responsibility of a separate local or county-wide 'MDO' group linked to commissioning and planning structures which the scheme's steering group can feed into.

Schemes should not remain static but should seek to develop to meet any unmet need or fill gaps in existing service provision. To achieve this, schemes should have a development plan drawn up by and reviewed by its steering group. The scheme should engage with service users to ensure that their views are considered. This might be by direct consultation, through existing channels, or facilitated by a service user organisation.

An organisational structure is shown over page.



Meeting the needs of all

Women: as has been seen from the Corston Report and other publications, women's experiences of both the criminal justice system and the mental health system are likely to be different to those of men. Schemes should try to provide a choice of worker to assess and work with women offenders, develop links with women-specific services, and actively record, monitor and analyse outcomes specific to women.

Because some women may not wish to engage with mental health services – either because of previous experiences or because they are worried their children may be taken into care – scheme's might wish to recruit a women's advocacy worker to try to overcome this stigma.

Black and Minority Ethnic Groups: as has been noted, a number of reports have highlighted the different experiences people from Black and Minority Ethnic communities receive from both the criminal justice system and the mental health system. Schemes may be the first point of contact in ensuring that BME service users access appropriate services which meet their specific needs. Therefore, schemes should try to offer the choice to be assessed by some of the same or similar minority ethnic group, develop links with a range of BME service providers, ensure they have access to interpreters when necessary, and actively record, monitor and analyse outcomes specific to this client group.

People with Learning Disabilities: People with learning disabilities who become involved in the criminal justice process create similar, but often not the same, challenges to criminal justice agencies. They are not only more vulnerable in the criminal justice system but also more vulnerable in being drawn into it as well.

To improve the services for offenders, reduce the likelihood of re-offending, and to ensure the most appropriate and effective use of resources across all agencies, it is imperative that people are identified as having learning disabilities as early as possible. While one way of achieving this would be to recruit or second specialist workers to existing generic schemes. These could assist with the identification of people with a learning disability, provide advice and guidance on possible outcomes, and link people into appropriate services.

Where such arrangements are not possible, schemes should develop close links with learning disability services to assist in this work.

Children and Young People: The level of mental disorder amongst children and young people who offend remains disturbingly high. 90% of those who were imprisoned have shown evidence of some mental disorder^{xxxiv}.

Where there is no provision to the Youth Court, diversion and liaison schemes should work in collaboration with Youth Courts, Yots, and CAMHS to assess need and, where appropriate, provide advice and assessments. Information gathered by the scheme, the Yot and CAMHS should be used to argue for the development of a specific and appropriate scheme to meet the needs of children and young people. This will help develop services in light of the current pilots.

Personality Disorder: The role of diversion and liaison schemes in relation to people with a diagnosis of personality disorder is likely to be two-fold. Firstly, they should look to ensure that this client group has their needs addressed as appropriately and effectively as possible. Where there are local personality disorder services, service users should be referred directly and schemes should work closely with these services. Where no such services currently exist, schemes will need to be

champions in ensuring that all relevant agencies come together to provide a multi-agency approach to individual clients. In such cases the scheme may also need to allay practitioners fears and help reduce the stigma the label carries.

Additionally, schemes may be best placed to assist with the gathering of information about the local demand for personality disorder services.

Recording & Monitoring

Recording and monitoring activity is a key element for any service. Without access to hard data it is impossible to be sure what is happening as well as being able to identify gaps in provision. However, it is not just enough to record information, it must also be collated and scrutinised to ensure that the scheme is providing a consistent service and that the needs of all groups are being met, and to highlight developments that might need to be initiated.

Schemes should record:

- ❑ date and time of initial assessment;
- ❑ personal details – including name, address, age, gender, ethnicity, marital status, employment status, accommodation status, language, faith;
- ❑ the use of interpreters;
- ❑ site of intervention – whether at police station , court, prison, probation centre, hostel;
- ❑ which agency the referral came from including details of the person who made the referral and reasons for the referral being made;
- ❑ mental health state – including diagnosis (if known), mental health status (i.e. whether under a section of the Mental Health Act 1983), previous contact with mental health services, care co-ordinator, Responsible Medical Officer (RMO), treatment (if relevant);
- ❑ subsequent assessment details – including response times (if subsequent mental health assessment required), time of assessment, length of time to complete the assessment;
- ❑ criminal justice history – including details of current involvement with the criminal justice system;
- ❑ risk factors – including risk of suicide and self-harm or risk to others;
- ❑ drug and alcohol concerns - including details of any involvement with services;
- ❑ recommendation – including ideal recommendation if services and resources were available;
- ❑ unmet need;
- ❑ and, outcome.

Training

Training plays a vital role in underpinning the delivery of services and increasing the understanding of key issues. This is especially true for many schemes where practitioners may work on their own or the scheme itself is isolated from mainstream practice.

Training should focus both on the general needs of offenders with mental health needs and how these should be met and also on the specific needs of offenders from disadvantaged groups. There should also be some focus on recommendations from relevant reports, circulars, and other guidance, which informs both service delivery and individual working practice.

Training should include: that required for CPD registration; relevant legislation eg, Mental Capacity Act; the specific needs of disadvantaged groups and how to meet them; and, anti-racist and anti-sexist training.

Performance Indicators/Targets

This should include:

- staff and range of skills recruited;
- operational details including days and times at different sites in the criminal justice process;
- numbers seen eg, to see x number of clients per month, percentage of women and people from BME communities to reflect local population;
- numbers screened pro-actively;
- numbers seen as a result of responding to a referral;
- response times eg, to respond to referrals from the police within x hours, to provide information to the courts within x days;
- outcomes eg, numbers re-engaged with services, number of people registered with a GP, number of 'revolving door' cases reduced;
- links made with service providers;
- protocols developed by the scheme;
- training – both delivered and participated in;
- quarterly/annual reporting to a range of stakeholders and commissioners.

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