# Independent evaluation of responses to

**The Independent Review of the Diversion of Individuals with Mental Health Problems from The Criminal Justice System and Prison**

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## Acknowledgement

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# Glossary of abbreviations

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|---|---|
| **ABI** | **Acquired Brain Injury** |
| **ADHD** | **Attention Deficit Hyperactivity Disorder** |
| **ASBO** | **Antisocial Behaviour Order** |
| **BAA** | **British Airports Authority** |
| **BME** | **Black and Minority Ethnic** |
| **C&YP** | **Children and Young People** |
| **CAMHS** | **Child and Adolescent Mental Health Service** |
| **CD** | **Court Diversion** |
| **CDLS** | **Court Diversion and Liaison Scheme** |
| **CDLT** | **Court Diversion and Liaison Team** |
| **CDRP** | **Crime and Disorder Reduction Partnerships** |
| **CDT** | **Court Diversion Team** |
| **CJ** | **Criminal Justice** |
| **CJB** | **Criminal Justice Board** |
| **CJIT** | **Criminal Justice Intervention Treatment** |
| **CJLS** | **Criminal Justice Liaison Scheme** |
| **CJLT** | **Criminal Justice Liaison Team** |
| **CJS** | **Criminal Justice System** |
| **CMHT** | **Community Mental Health Team** |
| **CO** | **Community Order** |
| **CPA** | **Care Programme Approach** |
| **CPN** | **Community Psychiatric Nurse** |
| **CPS** | **Crown Prosecution Service** |
| **CSIP** | **Care Services Improvement Partnership** |
| **CSU** | **Community Safety Unit** |
| **CYPPB** | **Children and Young People's Partnership Board** |
| **DAAT** | **Drug and Alcohol Action Team** |
| **DCSF** | **Department for Children Schools and Families** |
| **DD** | **Dual Diagnosis** |
| **DDA** | **Disability Discrimination Act** |

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| **DH** | **Department of Health** |
| **DIP** | **Drug Intervention Programme** |
| **DRR** | **Drug Rehabilitation Requirement** |
| **FME** | **Forensic Medical Examiner** |
| **GP** | **General Practitioner** |
| **HCC** | **Health Care Commission** |
| **HMCA** | **Her Majesty's Courts Administration** |
| **HMCIP** | **Her Majesties Chief Inspectorate of Prisons** |
| **HMCS** | **Her Majesty's Court Service** |
| **HMPS** | **Her Majesties Prison Service** |
| **HO** | **Home Office** |
| **HSCCJ** | **Health and Social Care in Criminal Justice** |
| **IAPT** | **Improving Access to Psychological Therapies** |
| **IDTS** | **Integrated Drug Treatment System** |
| **IDVAS** | **Independent Domestic Violence Advisors** |
| **IPP** | **Indeterminate Sentence for Public Protection** |
| **IT** | **Information Technology** |
| **JSNA** | **Joint Strategic Needs Assessment** |
| **KPI** | **Key Performance Indicators** |
| **LA** | **Local Authorities** |
| **LAA** | **Local Area Agreements** |
| **LCJB** | **Local Criminal Justice Board** |
| **LD** | **Learning Disabilities/Difficulties** |
| **LIT** | **Local Implementation Team** |
| **LSCB** | **Local Safeguarding Children Board** |
| **LSP** | **Local Strategic Partnership** |
| **MAPPA** | **Multi Agency Public Protection Arrangements** |
| **MARAC** | **Mulit Agency Risk Assessment Conference** |
| **MDO** | **Mentally Disordered Offenders** |
| **MHA** | **Mental Health Act** |
| **MHS** | **Mental Health Service** |
| **MHT** | **Mental Health Team** |

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| **MHTR** | **Mental Health Treatment Requirement** |
| **MI** | **Mental Illness** |
| **MoJ** | **Ministry of Justice** |
| **MP** | **Member of Parliament** |
| **NCJB** | **National Criminal Justice Board** |
| **NHS** | **National Health Service** |
| **NIMHE** | **National Institute of Mental Health Executive** |
| **NOMS** | **National Offender Management Service** |
| **NSF** | **National Service Framework** |
| **OCJR** | **Office for Criminal Justice Reform** |
| **PALS** | **Patient Advice and Liaison Services** |
| **PCT** | **Primary Care Trust** |
| **PD** | **Personality Disorder** |
| **PIAGs** | **Patient Information and Advice Groups** |
| **PICUs** | **Psychiatric Intensive Care Units** |
| **PiRR** | **Partnerships in Reducing Reoffending** |
| **PND** | **Penalty Notice for Disorder** |
| **PSA** | **Public Service Agreement** |
| **PUG** | **Patient User Groups** |
| **QOF** | **Quality and Outcomes Framework** |
| **RMO** | **Responsible Medical Officer** |
| **ROMS** | **Regional Offender Manager** |
| **SHA** | **Strategic Health Authority** |
| **SLA** | **Strategic Learning Agreements** |
| **SMB** | **Strategic Management Board** |
| **SMI** | **Severe Mental Illness** |
| **SpLD** | **Specific Learning Difficulty/Disability** |
| **SPoC** | **Single Point of Contact** |
| **STC** | **Secure Training Centres** |
| **TASC** | **Treatment Alternatives to Street Crime** |
| **TBI** | **Traumatic Brain Injury** |
| **TC** | **Therapeutic Community** |

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| **TSO** | **Third Sector Organisations** |
| **UNCRC** | **United Nations Convention on the Rights of the Child** |
| **VCS** | **Voluntary and Community Sector** |
| **YJB** | **Youth Justice Board** |
| **YOS** | **Youth Offending Service** |
| **YOT** | **Youth Offending Teams** |

# Introduction

The Secretary of State for Justice Jack Straw announced a review of the diversion of offenders with mental health problems or learning disabilities (LD). The Rt Honourable Lord Keith Bradley was asked to undertake this review and the following terms of reference were subsequently agreed by ministers;

*'To examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases: be diverted from prison to other services and the barriers to such diversion'*

The review team led by Lord Bradley acknowledged that the prevalence of mental health problems in offenders and ex-offenders is far higher than that in the general population. Furthermore within the Criminal Justice System (CJS) are often socially excluded, suffer from health inequalities and have high levels of health and social care needs which may be linked to their offending behaviours.

The review team therefore, state the need to explore diversion at all points of the offender pathway, including diversion away from the CJS itself, whilst continuing to safeguard the public. In order to do this, the team were keen to draw on the expertise of a wide range of service users, professional bodies, service providers and other interested groups for what was potentially a very broad agenda.

Recommendations to the Department of Health (DH) and the Ministry of Justice (MoJ) will be made on the organisation of effective court liaison and diversion arrangements and the services needed to support them in late 2008.

## The consultation process

Throughout the consultation process the Bradley review team wanted to engage with professional bodies, service commissioners and providers, service users and other interested groups. At the beginning of the review Lord Bradley wrote to stakeholders, peers and members of parliament (MPs) posing a series of questions;

- What are the key areas the review should focus on?
- What are the main strengths and weaknesses of the current system?
- What are the barriers and levers to change we can use to improve delivery?
- What are the specific issues we need to consider in relation to women offenders, children and young people (C&YP) and people from black and minority ethnic groups (BMEs)?
- Examples of good practice and areas where things were not working so well that we can learn from

The methodology for collating information for the review included a literature review, individual interviews and meetings, visits to service sites to review current working practices, regional stakeholder events and a consideration of international evidence.

This document is an independent analysis of; 1) the written responses to the consultation, 2) the information collated during individual meetings and through the regional stakeholder events.

## Responses

One hundred and seventy primary responses were received. Some respondents collaborated with other agencies to produce a single response; in total 178 discrete agencies responded in writing to the consultation. Additionally, 39 meetings were conducted with representatives from 71 different agencies in various sectors. In total, 249 agencies had input into the consultation. The 209 primary responses were grouped as follows:

- 3 from police services;
- 19 from court services;
- 2 from legal practices;
- 23 from prisons establishments;
- 9 from probation services;
- 19 from mental health services/trusts;
- 16 from primary care trusts;
- 3 from the commercial sector;
- 16 from government departments;
- 15 from private individuals;
- 6 from local government departments;
- 6 from academic institutions;
- 17 from parliamentary peers;
- 32 from third sector organisations and patient fora;
- 21 from professional bodies and trade unions and;
- 2 from religious groups.

Appendix 1 shows the list of respondents and collaborators.

## *Method of evaluation*

It was assumed that the Bradley team were already aware of the need for the diversion of people with mental health problems and learning disabilities. Responses that focussed solely on the need for diversion were therefore omitted.

The responses received largely reflected the broad agenda of the consultation with many directly addressing the issue of diversion and many addressing wider systemic issues which would need to be considered for diversion schemes to effectively operate. Some respondents had direct working knowledge of existing court diversion and liaison teams (CDLTs) and therefore reported their strengths and weaknesses to inform the development of future schemes.

It was also important to acknowledge during the analysis that some information was collected via face to face meetings with the Bradley team and some via written responses. All responses, additional documents and meeting minutes were analysed thematically and within their respective stakeholder groups. Answers to the five areas of consideration set by the review team were extracted from each consultation response respectively. These were: the key areas the review should focus on; strengths and weaknesses of the current system; barriers and levers to change; specific issues relating to women, children and young people and people from black and minority ethnic groups; and good practice examples.

Additionally, any documents, papers and web links submitted as part of or in support of a response have been listed in appendix 2.

# Results

Collectively, the respondents felt that the review was both timely and important and welcomed the chance to discuss wider systemic issues. However, it was widely felt that the broad remit did need to be narrowed and defined to ensure that diversion schemes are implemented after the consultation process. Responses to the consultation by stakeholder group are reported below:

## *Part 1: Academic institutions*

Six responses were received form academic institutions and are as follows;

*Strengths and weaknesses in the current system*

One respondent felt that there needs to be a move away from regarding the criminal justice system (CJS) as a gateway to the National Health Service (NHS). Also, it was stated that there needs to be a consideration of the legal frameworks that operate in the context of diversion as there are gaps between the rhetoric of policy and the constrained reality of service provision and commissioning. They also felt that the previous attempts to improve partnership working advocated for in the cross-governmental consultation *Improving Health, Supporting Justice* (Department of Health, 2007) together with *Good Practice in Prison Health* (Department of Health, 2007) would not suffice to achieve widespread diversion.

*Barriers and levers to change*

One respondent referred to an oral statement from the secretary of state for justice (December, 2006) who said that *'individual sentences should not be linked to the availability of correctional resources'* and stated that this is indeed the case for people with mental illness who the court wish to send to hospital for assessment or treatment. Currently, the court has to be sure that a place is available before the order is made, which the respondent felt was wrong in principle. A remedy would be to remove from the Mental Health Act (MHA, 1983) the criteria for place availability in order to alleviate this problem.

The same respondent suggested that a possible lever for change would be to incorporate the direct influence of senior criminal justice representatives into relevant NHS commissioning arrangements. They went on to say that some of the services that MDOs need are disproportionately expensive due to their clinical conditions, security needs and potential duration of care and that PCT consortia have placed an inflexible cap on future funding of high secure hospital care.

It was suggested that Improved care for mentally disordered offenders will need to be centrally imposed must do's to PCTs, as change is unlikely from merely encouraging partnership working and aligned commissioning.

*Examples of good practice*

*Example 1*

One respondent agency attached papers reviewing international diversion programmes. The first, a review of existing international literature on pre-trial court diversion of people with mental illnesses contained 145 articles retrieved from various countries; and actual programmes from North America, UK and Australasia. Findings showed that formal case finding procedures are important for the early identification of MDOs in need of service provision and stable housing upon diversion improves compliance with treatment and reduces the risk of recidivism. The conclusion was that diversion programmes internationally have not yet yielded generalisable knowledge on diversion and it was suggested that evaluations should involve well defined indicators, benchmarks and outcomes.

*Example 2*

The second paper highlighted some key considerations in the development and maintenance of successful pre and post charge diversion programmes for people with concurrent disorders, these included; systematic planning and interagency/government collaboration, streamlined funding, early case finding using standardised tools, the availability of a seamless range of integrated

services, evaluation using uniform elements, information sharing across agencies, culturally sensitive gender based services, cross training of staff and an expansion of diversion for serious indictable offences. It was also stated that the major barrier to the establishment and success of diversion programmes is the lack of a formal system of integrated mental health and substance abuse treatment in community based settings.

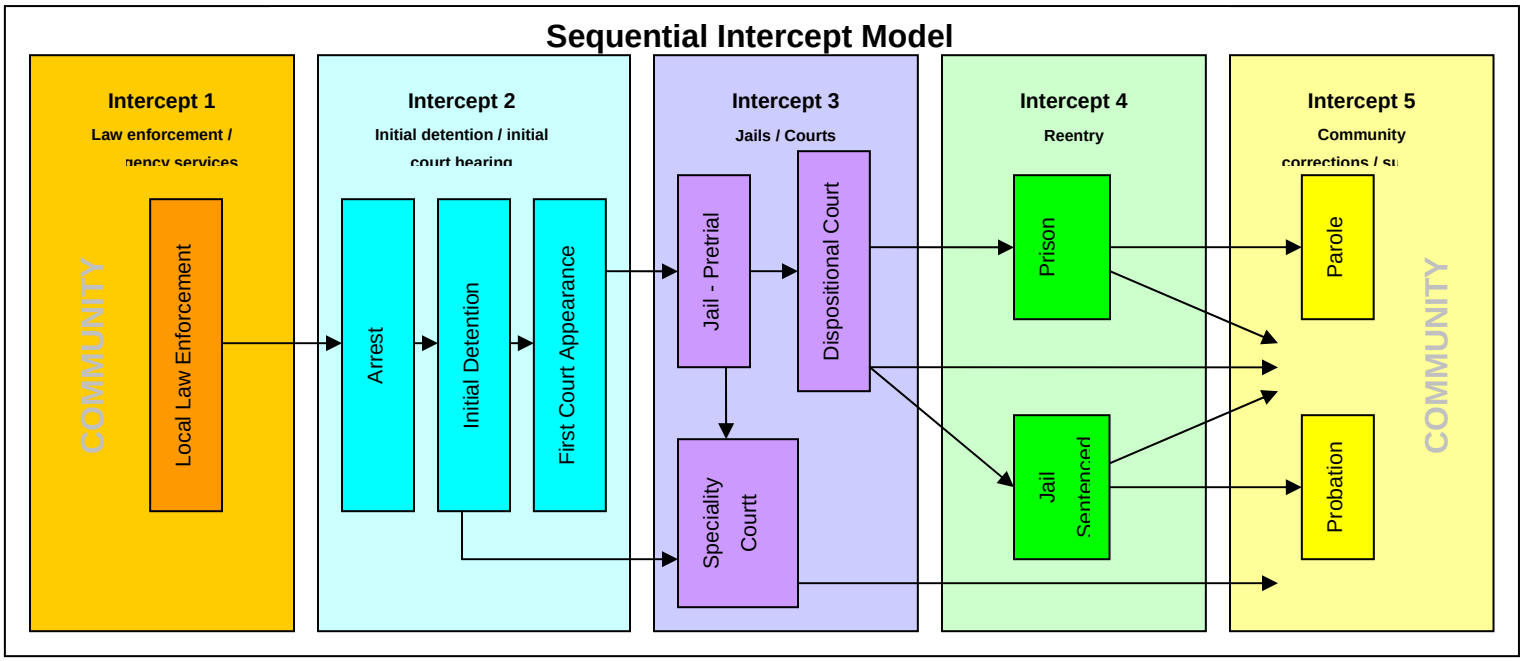
*Example 3*

The final paper evaluated the design of an algorithm to identify people with mental illness in a police administrative database. In North America, police databases have caution/dependency flags attached to peoples names for internal communications. An algorithm was designed which comprised these flags, addresses and key search words relating to mental illness. Those identified were then placed in one of three categories; definite, probable and possible mental illness. They concluded that the algorithm was a cheap and quick method to identify people for North American police whilst also enabling the monitoring of the effectiveness of pre arrest diversion schemes.

*Example 4*

Another respondent provided evidence from an American diversion scheme and stated that diverting from the CJS is easy, diverting into comprehensive mental health services is more challenging and that schemes in America have failed when they were not embedded in the state mental health system and without a personal champion. They provided an illustration as in figure 1 below of a Sequential Intercept Model. They suggest that from their experience the most cost effective services are located at intercept 2.

Figure 1: Sequential Intercept Model showing 5 possible diversion points




However, the respondent stated that the success was dependent upon the presence of; dual diagnosis services, assertive forensic community treatments, supported housing, access to employment and trauma services at intercept 2, a holistic care approach, training for all CJS and health workers, a better variety of sentencing options for courts and above all a unified view of diversion between agencies.

In response to direct questions from the Bradley team the respondent also stated two additional points. Firstly, from a cost benefit analysis of diversion, compared with custodial disposals the cost of diversion at intercept 2 initially rises but diminishes after 18 months. Secondly, there is little or no evidence and no evaluation of one stop shop schemes in the US; whereby teams of multi-disciplinary professionals work together in one location.

*Example 5*

Another respondent enclosed two papers in response to the Bradley review. The first is a published paper (Dyer, 2006) identifying the psychiatric and criminal careers of MDOs referred to a North East UK Diversion Scheme. The aim was to see if the policy of diversion for MDOs impacted on the psychiatric and criminal careers of the people referred to it. The research population comprised all people referred to the scheme within the research period who were over 18 with suspected or actual mental illness and having committed an actual or potential criminal offence.

Dyer (2006) identified 5 distinct 'criminal careers' of those people referred to the scheme. 'Career' types 1 (n= 280) and 2 (n=283) were classed as criminal offenders with no mental health problems, career 5 types (n=115) were made up of people that were referred to the community psychiatric nurses (CPNs) for further information and advice, no record of a criminal or psychiatric history was found and no current mental illness was recorded or social care needs identified. These groups therefore were not identified as needing any psychiatric input. Consequently, no one from this group was re-referred suggesting that appropriate action had been taken.

Career types 3 (n=226) and 4 (n=107) were the groups of interest as they were classed as mentally disordered offenders. Career 3 types received a full assessment from the CDT and then received care and support from health and social care services and had their needs met. This pathway was deemed as successful. However, career 4 types had a history of mental illness and had been convicted of a number of serious offences in the past. They were referred to the court diversion team by police or probation services but were not assessed. Instead, advice or information was provided to the referrer or to the individual concerned and two thirds were discharged within one month of referral. Every single person in this group was later re-referred to the team. This is the most important group as it suggests that referral to the team had a negative effect and

represents a failed pathway which eventually contributed to a revolving door. The question was posed as to how this could have been prevented.

Dyer concluded that in terms of measuring the impact of the diversion team on the criminal and psychiatric careers of the MDOs, types 3 and 4 were most important and relevant. To recap; type 3 people were referred, assessed, had their health and social care needs addressed, were not completely diverted but had their health and social care needs met during criminal proceedings, no one was re-referred and there were no revolving doors. This is a successful pathway rather than an, either *'divert or continue in the CJS'*, this reflects a more sophisticated approach whereby health and social care and support was provided during the CJS pathway. Type 4s were referred but not assessed had no needs identified and as a consequence were all re-referred at a later date.

Dyer (2006) concludes that as a consequence of this decision of non-involvement a revolving door was created. However, Dyer (2006) suggests a caveat in that if everyone was assessed as these findings promote a need for this would inevitably bring about resource issues.

*Example 6*

The second paper (Carpenter and Dyer, 2007) was a follow up study to Dyer 2006 and was funded by the National Programme on Forensic Mental Health R&D which looked at the outcome of custody diversion for violent offenders. The document should be read in its entirety (see appendix 2 for reference). In brief, the report comprises an introduction which includes an historical and political overview of diversion schemes, definitions of diversion, a summary of the stages in the CJ pathway where diversion could take place and who the decision makers are at each of the junctures. Additionally, it includes a review of more recent policy developments and reviews the previous studies that have evaluated CDLS's.

It also reports the findings of an empirical study which aimed to *'determine the outcomes of custody diversion for violent mentally disordered offenders by uncovering their career patterns before, during and after discharge'* (Carpenter and Dyer, 2007), from a CDLT in the North East of England.

## *Part 2: Commercial sector*

The three responses from commercial sector organisations addressed the wider systemic issues that if not addressed, may have a detrimental affect upon the success of current or future diversion schemes.

*Strengths and weaknesses in the current system*

One respondent from an independent sector secure unit stated that the private sector runs at a lower capacity compared with similar NHS units who run at 100% capacity. Even though there is ample evidence of a shortage of NHS low and medium secure units the NHS is not automatically inclined to work with them to meet the shortfall. The respondent stated that using the independent sector capacity both in terms of diversion and transfers from prison to hospital would have a discernable impact upon prison overcrowding.

Two respondents stated that the current funding arrangements between the MoJ and the DH need clarifying. This is undermining the effective diversion of offenders and two stated a need for more effective screening for mental illness, learning difficulties or personality disorders for people who may need diverting at different points along the CJ pathway together with a movement towards trusting the assessments conducted by professional colleagues.

*Barriers and levers to change*

One respondent suggested that a major barrier to change is the differing agendas of the prison service and the NHS and stated this needs addressing. One respondent suggested that we needed to address 1) the judiciary's lack of trust in diversion schemes and 2) the provisions in place in the community to divert to.

One respondent stated that in order to provide a lever to encourage change, commissioning responsibilities should be clarified and community intervention programmes and case management services should be invested in for offenders with mental illnesses, learning difficulties and drug problems.

One respondent felt we should be advocating for better in house services within prisons as well as appropriate diversion schemes and that to improve diversions from prison to hospital there should be fines for transfers taking longer than 14 days.

*Specific issues in relation to women, children and young people and BMEs*

One respondent stated that support for women, BMEs and C&YP is needed whilst in prison and on release and the transition from children's to adults services needs streamlining. Additionally, it was felt that those offenders who need health and social care input but do not pose a risk to society should be sent to specialist hostels.

One respondent felt that the needs of other specific groups needed addressing, stating that neither the cross-governmental document *Improving Health, Supporting Justice* or the joint National Offender Management Service (NOMs)/MoJ *Strategic Plan for Reducing Reoffending* directly addressed the needs of those with personality disorders. Also it was felt that diversion to appropriate services for older offenders who have complex needs but who still pose a risk to society is also needed. It was thought that the Bradley review marked a chance to address issues previously missed.

## *Part 3: Court services*

Nineteen responses were received from court services and are as follows;

*Strengths and weaknesses in the current system*

Court services described a number of problems when faced with people with an actual or suspected mental illness. Firstly, obtaining timely expert psychiatric assessments was a problem particularly for people with LD. One respondent suggested that delays in psychiatric report provision can lead to an additional 6 hearings. There were also many funding issues and disputes reported, it was stated that there was no coherence and consistency to the cost and quality of psychiatric reports provided to courts and this inevitably leads to unequal service provision. This, it was stated, left judges and magistrates exposed to delays beyond their control whilst giving a poor message to victims and witnesses of crime. One respondent agency reported that in a currently running scheme the court service are funding mental health services (MHS) to provide assessments and reports and that this worked well. However, the MHS only agreed services for those within their catchment area. If the defendant was out of area then costs have to be agreed first, which can be problematic and lead to long delays.

Reportedly, community orders with or without mental health treatment requirements (MHTRs) are underused. Suggested reasons for this are; judges not knowing enough about them, a lack of community services, the courts not being aware of what local community services they can divert to and finally that defence lawyers would not recommend this to their client if the community order is likely to be longer than a custodial disposal. It was stated that magistrates feel limited when sentencing low level offenders if the person was not appropriate for a community order due to limited provision and that there needs to be more use of a wider range of sentencing options such as conditional discharge, financial orders, community options as well as custody. Also reported was an underuse of conditional cautioning.

There were numerous calls for bail hostels for people with mental health problems. Others recommended engaging and training the judiciary on mental health issues. One respondent stated that magistrates want to work with mental health services and value their input and guidance and suggested the possibility of mental health professionals undertaking the role of the defendants advocate in court.

Court services also commented on the wider systemic issues. Firstly, the fact that offenders are still not a priority for the NHS. Secondly, the fear that developing diversion services at the police/court stage will redirect funding that is currently commissioning services in prisons. Additionally, court services stated that they are concerned that mental health disposals could be viewed as 'soft options' by the public. It was also stated that having court diversion schemes in some areas and not in other raises serious equality and diversity issues.

*Barriers and levers to change*

Some of the barriers to change were suggested as; different policies, procedures and aims between the different agencies involved as well as geographical differences in services; serious resource issues if court diversion and liaison schemes (CDLS) are placed in every court; and the Crown Prosecution Service (CPS) sometimes being reluctant to engage.

The issue of information sharing was raised. One respondent stated that after recent court inspections it was found that although pre sentencing reports and court case files highlighted offenders with mental health problems or LD, this information has not been passed on to other services. If the issue of information sharing is not addressed, it is suggested that this will be a major barrier to the implementation of diversion multi-agency working.

Individual responses from court services suggested that we need;

- engagement of all stakeholders round the table;
- a reworking of existing resources;

- an agreed framework for funding of both CDLS and psychiatric intensive care units (PICUs)/low secure units;
- new frameworks akin to the National Service Frameworks (NSF) in the NHS;
- courts as central focus for diversion;
- two-way information flows between courts and police;
- freedom of information from the British Airports Authority (BAA) to give information on activity of MDOs at Heathrow airport and funding to them for delivering a service;
- diversion post release from prison to prevent re-offending and;
- better early intervention schemes in schools.

Further suggested levers for the effective delivery of diversion schemes included the adoption of the 6 principles of effective practice which are already in place in pilot courts, they are as follows;

- information sharing;
- assessment and screening;
- facilitating access;
- multi agency arrangements;
- liaison;
- data collection and;
- analysis.

Finally, it was suggested that the review is an opportunity to raise the profile of mental health issues and address the current inequalities that exist but that this is not interpreted as a response to the current prison capacity crisis.

*Examples of good practice*

Many examples of good practices were provided from court services and are as follows;

*Example 1*

In Truro, mental health professionals are regularly in attendance at court to advise and assess and In Devon and Cornwall the Criminal Justice Board (CJB) has the PCT chair as a full member to help foster links and develop relationships between services.

*Example 2*

An oversees respondent stated that the review could learn from a US model of diversion entitled; treatment alternatives to street crime (TASC) in that they have a 3 tiered evaluation comprising; structured screening, full clinical and risk assessment and discussions of placement. They receive funding from a variety of statutory agencies at both national and state level yet the scheme is still open to local interpretation. This respondent firmly believes that MDOs in the CJS symbolises a failure of community services.

*Example 3*

Another respondent stated that there was a scheme operating in Essex that enables a defendant to see a mental health professional whilst they were at court, the scheme operated from the court custody facilities but will also see defendants on bail. Referrals are made by solicitors, Her Majesty's Court Service (HMCS) staff and custody staff. The scheme carries out on the spot assessments and reports to court on the same day without the need for further adjournment. It is felt that in areas without this provision where cases have to be adjourned, opportunities to divert from CJS will be missed. There is however no similar provision in the crown court in this area.

*Example 4*

A current multi-agency psychiatric diversion panel is in operation in North Hertfordshire with members from police, probation, social services and health

services meeting once a month. Additionally, an MDO liaison group meets quarterly to monitor the effectiveness of this system.

*Example 5*

West Lothian council's new civic centre is a collaborative venture between the council, police and the courts providing a joint approach to; child protection, custody management, anti social behaviour and the management of sex offenders. The centres' cross agency working has recommended joint performance targets and the need for specialist courts for mental health, drugs and domestic violence. It was stated that the joint location providing efficiency, effectiveness and value for money is key but it is the multi-agency joint working that is pivotal to its success.

*Example 6*

One respondent felt that the pilot court diversion scheme in 3 Magistrates courts in Harrow, Brent and Uxbridge has the potential to develop a national template. HMCS is partnered with Central and North West London mental health trust on this project.

*Specific issues in relation to women, children and young people and BMEs*

One respondent addressed the specific issues in relation to women suggesting the recommendations set out in the Corston report should be integrated into any court diversion approach as should service provision for women who have experienced childhood abuse or neglect.

In relation to children and young people and BMEs, more early intervention was suggested to provide early diversion from the CJS together with joint collaboration with the Department for Children, Schools and Families (DCSF), health services and the MoJ.

One respondent provided an overview of current diversion schemes and the challenges, best practice ideas and opportunities they have provided. There are

currently 125 schemes operating, 15 of which are in London. This is a decrease nationally since the mid 1990s. Only 2 or 3 schemes are operating at the youth court or with youth offending teams (YOT) nationally. Challenges to the schemes included their lack of clarity on; inclusion criteria; funding; operational and hosting arrangements; infrequent working hours and the lack of administrative support provided to them.

In order to learn from these schemes general ideas and not necessarily just for young people, women and BMEs consisted of; more adequate screening at police stations, operational policies and service level agreements (SLAs) between CJS and health, access to a wider range of follow up services, open access for referrals at all stages of the CJ pathway, wider inclusion criteria, shared and agreed risk assessments, access to a comprehensive range of assessments and reports for people with mental health problems, learning disabilities *and* dual diagnoses, the capacity to run clinics at probation centres and approved premises, links with resettlement planning in relation to both mental health and housing in prisons pre release and continuing through the prison gate and finally, training for all health and CJ staff.

Additionally, it was suggested that there is currently an immense opportunity to unify cross departmental and agency agendas, aiming for a national focus ie:

- DH, MoJ, HO: *Improving Health, Supporting Justice;*
- NOMs: *Reducing Re-offending Strategic Plan;*
- HO: *Crime Reduction Strategy;*
- Carter review of prisons;
- Corston Report: *Women with particular vulnerabilities in the CJS;*
- Lord Bradley review
    - national benchmarking work;
- local area agreements (LAA) on social exclusion & offenders subject to supervision in the community;

- strategic learning agreement (SLA) pilots in the south west region and London;
- Office for Criminal Justice Reform's (OCJR) mental health work
    - Revision of circular 66/90
    - Effective Practice, cost effectiveness and audit.

*Examples of good practice*

*Example 1*

The forensic adolescent consultant and treatment service (FACTS) was cited as an example of good practice. It provided diversion/liaison at a Manchester youth court between 1992 and 2004. The team received referrals from all court based agencies and conducted interviews in either the court liaison office or custody suite. The assessments included family and personal history, forensic and psychiatric history, current mental state and current charges and collated information from all available sources including; YOTs, custody staff, and parents. Reports were then prepared for court and passed to other relevant agencies throughout the persons' pathway. One of the reasons for success was that the team comprised experienced nurses who were competent to undertake assessments under difficult circumstances with the confidence to justify their professional judgement in a court. The service was viewed as critical in meeting the needs of the court as well as the individual. During it's running time the FACTS team delivered mental health awareness training for staff working in a court setting and conducted research to improve practice. They also built up and fostered connections with other agencies.

## *Part 4: Government departments*

Sixteen responses were received from government departments and are as follows;

*Strengths and weaknesses in the current system*

Many weaknesses in the system were highlighted. Firstly it was stated that there was a failure to identify mental illness within the police station and court room. The CPS has no direct contact with persons at the police station and rely on any information given with respect to any charging advice. In many cases the CPS are only alerted to a potential disorder on the interview tape and can only then refer the person to a forensic medical examiner (FME) to assess whether the person is fit to plead. This information is not supplied routinely. The CPS have to regularly infer things i.e. if there is an appropriate adult present during interview it usually means the person has a vulnerability. Consequently, issues surrounding mental illness or learning difficulties only surface in the court room. Secondly, there can be significant delays in obtaining reports necessary to inform diversion and sentencing decisions. The respondent said that the reasons for this stem from; a lack of properly qualified psychiatrists especially child and adolescent mental health service (CAMHS) practitioners, low payment scale for court ordered reports (stated by another respondent to be around £300) resulting in more remands into custody for longer periods pending reports.

Respondents felt that there has been too much reliance upon local development without a national template and that this resulted in each area doing their own thing. This, as one respondent stated has resulted in the culture of diversion being in place in some areas but not in others. It is suggested that the current chaos is due to no one having taken responsibility for coordinating and leading the national policy for diversion, leading to several pilots and few roll outs.

There was also agreement within this respondent group that the CJS should not be relied upon to enable access to services and treatment for MDOs and there is a concern that the CJS is being used to remedy shortcomings in the provision of

community mental health services. Respondents felt that the success of diversion schemes lies in having options to divert people to in the community. To support these schemes it was suggested there needs to be; more funding for alcohol services, better housing schemes together with a national programme to reduce the dual stigma attached to MDOs.

Respondents stated that there are strengths in the current system and comprise;

- marked improvement in the NHS since the National Service Frameworks (NSF) were introduced,
- Drug Rehabilitation Requirements (DRRs) which allow judges to monitor sentences which it is felt should be utilised for mental health disposals and;
- NOMS regional reducing reoffending strategies and delivery plans.

*Barriers and levers to change*

Many levers for change and suggestions for reforming the system to enable diversion schemes were suggested. One respondent referred to the document *'Prisons: Britain's 'Social Dustbins' :Proposals to keep people with mental health problems out of prison* (Revolving Doors Agency) and states that four main proposals for deep systemic change should be implemented. These were;

- targeted reform of community services driven by evidence of how and why vulnerable prisoners have fallen through the net;
- funding for preventative measures outside the CJS;
- early points in the CJS to be used for social inclusion with increased access to health and social care services to help target the risk factors associated with crime;
- an increase in community sentences with mental health support for those who continue to fall through the net, or whose offending behaviour is particularly entrenched.

Other respondents made suggestions for;

- skilled diagnosis in custody suites;

- the use of specialised courts due to the success of drug courts and domestic violence courts;
- integrated drug treatment systems (IDTS) to continue through the prison gate;
- consistency of information recording within police services;
- improved information sharing between police services and the CPS (as recommended in the *Offender Health Executive Health and Care Strategy*, November, 2007) and;
- continued funding into section 136 facilities which has successfully increased awareness of mental health issues within police services.

Finally, one respondent stated there are different types of MDOs; those that offend because they have a mental illness, those that offend and happen to have a mental illness and those that develop mental illness during the CJ pathway. The respondent said that disposals should reflect these different types of people and which highlighted the need for effective case management processes.

*Specific issues in relation to women, children and young people and BMEs*

In relation to women offenders' one respondent felt it important to acknowledge that when deciding on appropriate disposals for low level offences, the detrimental effects of breaking the family caring role and the impact of transferring mothers to prisons at a distance from their homes should be considered.

In relation to children and young people it was stated that there were a lack of adequate disposals for young offenders with mental illnesses and courts sentencing young people would welcome some system to work with, together with knowledge of where they can divert to. One respondent provided an example of when young offenders are unable to participate in their trial due to low cognitive ability. Reportedly, there are many cases that are being stayed. As set out in a precedent case, for a fair trial, young offenders have to understand what they have done wrong. Staying a case enables fitness to plead procedures

but the only order on a finding of fitness to plead is a hospital order or for those aged 16 and 17, a guardianship order. It was rarely the case that a person with low cognitive ability meets the criteria for detention in a hospital for compulsory treatment. Consequently, they then become immune from CJ intervention as their low cognitive ability prevented them from participating in their trials. Whilst also undermining victims and the confidence of communities in the YJS, especially when the offence is violent, sexual or persistent it also meant that offenders are not receiving appropriate intervention to tackle such behaviours. The recommendation from two respondents was made for new legislation that would allow youth courts to make a supervision order following a finding that a youth is unfit to plead/participate in trial.

Finally two respondents highlighted that YOTs haven't had a real evaluation suggesting the Bradley review marks an appropriate time to commission this.

*Examples of Good practice*

*Example 1*

One respondent reported a good practice example of a more proactive model of engagement comprising a link worker scheme designed to support people who are repeatedly arrested and often imprisoned throughout their journey through the CJS.

## *Part 5: Legal practices*

Two responses were received from legal practices.

One respondent was a specialist mental health lawyer, has attended the mental health review tribunal accreditation scheme and has extensive knowledge of representing clients both under civil and criminal sections at tribunals. The respondent acknowledged that the diversion of mentally disordered people away from the CJS and into hospital regimes was both humane and appropriate and should be facilitated at every stage of the CJ process. However, there should not be any deviation from the proper legal processes.

The respondent stated that the police are invariably the first point of contact for people with mental illness who come into contact with the CJS and are highly effective in providing a gateway to appropriate care and treatment. This was due to their daily exposure to mental disorder and their ability to identify those in need of treatment. The respondent continued to make a series of comments on the problems of the current system and made recommendations to change this.

Firstly, problems occurred down the chain if diversion did not take place including;

- clients being detained in hospital for longer than necessary due to bed blocking, sometimes waiting over a year. This problem is worse for those subject to restrictions, needing a higher level of supervision and support, accommodation for these people is in short supply. This delay is an impingement of civil rights, and adds financial pressures. Some get accommodation but it is far away from their community mental health team (CMHT) where they need to collect medication from;
- demand is higher than supply for specialist placements in the community resulting in people being diverted to services that do not meet their needs thus making them vulnerable to relapse and reoffending;

- a lack of coordination between release and aftercare facilities. The case of a client being re sectioned due to lack of accommodation and not due to symptoms was cited;
- mental health review tribunals are too cautious in discharging patients, it was stated that clients are faced with insurmountable obstacles even though their history shows no risk outside their mental health problem. There needs to be a culture change in the attitude of tribunals.

The respondent stated that the strength of the current system is with the number of provisions in place to facilitate diversion. However, some of the provisions are barely used due to a grave lack of awareness amongst judges and practitioners as to what is available for MDOs through the litigation process.

The respondent stated that one of the problems with the current provision is that mental health treatment orders are not being used enough and suggested that in order to increase their use we should commission crisis teams who can provide short term daily support to those suffering relapses in mental health. This may render more people eligible for MHTR with heightened access to this intensive support service. Also suggested was the need for mental health teams including a psychiatrist and an approved social worker (ASW) to be permanently based in every magistrates court ensuring the needs of the mentally ill are identified quicker. The team would also be well placed to liaise with health professionals locally.

The respondent made a series of recommendations for change, including;

- more training and guidance for magistrates on drug, mental health problems and dual diagnosis;

- a review of the use of section 35 of the Mental Health Act (1983) which is intended to be used to remand an accused person in hospital for a psychiatric report on his/her condition. This provision has the potential to

be highly effective as the accused can be evaluated within a psychiatric setting. However, it is rarely used. A possible reason for this is because the consent to treatment provisions contained in part IV of the act which authorise treatment without consent, do not apply, thus medical practitioners use sections 2 and 3 of the act to bring the accused person within part IV. The suggestion is that section 35 should be amended to allow for treatment without consent by the responsible medical officer (RMO);

- section 36 can only be used by the crown court, this should be extended so that magistrates have the same power as the crown court to remand an accused person to hospital for assessment and/or treatment;

- a complete review of section 45a;

- increased use of interim hospital orders, especially for those suffering from psychopathic disorder;

- to repeal section 51 (4) (b) allowing a court to impose a hospital order with restrictions without convicting the detainee;

- a more co-ordinated holistic approach between prisons and those responsible for the aftercare of the MDO.

The second respondent felt there should be more clarity surrounding who needs punishment and who needs therapy as this remains muddled and inconsistent. There are also issues surrounding divergence in views on the treatability of personality disorders which is likely to remain if not directly addressed. Also, it was felt that the legal processes surrounding the transfer of patients is over complicated and needs clarification. A stated strength in the system is the

development of specialist hostels in the community for sex offenders and those with personality disorders.

## *Part 6: Local government departments*

Six responses were received from local government departments.

*Strengths and weaknesses in the current system*

One respondent said there are chances for diversion at many stages in the CJ pathway at; police stations, courts, and via prison to hospital transfers. However, in order to reduce future reoffending we must ensure that resettlement planning through the prison gate becomes more of a priority.

*Specific issues in relation to women, children and young people and BMEs*

Many responses addressed the needs of children and young people. In looking to early intervention ideas, one respondent felt that 16-17 year olds who are in local authority care and are placed in bed and breakfast accommodation suffer under current arrangements. In the respondent's experience they engage in drug taking, smoking, break house rules and end up being moved causing disengagement from services. They have also in many cases been victims of abuse/family breakdown and are victims of poor parenting. The respondent suggested that extending specialist services such as therapeutic fostering would aid these problems. Similarly, one respondent agency felt that many of the lower-level young offenders could be diverted form the CJS if the supervision, containment and support offered by emotional and behavioural boarding schools were readily available.

Another respondent felt that the youth CJS acting as a gateway for services for young people works well for those needing access to tier 4 services but does not work as well for less acute illnesses. Therefore, it was suggested that ring fenced funding is needed to raise the level and degree of mental health services that are provided from within the YOS.

In relation to female offenders one respondent stated that there was a need for local services to reflect local needs better. They provided the example that Yorkshire and Humberside women's health needs were far higher that their male counterparts. They said that mental illness is often linked to a history of abuse and domestic violence, leading to self harm and self esteem/confidence issues which is turn was linked to misusing substances in order to cope and escape from past and current problems. Therefore, it is suggested that the Together Women's Project (TWP) was well placed to assess and address these needs and not only helps treat but also helps build up resilience. The project provides women only community based services, counselling provision and supported access to mainstream services whilst addressing women's child care issues. It was suggested that the TWP could be used as; a community support to help prevent offending; as a project that courts could divert to as an alternative to custody and as a support network for prisons to divert people to post release through the prison gate.

General suggestions were also made for more training for magistrates together with greater powers to refer cases back to the CPS to consider diversion from court and even back to the police to consider a final warning and stronger powers for district judges to deal with those unfit to plead rather than utilising the option of absolute discharge or hospital orders.

## *Part 7: Mental health services/trusts*

Nineteen responses were received from mental health services or trusts.

*Key areas*

One respondent gave suggestions for key areas the review should focus on which consisted of; screening and more appropriately qualified forensic mental health practitioners at police stations; the reduction in the legal aid budget to be reconsidered and for better screening for mental illness within prisons.

*Strengths and weaknesses in the current system*

Many respondents reported weaknesses in the system including; a lack of beds in low secure units, PICUs and female secure beds for detoxification and rehabilitation, all of which will prevent the success of diversion schemes. It was also stated that as the Mental Health Act does not apply in prisons and PICUs moving away from accepting MDOs, prison to hospital transfers will become a priority for the most severe cases and others will be subjected to long delays. Additionally, they raised the issue that some MDOs don't meet the criteria for a section 47 transfer as they are fully compliant.

Several respondents felt that mental health care for offenders is still not on the radar of key organisations and that there needs to be awareness raising with NHS confederation chief executives and chairs of mental health trust groups. Other weaknesses in the system were stated to be; lack of funding for PCTs without prisons in their catchment area, lack of secure services for LD and a lack of acknowledgement that for some people incarceration is important for them to take responsibility for their actions.

Finally, one respondent had concerns about how the system will cope with the increasing population receiving life or indeterminate sentences for public protection (IPP) and highlighted that courts use this sentence without any psychiatric assessment. If a significant amount of people with mental health

problems continue to receive such sentences there is concern that the prison service will be unable to meet the sentence planning needs as some prisoners will be unable to participate in accredited programmes because of mental illness.

*Barriers and levers to change*

Two barriers to change were highlighted, namely the high levels of bed occupancy within secure units in the NHS and the stigma attached to people with personality disorders.

Many respondents gave suggestions for changes in the system. It was suggested that the term diversion needs to be carefully considered as to many, it is a complete annexing of a person from the CJS which may only be appropriate for some. It was stated that for complex cases it is inadequate and would be better defined as an assessment and liaison scheme. It was also suggested that funding issues for CDLS need to be agreed and that funding should be received directly from the PCT to ensure consistency in service delivery. Once again, there was a call for prosecution procedures not to be dropped for MDOs who commit serious acts of violence, criminal damage, arson and sexual offences. The decision to continue prosecuting the MDO is in many cases a gateway to receiving appropriate care by police or CPS whilst ensuring that victims perceive that justice has been done.

It was stated that; improved prison reception screening would lead to the timely identification of people with mental illnesses and the implementation of prison rehabilitation wards in prisons. Furthermore, a wider range of professionals in prison in-reach teams would give mental health services more confidence in sending people back into prison once they have been treated if they still have time to serve on their sentence. This would also alleviate the silting up of the system.

It was also stated that for diversion schemes to be effective there should be provision in place to divert people out of the CJS to a wider range of services and

not just to an NHS bed. Examples given were; home treatment services or input from a CMHT. It was suggested that this would be more in keeping with the 'hospitals without walls' concept that the NHS has been moving towards. Additionally, it was suggested that day treatment and monitoring services could be implemented as part of bail or sentence conditions.

Two respondents stated that there needs to be more interventions at the earliest point within the CJS. With reference to a paper by Hodgins et al (2007) one respondent stated that certain groups of people start off in childhood with a conduct disorder and are vulnerable to behaviours that increase their risk of developing psychosis and antisocial behaviours and tend to form a large population of patients who end up in the CJS. They concluded that it was necessary to identify these people early to reduce future contact with the CJS.

*Examples of good practice*

Respondents from Mental health services/trusts reported good practice examples of either CDLS or services that provide for the needs of MDOs.

*Example 1*

In Telford, Wrekin and Shropshire there are two mental impairment services which comprise community based social worker led multi disciplinary teams providing a service for people with an identified LD who have been assessed to be at significant risk of offending. The aim is to provide them with a package of care and support to reduce their risk of offending or re-offending in the future. The range of care varies from 24-hour supervision for someone discharged from hospital on a 117 treatment order, to just a few hours support per week to help people to maintain aspects of their lives in areas such as housing and finance. Psychologists provide individual and group work alongside input in relation to housing, employment, education, health, free time, friends and family. An audit of the 162 referrals between 1998 and 2007 showed that only 5 males re-offended whilst being supported by the team. It is felt that this was a good early intervention programme to reduce contact with the CJS for people with LD.

The other is a full CJLS and has been operating for 13 years. Although this is a well established scheme there has still been problems which may help the future development of CJLS. They have found that; personality disorder is still a diagnosis of exclusion as there is no-where to divert them to other than prison; there are still disputes over which service a person with dual diagnosis should be cared for within; there is limited access to low and medium secure in-patient services and in some areas there are still problems convincing magistrates that there is a need to divert at all. However, the scheme reported that no problems had been encountered relating to either women or BMEs.

*Example 2*

The Avon Forensic Service for People with LD has been running for 7 years. It is a community based service for people with mild-moderate or borderline LD who have either been convicted of an offence, have had allegations made against them or are at risk of offending. The service includes preventative work, thorough risk assessment and management advice as well as assessment and intervention for specific offending behaviours in community settings with the mainstream CLDTs in Avon (Bristol, Bath, Keynsham, Kingswood, Thornbury and North Somerset).

*Example 3*

One respondent reported the work of the Henderson Hospital which is one of three remaining NHS residential therapeutic communities (TCs) as an example of good practice. The respondent stated that diversions schemes focus on those with psychotic disorders whilst leaving those with personality disorder (PD) in the CJS. The respondent reported the results of a cost offset study which showed the cost to the public purse of managing a person with PD during the 12 months prior to TC treatment at the Henderson Hospital was ten times greater than the costs incurred in the 12 months after treatment at the hospital. The respondent said that it was wrong to close the Henderson Hospital.

*Example 4*

The LD forensic service within Tees, Esk and Wear Valley NHS Trust is one of the largest LD community forensic teams in the country. It has strong multi agency working to meet the needs of the local population. Its main purpose is to assess those who have offended or are at risk of offending, to support people through the CJS and provide diversion into health where appropriate. The service is geared towards the philosophy that offenders with LD should be treated within welfare in the community rather than in penal settings and should be assessed on an individual basis. The respondent believes that generic LD services are well placed to identify those on a trajectory for an offending career. This service is appropriately diverting at an early stage already and this is seen through its exceptionally low readmission rates.

The respondent said that the Bradley team should consider the resistance from police or CPS to pursue CJS involvement with people with LD. They stated that it was easier to address treatment issues if the person is charged, tried and sentenced. They have a better prognosis as they can then be diverted into forensic beds for therapy and to ensure their potential risks are managed. They raised the issue that LD would only form a small part of a custody diversion workload and that it would be unrealistic to expect every team to have an LD specialist. They envisage that there needs to be a rapid same day response by an LD team locally. Additionally, the respondent stated that there are also issues at court stage as some don't adjourn for psychiatric reports. Some people with LD are not fit to plead but this is not acknowledged and there seems to be reluctance in using appropriate legislation i.e. to have a trial of the facts, as many have been diverted appropriately to services following this. The respondent felt that it is very important to identify people with LD before entering prison.

Based on the experiences within this service the respondents concluded that the Bradley review should therefore focus on; a multi agency approach including all CJS and health and social care agencies and also the voluntary sector, employment agencies and housing agencies to help the identification,

assessment, treatment and management of offenders with LD. The review should also define what focus of activity court diversion teams should have; the feasibility of providing LD services in prisons via prison in-reach services; how best to train the workforce and finally, whether there is a need to review current bed availability in the NHS and independent sectors.

The specific focus, it was stated should be on; the complex needs of women, the transition of young people from youth to adult services and those with borderline LD. It is felt that this service is a model of good practice for the following reasons;

- the Tees, Esk and Wear Valley NHS Trust has a dedicated learning disability forensic team with multiagency working with a broad professional skill mix;
- it has a model of integrated care which allows seamless transition between community services and inpatient services, ensuring continuity and reducing overall time spent in hospital;
- it has good partnership working with the local independent sector to assist the further throughput of people from hospital into community settings;
- strong links with local generic learning disability services, working in partnership in the identification, assessment and management of people at risk of offending;
- has a heavy emphasis on prevention and proactive intervention centred on least restricted practice and maintaining or enhancing social inclusion, and;
- a positive, person centred and needs-led risk management framework.

*Example 5*

Portsmouth adult mental health service CJ mentally disordered offenders (MENDOS) team was established in 1994 as part of the integrated mental health provision supplied jointly by Portsmouth city teaching PCT and Portsmouth city council health housing and social care directorate. The team accepts referrals from CJ agencies at police stations, courts etc. They also work closely with the local multi agency public protection arrangements (MAPPA) teams and the police community safety unit. It was stated that the schemes success is due to its

liaison with the local implementation team (LIT). The LIT has representatives from the local community safety unit (CSU), the CPS, Probation and advocacy services together with police inspectors. The scheme is currently trying to set up a diversion team.

*Specific issues in relation to women, children and young people and BMEs*

Due to the over representation of BMEs in the CJS, one respondent said that there needs to be a major shift to services focusing on preventing crime by BMEs. This will require better joined up thinking and working between education, social care, youth justice and health services than is currently the case.

With reference to children and young people, one respondent provided a good practice example of joint working in an arrest referral team in Middlesbrough, Redcar and Cleveland and Stockton Police custody suites. Respondents stated that the positives of the joint working initiative was that; it improved knowledge and understanding of services, provides one point of contact, direct and quick access to adolescent and forensic mental health professionals enabling timely assessments and reduced capacity pressures on CAMHS teams which in turn should have reduced the numbers of young people slipping through the net of services.

Weaknesses of the initiative to be considered when developing new schemes were; the inflexibility in YOS due to YJB target pressures, competing agendas, variation in clinical experience/expertise and an inappropriate focus upon management of systems as opposed to intervention development, and that many assessment tools were clumsy and unsuitable.

## *Part 8: Parliamentary peers*

Seventeen responses were received from parliamentary peers.

*Strengths and weaknesses in the current system*

Weaknesses of the current system are that; the transfer of commissioning of health services to the NHS should have included the wider CJS, assessments being conducted with people only upon entry into the CJS and PCTs not having a broad enough view of emerging problems during the pathway through the CJS. One respondent stated that having been a magistrate for 25 years, his heart sank when faced with someone with mental health problems, due to the knowledge that there were insufficient facilities to make an appropriate disposal.

*Barriers and levers to change*

Respondents described a number of barriers to change. Firstly, it was stated that people detained under section 136 of Mental Health Act (MHA) should not be kept in a police cell due to the risks of harm and even death due to mental health issues, substance misuse or alcohol problems. The respondent said that diversion from police custody was the best option as it is the earliest opportunity. However, this would need system reforms and new teams in custody suites as police officers, police doctors and staff are not experts in mental health and are the wrong people to deal with these issues.

A second barrier to change was that diversion has been within the domain of health not the CPS and the courts, and that it should be on everyone's agenda. In particular, probation services were finding that they are required to supervise a large number of people with mental health problems due to their over representation in the prison population.

Seven respondents said that joint service provision and commissioning was required. One respondent stated that we already have existing frameworks to facilitate this operational partnership such as via public service agreements (PSAs) and local area agreements (LAAs) and through joint collaboration

between national and local CJBs and crime and disorder reduction partnerships (CDRPs) and that we just need to use them effectively. Also, the CPS and health professionals need joint training on mental health and CJS issues.

They went on to say that diversion can only help people if the scheme not only diverts them from court or prison but also enables speedy and appropriate access into treatment and support thereafter. In order for this to happen there needs to be; full co-ordination of services, quick and appropriate 24 hour access to health assessments as close to the point of arrest as possible and funding to enable this to happen. Once again, suitable accommodation for MDOs was highlighted as a particular need.

Many respondents acknowledged that there is a need for a holistic approach to managing MDOs from the community through the CJS and beyond. It was stated that this approach has been successful in other areas for example in tackling domestic violence via multi agency risk assessment conferences (MARACs), independent domestic violence advisors (IDVAs) and specialist domestic violence courts. The reason for the effectiveness of these is believed to be due to the multi agency response with it's joint agency protocols ensuring that all agencies are aware of their own responsibilities. It was stated that this targeted intervention approach is akin to that advocated by Baroness Corston who stated that there should be a suite of interventions at our disposal that we can use to manage a range of MDOs.

*Specific issues in relation to women, children and young people and BMEs*

For specific issues relating to young people there was a consensus that early intervention within the CJS was beneficial especially for children who are in the care of local authorities. In order to prevent progression within the CJS, assessment of health and psychological needs was recommended at the earliest possible junctures. This would allow emotional and familial problems to be highlighted early enough to prevent CJS contact. They suggested a need for a

holistic approach at a familial not an individual level. Two respondents also expressed concern about withholding diagnoses in young people. Two respondents stated that CAMHS were too patchy, especially in rural areas.

## *Part 9: Police services*

Three responses were received from police services.

One respondent stated that we should remember that having a mental disorder does not provide an excuse for offending and that all agencies should acknowledge this. That said, they suggested that there should be guidance for the provision of care for those people with mental illnesses throughout their journey through the CJS. It was also stated that the common denominator in this population is social deprivation, and that we should use the amount it costs to keep people in custody to implement early intervention programmes. The same respondent stated that some police forces are very forward thinking about mental health are concerned and could help get other forces on board. They envisaged that improved relationships between mental health services and local police forces would increase the publics confidence in services.

*Examples of good practice*

*Example 1*

One respondent stated that Merseyside police have a dedicated mental health liaison officer. This is a trained police officer who is based at the public protection unit and provides a single point of contact to all agencies involved. It was reported that excellent relationships have been built up with the CJLT in each trust.

## *Part 10: Primary care trusts*

Sixteen responses were received from PCTs.

*Strengths and weaknesses in the current system*

Respondents suggested that current diversion schemes have not modernised in line with other parts of the system. There is still a need to retain the current system of diverting people from the CJS but also to prevent them from coming into contact with the CJS at all. This suggests a need for early intervention programmes and improvements in areas where we can make a difference to people's lives including their accommodation. There is also a need to clarify which agency holds primary responsibility for CDLS

*Barriers and levers to change*

Respondents made suggestions for change in many areas these consisted of the need for;

- a development of the services for people with LD;
- a wider range of sentencing options and if community sentences are given, housing should be a priority;
- increased use of remand to a non-custodial location such as a bail hostel;
- prevention and an early intervention mental health agenda;
- national validated programmes for people with LD.
- an acknowledgement that it is in many cases better to prosecute people with LD as only then do people learn that they have done wrong, this must be coupled with a full assessment and diagnosis of need in order for their needs to be met appropriately;
- capacity issues in NHS secure units to be addressed and;
- the needs of people with traumatic brain injury (TBI) to be addressed.

It was stated by one respondent that the Bradley review should not expect agencies to expand their remits into areas they are not equipped to manage and that additional training, resources and funding would be provided. Finally, one

respondent suggested that effective CDLS are currently relying on the dedication of one or two individuals with no clear funding. A national steer on partnership funding would be invaluable.

*Examples of good practice*

Numerous examples of good practice were suggested by respondents together with obstacles encountered in some of the CDLS;

*Example 1*

Firstly, the in-reach team at Leeds PCT attend court on request in addition to their prison roles. It is stated that one of the strengths of this system is that it allows a link from court to prison if required.

*Example 2*

Another respondent referred us to a clinical care pathway review of MDOs in South East London, commissioned to assess the potential to divert MDOs from the CJS into other services in 2004/5. A prison interface care pathway steering group with members from the police and probation services met to process map the end to end care pathway from arrest, through court, prison, NHS care and return to the community to explore the evidence base at each stage of the pathway and devise standards of best practice. The respondents attached the final report from 2005. The report is extremely comprehensive and should be considered in its entirety, it also includes a comprehensive literature review (see appendix 2 for references). The conclusion of the steering group was that it would be very difficult to implement, the main reason being due to lack of funding. Other issues raised were that an increase in recognition of MI at court would put increased pressure on the need for acute beds. They also suggested that funding needed to be moved from the forensic budget to the acute mental health budget yet there is no easy mechanism for this. Finally, there was no co-terminosity between the courts, prisons and mental health trusts and to realistically see benefits this would need to be focussed upon.

*Example 3*

Up until recently, each magistrate court in North Yorkshire had access to a CPN, who was part probation and part health funded. This was a useful service, however, funding for this has since ceased.

*Example 4*

One respondent described a bail project in York comprising a bail officer in each court supported by NACRO. The aim was to reduce the number of remands in order to reduce the pressure on the prison system. A similar scheme could run with CPNs in the court room. This scheme worked reasonably well but found that it is difficult to obtain expert information especially for young people and those with PD who don't meet the criteria for early intervention/community mental health team involvement.

*Example 5*

Gloucestershire partnership foundation trust has provided a mental health liaison service to the local CJS since the 1990s from point of arrest in local custody suites to post sentence. A triage service is also provided to local courts (both magistrates and crown) to assist them in obtaining psychiatric reports. This saves Her Majesty's Court Service (HMCS) money as it reduces the amount of inappropriate reports and reduces the numbers of adjourned cases. The service also has good links with the prison in- reach team. Reportedly, problems arise if a person needs a medium secure bed and they do not fulfil the criteria for transfer under section 48 of the MHA (1983). In these cases, courts are often required to adjourn for psychiatric reports which can take up to 6 weeks.

*Example 6*

One respondent stressed the need for meaningful social engagement for young people and indicated that early intervention to prevent future involvement with the CJS was preferred. Unity radio in Manchester works with young people and provides an outlet for them to present their own music. This diverts their attention from belonging to gangs in Hulme, Moss Side and North and East Manchester.

The programme is starting to engage people and provides a lever for them to be reconnected to mainstream education programmes (see appendix 2 for web link).

Example 7

One respondent stated that in 2004-5 a clinical care pathway review for mentally disordered offenders in London was commissioned to assess care pathways. A small clinical group, with representatives from the police and probation service met regularly to work through the implications of the care pathway mapping. Subsequently, a proposal for a new care pathway was produced which explored the evidence base at each stage of the pathway to devise standards of best practice. The prison interface care pathway steering group produced a report entitled: *London MDOs care pathway (South East London pilot) and good practice guides; end to end care from arrest, through court, prison, NHS care, and return to the community*. The report should be read in its entirety.

*Specific issues in relation to women, children and young people and BMEs*

One respondent commented on the needs of BMEs suggesting that they would not want to engage with services that did not reflect their views and values. Therefore cultural awareness training and specific services are needed.

One respondent suggested a need for more attention to the needs of women coming into contact with the CJS who have caring roles. There is a need for holistic services based at familial as well as individual levels.

## *Part 11: Prison establishments*

Twenty three responses were received from prison establishments.

*Strengths and weaknesses in the current system*

Respondents stated the main weaknesses in the current system were;

- a lack of provision for people with dual diagnosis;
- a lack of information sharing to prisons with insufficient IT systems;
- bed blocking in secure units which is caused by a lack of step down facilities in the community which in turn can cause people to be remanded inappropriately;
- a lack of resettlement packages upon release from prison which includes housing, employment and education;
- probation service not picking up people who have served sentences under 1 year;
- long delays in transfer from prison to hospital caused by PCT out of area disputes;
- not enough dual training on mental health and CJS issues for all;
- reception screening not thorough enough and;
- a lack of community detoxification programmes to divert people to.

*Barriers and levers to change*

The respondents made several suggestions for change comprising;

- 24-hour access to criminal justice liaison teams (CJLTs) and an open access referral system;
- increased use of the adapted sex offender treatment programme and the adapted better lives booster programme for people with LD who sexually offend (recently accredited by the Correctional Services Accreditation Panel);

- increase access to housing provision for people with mental illness and better links with the CJLTs and;
- an integrated CJS model 'one stop shop' comprising all agencies.

Although respondents agreed with the need for diversion schemes many responses didn't want this to detract away from the need for further improvements in prison in-reach services as it was stated that there are still difficulties in communication between prison and primary care trusts. Once again the need for an economic analysis was stressed as the costs of going through trial, remand, sentencing only to be identified as mentally ill and commencing procedures for hospital transfer is thought to be higher than a psychiatric report at court stage. The need for the 14 day prison to hospital transfer pilot to be rolled out nationally was stated by two responses.

*Specific issues in relation to women, children and young people and BMEs*

Two respondents stated that women offenders could be more appropriately managed in the community with one stating that it is universally acknowledged that prisons are no place for women.

One respondent stated that there was need for special services for women BMEs with mental health problems. They reported that Revolving Doors agency suggested that it is difficult to estimate the level of mental illness among BMEs as it is construed differently. What is needed is a better understanding of the interrelationship between race, ethnicity, culture, offending behaviour and psychiatric symptoms. Additionally, the respondent stated that there seems to be a lack of family support within some BME communities due to stigma and mental illness being a taboo subject. There also seemed to be problems accessing services due to language/communication barriers and when accessed, the services were not culturally appropriate.

## *Part 12: Private individuals*

Fifteen responses were received from private individuals.

*Strengths and weaknesses in the current system*

Responses from individuals were heavily focussed on LD, with many stating that diversion schemes should address the needs of people with learning difficulties and understand the complexities of their condition. It was thought that due to the small numbers of people who come into contact with the CJS there was a lack of experience in dealing with this client group. Respondents stated that there needs to be a differentiation between those with mild and borderline LD who possibly should be held responsible for crimes and those with severe intellectual and social impairment who possibly should not be held responsible for crimes. One respondent suggested that in terms of interventions after diversion, the approaches that offenders with LD need are not fundamentally different to that of other groups, but that they just need them in an adapted form. The parent of a child with Autism stated that she has fought to keep her son out of the CJS for a number of years and attempts to delay the diagnosis and labelling of people with LD is wrong as this is sometimes the only route to help. The respondent states a need for early screening for LD.

Another respondent stated that people with LD are misunderstood by the CJS and are often viewed as disrespectful, unconcerned and uncooperative. This can result in some being regarded as prolific offenders without the benefit of a comprehensive assessment. This was viewed as a failure of agencies such as schools, education authorities and social services to identify these problems. Numerous respondents stated a need for specific assessments for LD at court, and that there is widespread confusion about the difference between mental illness and learning difficulties. It was reported that it can be difficult to explain to courts that a psychology report rather than a psychiatric report may be needed and that only when fair assessments are conducted can fair disposals follow.

One respondent submitted a first hand account of a person with learning difficulties and the different experiences she had in prison and hospital. This quotation is an excerpt from this response;

*'It was not much fun [prison], but it isn't meant to be fun right? It's meant to be a punishment. Well, that's all very well if you are a true criminal and you are there because you deserve it, but its not much fun when the courts put you there because they have no where else for you to go…. you see I have a Learning Disability and a Personality Disorder. If you saw me you wouldn't think so, I am not a true criminal, I was crying out for help and there was no where that I could go'*

('Prison' by Miss X)

*Barriers and levers to change*

Single respondents stated a need for; an advocacy service for people with LD who come into contact with the CJS, which will initially have cost implications in the short term but would be recoverable in the long term due to reductions in prison sentences and secondly, for clinical psychologists to be employed in probation services.

Finally, one respondents stated that CDRPs must play their part if there is to be a systematic approach to the development of effective diversion of MDOs from the CJS. CDRPs should consider the impact on local offending and should devise action plans to support people with mental illnesses as they currently do with people misusing drugs.

## *Part 13: Probation services*

Nine responses were received from probation services.

*Strengths and weaknesses in the current system*

Respondents in this group described a number of weaknesses in the current system particularly in relation to services for people with personality disorders (PD). They suggested there is a lack of community assessment and treatment and many offenders with PD slip through the net between services. They also stated that there was very limited joint working between the NHS and probation services and that NHS service stops in prison and sometimes does not begin upon release. Additionally, lack of commissioning arrangements for co-morbidity i.e. LD, PD with mental illness means that people fall through the net of services. Reportedly, there is still some refusal to treat mental illness if there are drug/alcohol problems too and the split between drug and alcohol action teams (DAATs) and NHS teams provides a fragmented service for people with dual diagnoses.

*Barriers and levers to change*

Recommendations for change included;

- the need for increased number of beds in secure units;
- training for staff (especially probation staff) on mental health issues;
- a clarification of who is responsible for court mandated psychiatric reports and;
- a separate service for people with LD.

One respondent agency was unclear as to whether the review applies to Wales where the DH doesn't have jurisdiction but the MoJ does and requested clarification of this problem which has been present since devolution.

It was stated that there needs to be a forum for debate within defence teams, as often the incentive is to plead not guilty where a guilty plea may ensure mitigating factors are taken into account and diversion to appropriate services.

It was suggested that strategic management boards (SMB) are developed comprising; NHS trusts and commissioners, police, probation, the DCSF, prison service, the courts service, CPS and YOTs. These agencies should have a duty to co-operate on issues surrounding housing, employment and benefits. It was suggested that these SMBs should be expected to produce a three year plan and facilitate links with MAPPA panels and the local safeguarding children boards (LSCBs). The SMBs would then set up MDO panels to implement the plan and collate data on need, which would be aligned with magistrate court boundaries. The MDO panels would then be responsible for MDOs from arrest and continue their care throughout the CJS. It was also envisaged they would have a key role in appropriate Indeterminate Public Protection (IPP) cases producing joint community release plans which would continue risk based work from prison.

*Examples of good practice*

*Example 1*

Numerous examples of good practice were suggested by respondents. Firstly, in Merseyside they have 3 CJ mental health teams who lead diversion. Staff from probation services' have excellent working relationships with these teams and CJ staff attend probation offices to assess and divert at an early stage. They feel that diversion works well for people with serious mental illness but not for people with LD who often do not have the capacity to follow proceedings.

*Example 2*

Another good practice example was the Gwent health trust and forensic mental health services which operated a diversion scheme in Newport magistrate's court over an 8 month period in 2003/2004. This was considered successful but continuation was blocked because of a lack of any long term funding provision

from the courts service. More recently a service commissioned by the five local health boards in Gwent and working in partnership with and having full support from local authorities (Las), police, probation and the CJB has received funding for a diversion scheme. The Gwent Criminal Justice and Mental Health Liaison Team (CJLT) will provide a diversion scheme to the three designated custody suites in Gwent, a mental health liaison service to Gwent magistrates court and a liaison service to mental health and criminal justice services. It's aim is to; 'deliver a sensitive approach to the individual needs of MDOs (over 16 years old) via an open referral service'. The CJLT will act as a gateway within the CJS to all primary and secondary mental health and social care services by assessing at the point of arrest at police stations for those in need of help for mental health or co-occurring mental health and substance misuse problems. They will act as a central point of contact and liaison for police, probation and courts. They will cover core working week hours as well as providing an on call weekend service.

*Example 3*

Three good practice examples were submitted by one respondent. Birmingham magistrates court mental health diversion scheme, the borough of Sandwells joint probation and mental health forensic liaison team initiative which includes diversion work in the Warley and West Bromwich magistrates court as well as in-reach work with remand prisoners and Elliot house approved premises (AP) which is a probation hostel which provides housing, support and management for MDOs whether on bail, post sentence or post release from prison. The AP works closely with local psychiatric services.

*Specific issues in relation to women, children and young people and BMEs*

Two respondents felt that the transition from juvenile/YOI to the adult system is not smooth with many people falling through the net of services.

In relation to the needs of women it was suggested that the Together Women's Project (TWP) was cited as an example of good practice. TWP is a voluntary

support service specifically for women offenders and those at risk of offending. TWP acknowledges that the issues that women face that make them vulnerable within the Criminal Justice system are often complex and multiple but commonly include mental health problems, substance misuse, sexual and domestic abuse and concerns about their children's welfare, poverty and homelessness. TWP is delivering services that try to remove some of the barriers that have previously prevented women from accessing services in the community.

It has been suggested that instead of being voluntary, when there is risk of a custodial sentence for tier 2-4 offenders it may be appropriate to mandate attendance at TWP as part of national standards in order to secure a diversion from custody. Decisions should be made on a case by case basis by the offender manager to TWP. For tier 1 offenders, contact with TWP will always be voluntary. There should be more awareness raising of the project through the courts and enforced TWP contact considered as a means of influencing the courts towards a community sentence. TWP also has the potential to provide additional support (as part of national standards for sentence planning) in relation to; finding and sustaining housing, parenting support and classes, life skills and personal development group work activities, finance, benefit, debt advice/management and support for substance abuse and anger management. Additional provisions could also be provided (not as part of national standards) i.e., counselling, psychotherapy, self esteem and confidence work and complimentary therapies. It was envisaged that if a community sentence with supervision was passed and engagement with TWP as part of national standards was deemed appropriate, the offender manager will draw up a sentence plan and the status of appointments (voluntary or national standard) will be made known to all parties. Currently, meetings with TWP leads were set up in each of the probation offices together with quarterly meeting with assistant chief officers in South and West Yorkshire to review the TWP and probations partnership.

## *Part 14: Professional bodies and trade unions*

Twenty one responses were received from professional bodies and trade unions.

*Strengths and weaknesses in the current system*

Respondents suggested that one of the weaknesses in the system lies in the contradictory policies between the HO, DH and the DCSF. Another respondent, making reference to the findings in a National Probation Service report stated that mental health treatment was not being initiated as part of community orders for MDOs. They said that this may indicate weaknesses in the identification of mental health needs at the pre-sentence report stage. They continued to state that there is a lack of clarity over who pays for assessments, together with weak partnerships between local probation and PCTs.

*Barriers and levers to change*

One response provided an analysis of the problems facing MDOs. It recognises that the CJS acts as a filter system for its population which is a group of people marked by social exclusion and multiple disadvantages. Some of these people are sub threshold for inclusion in most service areas due to low intellect but with IQs above 70 excluding them from LD services. Each agency could legitimately refuse offenders as not meeting the criteria for their services. This needs to be acknowledged and addressed. In this sense the term diversion is inappropriate as it implies a neat split between those who are mentally ill enough to be diverted and therefore treated by health services and those that can't and stay in the CJS. The respondents state that the review needs to consider not just diversion but models of multi agency approaches to offenders based on examples such as child protection and MAPPA.

They also state that it is necessary to examine the relationship between mental disorder and criminal behaviour. The respondent alerts us to a crude but common classification of mental disorder and its relationship to offending behaviours, these give rise to the notion that mental health input then, could

occur at a number of levels relevant to the classification. These have been reproduced below:

- those whose offence was directly related to/driven by aspects of mental illness. Treating the mental illness is seen as likely to reduce risk of reoffending;
- those whose offence was indirectly related to the disorder i.e. it lowers the resistance to antisocial behaviour. Treatment of the mental illness is likely to make a contribution to reducing reoffending;
- the crime and mental illness are related by a common antecedent i.e childhood abuse. Treating the cause of the mental illness and offending behaviour is likely to reduce reoffending and improve health but treating the mental illness alone is not sufficient to tackle re-offending;
- antisocial behaviour and mental illness are coincidental. It is unlikely that the risk of re-offending will decrease if the mental illness if treated but the person should still be entitled to treatment for the mental illness;
- mental illness is at least partly secondary to antisocial behaviour e.g the person may have PTSD following being the perpetrator of a violent offence. The MI not linked directly to the offending no would it reduce future re-offending. The person should still be entitled, via equivalence to treatment for MI.

Consequently, the respondent feels that disposals should then be given accordingly and appropriately and suggests a number of options:

- full ‘true’ diversion to services for treatment of MI for those who are not prosecuted in the interest of the public, where the offence is directly driven by the MI;
- disposal by hospital order following conviction with or without restrictions;
- mental health care as a condition attached to a community penalty;

- prosecution through the CJS with a custodial or community sentence where the person receives healthcare as part of the sentence management;
- access to mental health service care and social support on a voluntary basis whilst receiving a community penalty.

As far as service provision in respect to diversions the respondent agency feel that we need to look at service delivery as comprising of a number of filters which are the points in the CJ pathway where diversion can take place. Below is a description of these filters together with suggested issues and barriers affecting diversion at each of the stages:

Filter 1: The police station and 1st appearance at magistrates court

Diverting from police stations has been effective but services have been cut. Services are only likely to work if they are owned by mainstream generic MHS and if there are low secure non-forensic beds available. This poses a challenge when low secure type services have been dismantled within the NHS. Home treatment and crisis resolution services followed on from these ward closures. The Royal College of Psychiatrists in their report *'Not just Bricks and Mortar'* advocates for a bed occupancy rate of 85% so patients can be admitted to the most appropriate ward and not to expensive forensic beds divorced from mainstream services and meant for those of high risk. With this lack of low secure beds, and occupancy too high, courts have no choice but to remand the individual to prison.

Filter 2: Prison reception and induction

At the highest risk point for suicide this should be a good time to divert, we have seen improvements here but LD are being missed by screeners. Little information is passed to prisons on reception, communications between court and prison is poor and CMHTs don't continue the care from community to prisons. Once again it is the lack of low secure beds that is the problem.

Filter 3: Bail

The bail act could be used to divert people to services instead of remanding them to prison. Bail hostels could be used instead of prison if this idea were to be developed. The advantages and disadvantages of mental health courts in from oversees could also be looked at here.

Filter 4: Psychiatric treatment combined with a community penalty

Mental health treatment should form part of community treatment orders but does not. There are long delays in obtaining psychiatric reports due to available consultants and funding etc. Other professionals could easily be involved here but are not. This would then put pressure on already overstretched probation services, to help them we propose they have better access to social advice and support regarding; benefits, housing, literacy and education courses related to offending behaviours.

Filter 5: Diversion following conviction with a custodial sentence

There will always be people who need mental health care whilst in prison and possibly a transfer to hospital. There is still a need, therefore to train prison staff in issues as some behaviours can be construed as misconduct when they may be for example Attention Deficit Hyperactivity Disorder (ADHD). Hospitals are not good however in transferring prisoners back to prison after treatment for example, after an episode of psychosis. This creates a sludging of the system which needs addressing.

Concurrently, this respondent would like to see; research into how much diversion is currently taking place. To the respondents knowledge this is currently unknown; and a wider agenda addressing social exclusion not just health, this would include leisure, social support and housing on discharge

Finally, the respondent welcomes the DH initiative of the violence strategy security management service to issue guidelines for the prosecution of patients with mental illness who commit violent acts against healthcare professionals. It is

believed that the act of charging them can have a positive affect upon behaviour and reduce the belief of being above the law by virtue of having a mental illness. Criminal proceedings have sometimes been dropped for people with LD this should not happen as it can lead the person to believe they have done nothing wrong.

Another respondent stated that issues about diversion arise at every stage in the CJS. What is needed to ensure diversion can operate at these stages fall into three categories; political commitment, policy commitment and joined up working that will reconcile differences in NHS and CJS for the benefit of public and resources. The respondent spoke about what is needed at each diversion point

Point 1: Pretrial diversion

Assessment at police stations is crucial. More and more stations have CPNs instead of FMEs. CPNs can conduct assessments but can't make recommendations for detention. Therefore, the police should be connected to CMHTs so that multi-disciplinary assessments can be conducted. Diversion here will save time and money.

Point 2: Diversion by court

The power under the bail act to remand on bail for mental health assessment is underused. Judges may be encouraged to use this power by including it directly in mental health legislation. There are problems when the court wants to send a person with mental illness to hospital due to PCT/catchment area disputes and level of security. This can cause the court just to remand or impose a prison sentence. The Home Office circular (No.66/90) does not address this.

Point 3: Transfer from prison to hospital

Many problems arise here, the MoJ assesses risk differently to health professionals, PCT deadlock is a major barrier and the wording of section 47 is ambiguous. Matters relevant to the decision whether to direct a transfer may include the availability of a hospital bed. Moreover the courts have stated from a

precedent case (R v Secretary of state for the Home Department ex p K (1990) 1 All ER 703 (DC) McCullough J *obiter* at 716) that the *'secretary of state is never obliged to act under section 47 even if he thinks that the necessary preconditions are fulfilled'. S*ection 47 is an ineffective mechanism for transfer. When two clinicians state transfer is necessary, the MoJ should automatically order the warrant.

Point 4: Release from prison and discharge from hospital

Movement around the prison estate makes discharge planning almost impossible. This causes people with mental illness to be released without care plans and ensuring a higher risk of becoming revolving door cases.

Many suggestions for system reform were stated they comprised;

- removing funding barriers between DH and MoJ and better communication between the two. It was stated that it is unclear whether diversion is a matter for the MoJ (once people with mental illness are in the CJS) or the DH (to prevent people with mental illness getting into the CJS);
- ensuring probation services revert back to supportive roles rather than the newly adopted punishment and enforcement role;
- increased use of bail hostels;
- ring fenced funding for mental illness as with drug services and;
- improved capability of MHS to deal with a range of demand and addressing their lack of interest In treating offenders. One respondent stated that there is a dialogue from prison officers that MDOs should be in hospitals and hospital staff state MDOs should be in prison. It is hoped that with increased training for all, boundaries will blur as understanding of the issues increases.

Other respondents stated there is a need;

- to look at the way PCTs are commissioning services for MDOs;
- to increase numbers of prison healthcare officers to ensure 24-hour care. It was stated that in one prison in the north the prison and PCT work well together thought to be due to a high number of healthcare officers;
- for a balance between diversion and prosecution as it was felt that the scales have tipped too much in favour of diversion into healthcare. It was stated that HO guidelines 66/90 and 12/95 are seeing too many criminal cases being taken away from the CJS;
- to embrace the need for early diagnosis upon entering the CJS stated as the key to reducing re-offending;
- to address the delays in obtaining psychiatric reports for court and;
- work to improve the differences in attitudes between healthcare and custody staff. It was stated that negative attitudes to health care within prisons are still prevalent by a few governors. At a Prison Officers Association (POA) 2 governors asked when they could get rid of healthcare. That said, it was stated that there has been positive shift to changing these attitudes with the POA now including secure psychiatric workers. Subsequently, this move has been successful with some governors and not others.

One respondent felt that diversion for mental health problems should mirror the existing practice for that of people with drug abuse issues. Here, if a defendant is arrested and tests positive for drug misuse in the custody suite they must agree to start treatment immediately usually within the probation service. If they do not agree they will be remanded into custody. This scheme is called the Criminal Justice Intervention Treatment (CJIT). There are no similar schemes for mental health.

Finally, one respondent provided information from current research being conducted on behalf of the IPCC (Docking and Grace) that looks at how police custody can be minimised and alternative places of safety be used to divert

people with mental illness away from the CJS. This research was borne from the concern that section136's were not suitable for police custody. The report provides us with the extent to which police cells are used as places of safety, the length of time spent in cells, the profiles of the detainees and where they were disposed to. The report intends to provide a model of good practice which can be used to reduce detentions in police custody.

*Examples of good practice*

*Example 1*

One respondent stated that a stepped care model is an excellent model for commissioning mental health services that respond to the needs of the patient. The patient journey can be represented using a Kupfner curve detailing a curve with decreasing mental health, increasing social exclusion and demand for services at the trough and improving mental health and therefore decreasing social exclusion and less demand on services at the peak. When being cared for in either a prison or a forensic mental health facility services are rarely unequal to that offered for non offenders. However, more emphasis should be placed on offenders presenting earlier in their illnesses which at this point will make less demand on provision. Treatment for offenders needs to be based on a recovery model. As relapse is common, services need provisions for early intervention to prevent people falling down the curve into crisis. They could do this by; ensuring continuity of care for offenders leaving custody and passing information to other services where appropriate and by ensuring that basic human needs i.e. housing, education and work are addressed.

*Specific issues in relation to women, children and young people and BMEs*

In relation to children and young people respondents stated a need for:

- early prevention and identification of mental illness as children enter schools which highlights a need for comprehensive screening and assessment tools that will pick up mental illness, substance misuse and disorders on the autism spectrum;

- improved access to CAMHS for 16 to 17 year olds;
- a mechanism to identify LD in education as it is needed at this early stage;
- access to speech and language therapy;
- courses that lead to acquisition of life skills than would enable people with LD to better adapt socially in later life;
- an increased understanding of LD issues via training packages for CJS workers and;
- communication issues to be addressed as there is a link between a unmet communication needs and offending behaviours.

Reportedly, there is currently an 11 Million enquiry at post funding stage into how to successfully divert children and young people away from the CJS and custody in a way that safeguards their rights and meets their needs.

One respondent stated that it is important to be mindful of the high levels of deaths, near deaths and suicide investigations in prisons, many of which have focussed on mental health issues. One investigation is concerned with the case of SP, a teenager who was recently transferred from prison to Rampton. This investigation will look at prison to hospital transfers and the barriers to these; in for example the availability of secure beds for young women, the assessment process and any regional inequalities.

Finally, respondents stated that housing is a huge problem for young people particularly 17 years old who do not wish to live at home but have difficulty getting accommodation. This can often lead to abuse issues and criminality.

With respect to BMEs it was stated that the nature of need is often based on the needs of white western adult males which is an unhelpful set of assumptions. Voluntary organisations and faith leaders could be commissioned to support MDOs by courts.

Four respondents stated that the recommendations set out in the Corston review should be implemented, one respondent expanded on this suggesting we should be mindful of the special problems faced by women prisoners as featured in many death in custody investigations for example in the 6 fatalities at HMP Styal which was one of the drivers leading to the Corston Report.

## *Part 15: Religious groups*

Two responses were received from religious groups.

*Strengths and weaknesses in the current system*

One respondent stated that there were several weaknesses in the system; firstly the overuse of anti-social behaviour orders (ASBOs) and penalty notices for disorder (PNDs) which just dealt with effects rather than causes. Secondly, that police are in a position to provide early diversion for intervention but didn't and thirdly, there were long delays in transfers from prison to hospital. Additionally, one respondent felt that some CDLS were fragmented, diverse in operation, and need better planning and co-ordination of all agencies involved.

*Barriers and levers to change*

One respondent stated the Bradley review was the main lever for change and a chance for analysis of the problem to come to an end and serious action in diverting people from the CJS to begin. It was hoped that the review would prove to be a new beginning rather than another false start.

Other suggestions for change included;

- mental health problems to be tackled in conjunction with other needs such as housing and substance misuse;
- more use of community orders as mental health disposals, not just hospital orders;
- better reception screening in prisons;
- the effectiveness of the Grubin screening tool to be evaluated;
- the option to use diversion from prison to a community order with a MHTR as well as to hospital and;
- a realisation that diversion schemes should not detract away from the need for further improved prison healthcare.

One respondent felt that there should be an increased use of voluntary sector and faith based services to support care pathways to resettlement as they are potentially good creative partners for community mental health services.

*Specific issues in relation to women, children and young people and BMEs*

The respondents both felt that an awareness of culture needed to be addressed and there needed to be better planning of services for complex needs i.e. for women, BMEs, those with dual diagnoses of mental illness and substance misuse and for children and young people. It was felt that YOTs were thinly resourced for mental health care and assessment but could potentially serve as an early intervention for C&YP if resources were increased.

## *Part 16: Third sector organisations and patient fora*

Thirty two responses were received from third sector organisations (TSOs) and patient user groups (PUGs).

*Strengths and weaknesses in the current system*

One response stated a weakness in the system was a lack of awareness of the needs of people with specific learning difficulties/disabilities (SpLD). This respondent felt it unlikely that diversion schemes for people with SpLD would result in diversion from police custody rather that they would allow diversion from prisons. They suggested there were specific difficulties faced by people with SpLD in the CJS such as problems in giving accurate answers in court, answering complex questions which may result in misinterpreted meanings, adverse implications from remaining silent to prevent stuttering, word retrieval problems, visual stress and mental and/or sensory overload.

The respondent stated that the CJ system was not working well for people with LD, as the prosecution would look for things that could not be helped such as hesitating, misinterpreting questions and producing inconsistencies. Reportedly, it was stated that courts were not taking account of documents prepared by specialists relating to the impact of SpLD on people and were not making reasonable adjustments as stated in the Disability Discrimination Act (DDA). Therefore, there needed to be training to raise awareness of the effect of LD for all CJS workers especially courts.

Other responses suggested weaknesses in the system were poor awareness and unsuitable facilities for treatment and aftercare for people with disorders on the autistic spectrum; problems in the request for defence psychiatric reports as opposed to court reports, which may not contribute to securing ongoing treatment for the client. Subsequently there is gate keeping of information issues.

Other weaknesses related to the socially excluding label ‘PD’ resulting in a person that no one will take responsibility for due to negative attitudes and a lack

of suitable approved premises to allow bail instead of remanding people in custody for psychiatric reports

*Barriers and levers to change*

In relation to people with SpLD suggestions for change to better meet their needs were suggested by three respondents and comprised;

- assessments conducted by specialists located via the working with dyslexia website (see appendix 2);
- all documentation to be considered in court;
- awareness raising of LD;
- reasonable adjustments made to court proceedings such as breaks and repeating questions;
- increased use of video links;
- disability advisors/befrienders in court and;
- improved liaison between police and LD services in relation to fitness to be interviewed.

There was a consensus that there needed to be recognition that there was a wider group of people with pervasive impairments whose needs were not being addressed by mental health services or the CJS i.e. people with LD, disorders on the autistic spectrum, ADHD, and acquired brain injury (ABI). Generally there was a perceived lack of early identification and a lack of CAMHS LD services. Once again it was stated that failure to prosecute may only hinder further risk assessment, potentially reinforce maladaptive behaviours at times appearing contrary to public interest.

The Sainsbury's Centre for Mental Health (SCMH) is currently in the process of reviewing and evaluating diversion systems internationally and assessing whether they are adaptable for use in the UK. Results from a video conference with people from 7 countries found that, when setting up diversion schemes, there was a need to show they were cost effective to agencies such as the police and prison service and that they improved public safety as there was a

misconstrued view that they increased risk to the public. There was also a need for ‘bottom up’ implementation as a result of grass routes initiatives that made use of existing legislation rather than necessarily requiring new legislation, utilising, multi agency working through shared protocols and service level agreements. The single most important factor in the success or failure of diversion schemes was found to be an adequate number and type of services to actually divert people to.

Other suggestions for change included;

- the use of arrest referral and court referral schemes;
- better wraparound care, such as the need to ensure people have adequate housing, employment and education, in addition to access to health and social care support with increased third sector input;
- instilling the trust of magistrates in the use of community sentences to create greater use of (ATRs) and MHTRs;
- addressing the exclusion associated with the label ‘PD’ and;
- stopping people with dual diagnoses slipping through the net of services.

Once again, the need to look at wider care pathways was suggested by Thames Valley court diversion scheme. They stated that in a 12 month period the scheme only diverted 10 out of 65 cases (projected from 3 months data). From these findings, they suggested that there was a greater need to address the wider vulnerable population living in socially and economically deprived areas and that providing increased help more generally would be a better use of resources as diversion dealt with relatively small numbers.

Another respondent stated a need for the review to address the erratic availability and variable quality of current court liaison teams and stressed the importance, as many other respondents stated, of providing a range of support for MDOs in addition to health interventions including accommodation, education, training and employment and finance management. In order to do this it was stated there is a gap for allied health professionals to deliver services to ensure a co-ordinated

approach. This could be done with joint commissioning, perhaps through regional offender managers (ROMs), but also at a local level with a joint approach by police and probation services in partnership with housing and employment agencies. The main barriers to implementing such schemes were suggested as funding, joint working when boundaries are not coterminous, organisational will and differing organisational cultures requiring joint training/awareness raising of each organisations' remit and priorities. Finally, one respondent stated that the review should address how diet affects behaviour/wellbeing in the context of the CJS.

*Examples of good practice*

Several good practice examples were suggested by respondents.

*Example 1*

Firstly, Lancashire police circulate information relating to young people with ADHD that are undergoing questioning and sentencing. It is thought this approach should be used more widely.

*Example 2*

Autism West Midlands promotes a scheme whereby young people carry a card authenticating their condition for use in police and medical emergencies. This is supported by a number of police forces. More information can be found at: www.autismwestmidlands.org.uk.

*Example 3*

Elliott House is one of three approved premises in the West Midlands accommodating male MDOs, They will accept those with a 'treatable' mental illness/PD and will consider dual diagnoses. They will not accept people with substance misuse problems if it is the primary problem; people with LD or those with a single diagnosis of PD; or child sex offenders. People are accepted on licence, bail or subject to a community order. They are usually actively mentally ill but not requiring hospitalisation or undergoing/awaiting further assessment for a

suspected mental illness. They are expected to comply with hostel rules, including compliance with psychiatric treatment and are required to pay rent.

*Example 4*

Rethink have developed a diversion toolkit for use by staff and volunteers helping families of people with mental health problems in prison or facing imprisonment. The view here is that current diversion arrangements simply do not work so the toolkit provides a flowchart illustrating the procedure through the CJS from arrest to imprisonment and draws attention to the points at which diversion could take place. It also explains the roles of officials who are encountered during the journey and how they might facilitate diversion i.e. the custody sergeant, the duty solicitor, the forensic physician, the crown prosecutor and the probation officer. The mains problems in the system highlighted for diversion schemes to be effective are; inadequate numbers of secure unit beds, funding and resource issues, specialist mental health training for solicitors and negative attitudes towards mental illness and PD to be addressed.

*Example 5*

The NSPCC currently have 24 projects across England, Wales and Northern Ireland that provide assessment and therapeutic interventions for young people who display sexually harmful behaviours. One third of referrals are through the CJS. Current projects include;

1. The AIM (Assessment, Intervention and Moving on) project in Manchester, which focuses on working with the YJB assessing and treating young people who have committed sexual offences. This project found that services for this group were fragmented, geographically patchy and hidden within generic services. The aim is to ensure consistency in practice to ensure children are assessed and referred to appropriate services preferably before offences are committed;

2. Therapeutic and advocacy services provided for young people at the Hillside Local Authority Secure Unit in Neath;

3. Counselling and peer mentoring support provided for young people In Thorn Cross young offenders' institution (YOI);

4. Therapeutic interventions for young offenders provided at the young people's centre in Sheffield and;

5. Assessment and family therapy for first-time young offenders provided by the NSPCC and North Yorkshire YOT.

*Example 6*

The Surrey drug and alcohol advisory service (SADAS) works with dual diagnosis patients who have come into contact with the CJS.

*Example 7*

The Asha Centre in Worcester works as an early intervention to divert people away from the CJS. They receive referrals from probation and mental health trusts.

*Example 8*

The Coram Community Campus is a partnership between the local authority, the health authority and six voluntary organisations in the London area. It provides an integrated and flexible service for over 600 families and children. Coram's family drug and alcohol court was cited as a good practice example together with their Boys2men Project. This project is a male specialist engagement service which aims to reduce social exclusion in boys, young men and fathers. The project has successfully achieved one of their aims to increase male contact with mental health services.

*Example 9*

As previously stated, Lancashire police are circulating information to relevant agencies on people with ADHD that are undergoing questioning and sentencing. This project is entitled *'kids of the cone, a criminal justice approach'* is available from the ADHD information service Attention Deficit Disorder Information Support Service (ADDISS, see appendix 2 for web link).

*Example 10*

Autism West Midlands promotes a scheme whereby affected young people carry a card authenticating their condition for use in police and medical emergencies. This is supported by a number of police forces (see appendix 2 for web link).

*Specific issues in relation to women, children and young people and BMEs*

In relation to specific issues for women, respondents felt that there needed to be an increase in community sentencing to prevent family break ups and help reduce the risk of offending by different generations of the same family. There was also an appeal for the recommendations of the Corston report to be implemented. Many respondents stated that for many, community sentences would be far more beneficial both to the public, the offender and their families. One respondent stated that women were often placed in very restrictive settings with their needs not being recognised or met whether they had LD or mental health problems. It was also stated that there needs to be specific services for women BMEs in the community with the aim of early intervention and as option for courts to divert to.

With respect to people from black and ethnic minority groups, work conducted by the Association of Black Social Workers and Allied Professionals (ABSWAP) suggested that there were issues providing suitable accommodation for BMEs with mental health problems which could lead to stress, relapse and readmission to hospital. Additionally, unemployment rates for BME users exceeded national averages and there was research that suggested there were barriers to accessing education, employment and training. Reportedly, research conducted

by ABSWAP, had uncovered feelings of being discriminated against due to no effort by service providers to develop culturally sensitive services for BME groups.

With respect to children and young people, barriers to diversion were suggested by one respondent;

- inadequate early identification and intervention in primary care settings such as schools and nurseries;
- CAMHS being generally inaccessible and not child, young person or family friendly in approach and;
- a lack of an interagency approach.

Therefore, a series of suggestions were given which consisted of the need for;

- C&YP specific diversion schemes and more resources to support this;
- an access support worker role funded by MHS locally piloted in police stations to identify mental health and LD;
- mental health awareness training for CJS staff;
- use of multi-systemic therapy approaches, wraparound services and multidimensional fostering delivered collaboratively by YOTs and CAMHS and;
- an increase in the use of MHTRs.

Another respondent felt that the review should focus on children and young people in line with the UN Convention on the Rights of the Child stating that prison was no place for children and young people and should be used as a last resort.

The respondent felt that there is a need to understand why in the UK, we incarcerate so many children. They suggest there is a need to address the needs of vulnerable children, children from BME groups, looked after children, and those with LD before they come into contact with the CJS. Consequently, this would give rise to the need to look at helping teachers keep those children with

problems in school and improving teacher training programmes to enable them to do this.

Other suggestions included;

- the need for more speech and language therapists;
- drug and alcohol awareness raising;
- a rethink of the decision to close local authority children's homes;
- a need to evaluate tier 4 CAMHS in order to evaluate it's effectiveness since the rapid expansion;
- an expansion of the alternatives to custodial sentences such as community sentences, restorative justice approaches and treatment foster care approaches and;
- increase the provisions for post release resettlement for children.

One respondent stated that there was a link between childhood maltreatment and offending behaviour and therapeutic services should help children and young people overcome the effects of violence, maltreatment and neglect that they may have experienced. It was felt that more service provision for people who displayed sexual harmful behaviours was essential as they could come into contact with the CJS due to a lack of resources to address their behaviours. The NSPCC works with such children and runs 20 centres nationally. The NSPCC are aware of a growing body of evidence to suggest this was effective in reducing sexual risk to others.

# Appendices

## *Appendix 1: List of respondents including collaborators*

A

Association of Black Social Workers and Allied Professionals

Association of Chief Police Officers

Archbishops Council

Archway

Avon Forensics, Bristol South

B

Birmingham and Solihull NHS Trust

Birmingham Magistrates Court

Bishop of Liverpool/HM Prisons

Bishop of Ripon and Leeds

Bolton, Salford and Trafford NHS Trust

Bradford and District NHS Trust

Brent Magistrates Court

Brent Mental Health Services

Bristol Magistrates Court

Bronx Mental Health Court, New York City, USA

C

Calderstones NHS Trust

Campbell Taylor Solicitors

CBI The Voice of Business

Central and North West London NHS Trust

Central Criminal Court London

Clinks

CNWL NHS Foundation Trust

Coram Community Campus
Council for Disabled Children
Criminal Justice Alliance
Crowley House Approved Premises
Crown Prosecution Service

D
DANDA
Derbyshire Mental Health Services
Devon and Cornwall Police
Department of Health
Dudley PCT
Durham cluster of prisons

E
East London NHS Foundation Trust
Eastern Region Government Office
Elliot House Approved Premises

F
FACTS Team Court Liaison Service
First Step Trust
Foundation for people with Learning Disabilities

G
Gloucester Partnership Foundation Trust
Gloucestershire Criminal Justice Liaison Team
Greater Manchester West Foundation NHS trust
Greenwich teaching PCT
Gwent forensic Mental Health Services
Gwent Probation

H

Harrow Mental Health Services

Hertfordshire Probation area

Hillingdon Mental Health Services

Her Majesty’s Courts Administration

Her Majesty’s Chief Inspector of Prisons

Her Majesty’s Court Service

Her Majesty’s Court Service London

Her Majesty’s Court Service South Wales

Her Majesty’s Court Service Stratford

Her Majesty’s Court Service West Lothian

Her Majesty’s Inspector of Prisons

HMYOI Styal

HMP Belmarsh

HMP Preston

HMP Garth

HMP Wymott

HMP Birmingham

HMP Edmunds Hill

HMP Featherstone

HMP Foston Hall

HMP Grendon

HMP Holloway

HMP Hull

HMP IRC Haslar

HMP Liverpool

HMP Shrewsbury

HMYOI Usk and Prescoed

HMP Whatton

HMP Winchester

HMYOI IRC Glen Parva

HMYOI Warren Hill

HMP Woodhill

Home Office

Howard League for Penal Reform

Humberside Probation

I

Independent Police Complaints Commission

Inquest

Institute of Psychiatry

J

JD Spicer and Co Solicitors

Julian Housing

K

Kent Probation

Kirklees Youth Offending Team

L

Lancashire Care NHS Trust

Leeds PCT

Legal Services Commission

Leicester City Council CDRP

Leicester City health and well being partnerships

Leicester City PCT

Leicester Youth Offending Service

Leicestershire and Rutland Probation boards,

Leicestershire and Rutland Youth Offending Service

Leicestershire County and Rutland PCT

Leicestershire Partnership Trust

London Borough of Tower Hamlets
London Criminal Justice Bureau
London Development Centre
London Metropolitain Police
London Probation Service
London Regional Offender Management Service

M
Merseyside Police
Merseyside Probation
Ministry of Justice

N
NACRO
National Audit Office
National Bench Chairmans Forum
National Children's Homes
National Probation Service
National Treatment Agency
NHS Confederation
Norfolk and Waveney NHS trust and Norfolk,
North East London Mental Health Trust
North Hertforshire Liaison Services
North Staffordshire combined Healthcare NHS Trust
North Yorkshire and York PCT MDO steering group
North Yorkshire and York PCT
North Yorkshire forensic psychiatry service
Northumberland and Tyne and Wear Mental Health Trust
Northumbria Probation
Northumbria University
NSPCC

O

Office for Criminal Justice Reform

Office for Criminal Justice Reform out of Court Disposals Team

Ontario Telemedicine Network

Oxleas NHS Foundation Trust

P

Park Royal centre for mental health

Partnerships in Care

Policy Research Associates, New York City, USA

Portsmouth Collaboration

Prison Reform Trust

Prisons and Probation Ombudsman

Providence Row Housing Association

R

Rethink

Revolving Doors Agency

S

Sandwell Mental Health Trust

Sandwell Probation

Secure Healthcare

Serco

Sheffield PCT

Social Exclusion Task Force

Somerset PCT

South London and Maudsley NHS Foundation Trust

South Staffordshire and Shropshire NHS Foundation Trust

South Wales Probation

South West London and St Georges Mental Health Trust

South view Approved Premises

St Mungo’s

Staffordshire County Council

Staffordshire Social Care and Health

Suffolk and Cambridgeshire Forensic Services

Suffolk mental health services

Surrey Alcohol and Drug Advisory Service

Sussex Partnership Trust

Sustain food

T

Tees, Esk and Wear Valley NHS Trust CAMHS

Thames Magistrates Court

The British Psychological Society

The Law Society

The Magistrates Association

The Priory Group

The Prison Officers Association

The Prison Reform Trust

The Royal College of General Practitioners

The Royal College of Nursing

The Royal College of Psychiatrists Secure Environments Group

The Royal College of Speech and Language Therapists

The Royal College of Psychiatrists

The Sainsbury’s Centre for Mental Health

The University of Cambridge

The University of Lincoln

Together Forensic Mental Health Practitioner Service

Together Women's Project

Transition Information Network

Turning Point

V

Victims Voice

W

Wandsworth PCT

Wessex forensic psychiatry service

West London Drugs Court

West London Mental Health Trust

West Midlands CJB

West Midlands Probation

West Sussex County Council

West Yorkshire Police Kirklees Division

Wolverhampton PCT

Women and Young People's Group

Y

Youth Justice Board

Yorkshire and Humberside Probation Commissioner

Yorkshire and Humberside ROMS

Z

Zito Trust

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Responses were also received from members of parliament, service users and private individuals. Names were not individually listed.

## *Appendix 2: Additional documents and web links referred to in responses*

Associate Parliamentary Food and Health Forum (2007) *The Links Between Diet and Behaviour: The Influence of Nutrition on Mental Health.* Associate Parliamentary Food and Health Forum [Online] Available at: http://www.fhf.org.uk/meetings/inquiry2007/FHF_inquiry_report_diet_and_behaviour.pdf

Bercow, J. (2008) *The Berco Report: A Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs.* [Independent Review, Online] Available at: http://www.dcsf.gov.uk/bercowreview/

Cabinet Office (2008) *Background on Public Service Agreements.* [Online] (Updated 22nd May 2008) Available at: http://www.cabinetoffice.gov.uk/social_exclusion_task_force/psa.aspx [Accessed 15 Oct 2008]

Cabinet Office (2008) *Families at Risk Review* [Online] (Updated 01/08/2008) Available at: http://www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk.aspx [Accessed 15 Oct 2008]

Care Services Improvement Partnerships (2007) *Positive Practice, Positive Outcomes: A Handbook for Professionals in the Criminal Justice System working with Offenders with Learning Disabilities*. London: Care Services Improvement Partnerships [Online] Available at: http://kc.csip.org.uk/viewdocument.php?action=viewdox&pid=0&doc=33224&grp=1

Carpenter, J and Dyer, W (2007) *Outcomes of Custody Diversion for Violent Offenders*. Department of Health, National Forensic Mental Health R&D Programme.

Church of England Board for Social Responsibility (1999) *Prisons: A Study in Vulnerability*. London: Church House Publishing [Online} Available at http://books.google.co.uk/books?id=idd4l_DKsDAC&printsec=frontcover#PPA3,M1

Department of Health & HM Prison Service (2001) *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons*. London: Department of Health & HM Prison Service [Online] Available at:http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009699

Department of Health (2002) *Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide*. Department of Health [Online] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058

Department of Health, Department for Children Schools and Families, Ministry of Justice, Youth Justice Board and Home Office (2008) *Improving health, supporting justice: a consultation*. London: Department of Health [Online] Available at: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_080816

Dyer, W (2006) The Psychiatric and Criminal Careers of Mentally Disordered Offenders Referred to a Custody Diversion Team in the United Kingdom. *International Journal of Forensic Mental Health.* Vol. 5(1), 15-28

Fennell, P (1991) Diversion of Mentally Disordered Offenders from Custody. *Criminal Law Review*, May: 333-348

Grounds, A (2007) *Elderly and mentally disordered prisoners, European committee on crime problems (CDPC): 14th Conference of Directors of Prison Administration (CDAP).* Vienna: CDPC [Online] Available at: http://www.coe.int/t/e/legal_affairs/legal_co-operation/prisons_and_alternatives/conferences/cdap%20(2007)%2005%20rev%20-%20e%20(Adrian%20Grounds).pdf

HM Prison Service, Women and Young Peoples Group (2006) *Strategy and resource guide for the resettlement of women prisoners*. London: HM Prison Service, Women and Young Peoples Group [Online] Available at: http://www.mediafordevelopment.org.uk/attachments/documents/resettlement%20of%20women%20prisoners.pdf

HM Inspectorate of Court Administration (2007) *Meeting defendants' needs: An overview of the quality of service for defendants' in the criminal courts in England and Wales*. HMICA [Online] Available at: http://www.hmica.gov.uk/files/Meeting_Defendants__Needs_embargoed_to_31_Jan_07_FINAL.pdf

HM Inspectorate of Prisons (2007) *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs.* London: HM Inspectorate of Prisons [Online] Available at: http://inspectorates.homeoffice.gov.uk/hmiprisons/thematic-reports1/Mental_Health.pdf?view=Binary

Hodgins, S., Alderton, J., Cree, A., Aboud, A. and Mak, T. (2007) Aggressive behaviours, victimisation and crime among severe mentally ill patients requiring hospital treatment, *British Journal of Psychiatry*, 191, 343-350

Home Office Press Office (2005) *Speeches and Statements: Where next for Penal Policy?* Speech by the Home Secretary of the Prison Reform Trust [Online] Home Office Press Office. Available at: http://libweb.anglia.ac.uk/referencing/harvard.htm?harvard_id=64#64 [Accessed 14 Oct 2008]

House of Commons Committee of Public Accounts. *National Offender Management Service: Dealing with increased customer numbers in custody*. Forty –Fourth Report of Session 2005-2006. London: HC Committee of Public Accounts [Online] Available at: http://www.parliament.the-stationery-office.co.uk/pa/cm200506/cmselect/cmpubacc/788/788.pdf

Jacobson, J. (2008) *No One Knows, Police Responses to Suspects with Learning Disabilities and Learning Difficulties: A Review of Policy and Practice.* London: Prison Reform Trust [Online] Available at: https://fflm.ac.uk/upload/documents/1213006033.pdf

Talbot, J. (2007) *No one knows: Identifying and supporting prisoners with learning difficulties and learning disabilities: the views of prison staff*. Prison Reform Trust [Online] Available at: http://www.prisonreformtrust.org.uk/temp/NospOnespKnowsspreliminaryspreport2.pdf

Laing and Buisson (2007) *Mental Health and specialist care services, UK market report: Second edition*. [Online] Available at: http://www.laingbuisson.co.uk/Portals/1/MarketReports/contents_mhscs07.pdf

Leggett, J., Goodman, W and Dinani, S (2007) People with learning disabilities' experiences of being interviewed by the police. *British Journal of Learning Disabilities*, 35, 168–173

Loucks, N. (2006) *No One Knows: offenders with learning difficulties and learning disabilities – review of prevalence and associated needs*. London, Prison Reform Trust [Online] Available at: http://www.prisonreformtrust.org.uk/temp/Prevalencecmspfullspreport.pdf

Maunder, L., et al (submitted) *The Effectiveness of self help materials for anxiety adapted for use in prison: a pilot study.*

Mental Health Foundation (2006) *Feeding Minds The Impact of Food on Mental Health*. London: Mental Health Foundation [Online] Available at http://www.mentalhealth.org.uk/publications/?EntryId5=38571&char=F

Michael, J. (2008) *Healthcare for all: Report of the Independent Inquiry into access to healthcare for people with learning disabilities*. Secretary of state for Health [Online] Available at: http://www.iahpld.org.uk/Healthcare_final.pdf

National Audit Office Report (2004) *The Drug Treatment and Testing Order; Early Lessons*, HC 366 Session 2003-2004. London: National Audit Office [Online] Available at: http://www.nao.org.uk/publications/nao_reports/03-04/0304366.pdf

National Audit Office (2008) *National Probation Service: The Supervision of Community Orders in England and Wales*. HC 203 Session 2007-2008. London: National Audit Office [Online] Available at: http://www.nao.org.uk/publications/nao_reports/07-08/0708203.pdf

National Audit Office (2008) *Meeting Needs? The Offenders' Learning and Skills Service*. HC 310 Session 2007-2008. London: National Audit Office [Online] Available at: http://www.nao.org.uk/publications/nao_reports/07-08/0708310.pdf

National Institute for Clinical Excellence (2007) *CG51 Drug misuse: psychosocial interventions*. London NICE Guideline, The national institute for clinical excellence [Online] Available at: http://www.nice.org.uk/Guidance/CG51

Northumberland, Tyne and Wear NHS Trust (2008) *Stress and Anxiety A self help guide for people in prison*. Northumberland, Tyne and Wear NHS Trust [Online Leaflet] Available at: http://www.ntw.nhs.uk/pic/docs/prisoners/Stress%20and%20AnxietyTO.pdf

Northumberland, Tyne and Wear NHS Trust (2008) *Post Traumatic Stress How to deal with the effects of distressing events: A self help guide for people in prison.* Northumberland, Tyne and Wear NHS Trust [Online Leaflet] Available at: http://www.ntw.nhs.uk/pic/docs/prisoners/1282_SHP%20-%20Post%20Traumatic%20Stress.pdf

Peay, J and Eastman, N. (1998) Sentencing Psychopaths: is the hospital and limitation direction an ill-considered hybrid? *Criminal Law Review*, February: 93-108

Rethink Severe Mental Illness (2007) *Personality Disorders: information for carers*. Rethink Severe Mental Illness [Online Leaflet] Available at: http://www.mentalhealthshop.org/products/rethink_publications/personality_disord_1.html

Rethink Severe Mental Illness, Turning Point (….) *Dual Diagnosis Toolkit, Mental Health and Substance Misuse: A Practical Guide for Professionals and Practitioners*. London: Rethink, Turning Point [Online] Available at: http://www.turning-point.co.uk/NR/rdonlyres/D7775B51-37B0-4CD4-BCED-EE0177F2C454/0/Dual diagnosis toolkit.pdf

Revolving Doors (2006) *Development Programme for Extending Offender Healthcare Support: Early Interventions Work stream Final Report.* Revolving Doors Agency [Online] Available at: http://www.revolving-doors.org.uk/documents/reports/Early_Interventions_Report_2006.pdf

Rogers, T. P., Blackwood, N. J., Farnham, F., Pickup, G. J and Watts, M. J (2008, in press) *Reformulating fitness to plead: a qualitative study*

Rogers. T., Blackwood, N., Farnham, F., Pickup, G., Watts, M. (2008, in press) Fitness to plead and competence to stand trial: a systematic review of the construct and its application. *Journal of Forensic Psychiatry and Psychology*

Royal College of Psychiatrists (1998) *Not Just Bricks and Mortar, report of the Royal College of Psychiatrists working party on the size, staffing, structure, and security of new acute adult psychiatric in-patient units.* London: Royal College of Psychiatrists [Online] Available at: http://www.rcpsych.ac.uk/files/pdfversion/cr62.pdf

Rutherford, M., Duggan, S. (2007) *Forensic Mental Health Services, Facts and Figures on Current Provision*. The Sainsbury Centre for Mental Health [ *http://www.scmh.org.uk/pdfs/scmh_forensic_factfile_2007.pdf*

Sainsbury Centre for Mental Health (2006) *London's prison mental health services; a review*. London: The Sainsbury Centre for Mental Health [Online] Available at: http://www.scmh.org.uk/pdfs/policy5_prison_mental_health_services.pdf

Seymour, L., Rutherford, M. (2008) *'The Community Order and the Mental Health Treatment Requirement'*. Sainsbury Centre for Mental Health [Online] Available at: http://www.scmh.org.uk/pdfs/scmh_mental_health_treatment_requirement_paper.pdf.

Shaw, S. (2007) Mental Health in Prisons: Some Insights from Death in Custody Investigations. *Prison Service Journal,* 174: 11-14 [Online] Available at: http://www.phrn.nhs.uk/Policy/MentalHealthInPrisons.pdf

Social Exclusion Unit (2002) *Reducing re-offending by ex-prisoners. Social Exclusion Unit.* Office of the Duty Prime Minister [Online] Available at: http://www.cabinetoffice.gov.uk/~/media/assets/www.cabinetoffice.gov.uk/social_exclusion_task_force/publications_1997_to_2006/reducing_report%20pdf.ashx

Social Exclusion Unit (2004) *Mental Health and Social Exclusion*. London: Social Exclusion Unit, Office of the Duty Prime Minister [Online] Available at: http://www.socialinclusion.org.uk/publications/SEU.pdf

Sustain (2008) *Publications and Research: Changing Diets, Changing Minds: how food affects mental health and behaviour.* [Online] (Updated 23rd May 2008) Available at: http://www.sustainweb.org/page.php?id=132

TheyWorkForYou.com (2008) *Written Answers*: *House of Lords, Health: Untreatable Patients.* [Online] (Updated 20th Feb 2008) Available at: http://www.theyworkforyou.com/wrans/?id=2008-02-20a.70.4&s=speaker%3A13471#g70.5
[Accessed 13 Oct 2008].

TheyWorkForYou.com (2008) *Written Answers*: *House of Lords, Health: Untreatable Patients.* [Online] (Updated 21st Feb 2008) Available at: http://www.theyworkforyou.com/wrans/?id=2008-02-21a.85.0&s=speaker%3A13471#g85.1
[Accessed 13 Oct 2008].

Turning Point (2004) *Routes into Treatment: Drugs and Crime*. London: Turning Point [Online] Available at: http://www.turning-point.co.uk/NR/rdonlyres/A903EA89-5FC5-4607-8F13-05C9B8C03EF8/0/Routesintotreatmentreport.pdf

Van de Weyer, C. (2005). *Changing diets changing minds: How food affects mental wellbeing and behaviour*. London: Mental Health Foundation [Online] Available at: http://www.mentalhealth.org.uk/publications/?EntryId5=40150&char=C)

www.autismwestmidlands.org.uk

www.addiss.co.uk

www.unityradio.co.uk

www.workingwithdyslexia.com