Alternatives to Custody for People with Mental Health Problems

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Executive Summary

Current government policy is working toward the reduction of short term custodial sentencing where suitable community alternatives exist which both suitably and appropriately punish offenders and reduce the likelihood of re-offending.

The Offender Health Research Network was commissioned by Offender Health at the Department of Health to examine the impact of a potential change in sentencing practices in terms of health and criminal justice services’ responses to people with mental health problems who are in contact with the criminal justice system, making recommendations for improving current service provision.

We conclude that the Mental Health Treatment Requirement, available as part of the Community Order, has not been fully adopted by sentencers or mental health and criminal justice service professionals as a mechanism through which to better engage mentally ordered offenders with treatment services. The reasons for this are discussed and we suggest a number of adaptations to the current legislation and associated working practices which are designed to increase the uptake of, and benefits from, the Requirement.
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<td>Criminal Justice Joint Inspectorate</td>
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<td>CJS</td>
<td>Criminal Justice System</td>
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<td>CMHT</td>
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<td>IAPT</td>
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1 Aims and objectives

This report forms part of the Offender Health Research Network’s (OHRN) review of current community service initiatives and practices for mentally disordered offenders, conducted at the request of Offender Health at the Department of Health (DH).

Our earlier report, *Liaison and Diversion Services: Current practices and future directions* (OHRN, 2011) examined how mental health liaison and diversion services, based in either police custody or magistrates’ courts, currently indentify, assess, refer and/or treat people with mental health problems early in the criminal justice process and made recommendations designed to improve practice. We also addressed issues of how the work of liaison and diversion services can be evaluated in terms of their impact upon individuals’ well-being and the wider possible effect upon re-offending.

In this second report, we look at what services are currently available in the community to both help and manage people with mental health problems who are in contact with the criminal justice system (CJS). We examine professionals’ views around how Government policy to reduce short term prison sentences may impact upon community management of those with mental health problems in contact with the CJS through non-custodial sentencing options. We will address the latter issue with particular reference to the Mental Health Treatment Requirement (MHTR) available as part of the Community Order.
2 Method

To inform our earlier report (OHRN, 2011) examining liaison and diversion services, we made site visits or arranged telephone conferences with all of the 21 ‘Pathfinder’ services which currently comprise the DH’s national network of liaison and diversion services. The network also includes a further 27 ‘development’ services\(^1\).

The main focus of the visits was to identify referral processes, methods of screening for mental illness and subsequent assessment and onward referral processes. Additionally, and relevant for this report, we asked services a number of questions covering:

- The types of statutory and third sector community health and social care services they referred clients to;
- Whether their teams were involved in the assessment for, or management of MHTRs;
- Whether MHTRs were used regularly in their area;
- Barriers and facilitators to the use of MHTRs; and
- What changes would be required in current community service provision, in terms of type of service, or capacity, if more offenders with mental health problems were managed through non-custodial disposals.

These issues were raised during site visits and via a follow-up questionnaire sent after the face-to-face visits (Appendix 1).

To supplement the questionnaire and site visits we interviewed a further, purposive, sample of professionals including probation service and mental health staff and a number of clinical-academic researchers with expertise in the field and conducted a targeted literature search.

\(^1\) Services were ascribed to one of the two categories based on their responses to a questionnaire from the DH which identified current practices and approaches to a number of key activities, including screening, assessment, referral, multi-agency working, information sharing, commissioning and governance arrangements and financial sustainability.
3 Alternatives to custody: community sentencing and the role of health and social care services

"Community sentences provide a robust alternative to short custodial sentences. Short prison sentences are often just long enough for a prisoner to lose their home, their job, their family, their benefits, their health and their mental health. Yet they are rarely long enough to establish robust resettlement plans, and they rarely achieve positive health, housing or employment outcomes”

(Khanom, Samele & Rutherford, 2009)

Prisons have long been regarded by social reformers as serving as repositories for the mentally ill, disabled and the addicted as well as those who break the law (e.g. Howard, 1777). The size of the prison population in England and Wales has been a constant feature informing government policy over a number of decades, with changes in sentencing legislation and wider criminal justice initiatives combining to exert a powerful influence upon who our society locks up, and for how long. In particular, short prison sentences have been criticised as ineffective in terms of offering any useful contribution to rehabilitation or reducing criminal recidivism; re-offending rates for short prison sentences of less than 12 months increased from 58% in 2000 to 61% in 2008 (MoJ, 2010).

3.1 Prevalence of mental health problems in community offender groups

Whilst less is known about the prevalence of mental health problems of those serving community sentences or under probation supervision than the scale of the problem in the prison population (e.g. Fazel & Danesh, 2002; Singleton et al., 1998), evidence does suggest that this group experience mental health problems at greater levels than the general population. For example, an examination of the national risk and needs assessment tool for adult offenders in England and Wales, the Offender Assessment System (OASys), found that 43% of offenders reported a level of emotional needs that may have been directly related to their criminal behaviour (Solomon & Rutherford, 2007). Earlier research identified that one fifth of men and one third of women subject to community probation supervision said they had a mental disorder (Mair & May, 1997).

More recently, Brooker et al. (2008) conducted a health needs assessment of 183 individuals on probation caseloads in Nottinghamshire and Derbyshire, concluding that offenders’ health was significantly worse than the ‘manual’ social class of the general population and that the health profiles of the female offender sample were significantly worse than male offenders. Problem drinking was four times higher than the general population for men and eight times higher for women; 38% of the
sample was at risk of having a significant drug problem. One in four (27%) had been seen formally by a mental health service.

3.2 The efficacy of offender management in the community

As noted in our previous report (OHRN, 2011), there is a lack of empirical research evidence around the efficacy of liaison and diversion interventions for people with mental health problems. Similarly, our examination of the literature evaluating community-based criminal justice sentencing options for this group revealed a lack of high quality published trials of interventions to provide reliable evidence of the impact of different service and treatment models. Research into ‘what works’ with regard to probation supervision has generally been limited, often based on studies with sub-optimal designs and imperfect matching of terms and concepts under evaluation e.g. differential definitions of supervision, treatment requirements, completion of orders etc (Pearson et al., 2011; McDougall et al., 2006).

Redondo, Sanchez-Meca and Garrido (1999) carried out a meta-analysis of 32 studies evaluating treatment interventions for offenders in Europe. On average, treatment caused a 12% decrease in recidivism. Best results were generated following behavioural and cognitive-behavioural programmes, causing an average 23% reduction in recidivism. Programmes for violent offenders were most effective.

Ross and Lawrence (2005) examined an archival dataset of 6,815 community corrections orders made by courts in the Australian state of Victoria. Their aim was to identify what information about an offender and a criminal case was important when sentencers made decisions about whether to require psychological or psychiatric treatment under a court order. A total of 845 orders (12.4%) had a psychological or psychiatric treatment condition attached. Analysis of sentencing decisions generated a multivariate model of the relationship between offender and case characteristics and decisions about the application of treatment conditions. The best predictor of whether or not a treatment order was applied was whether the offender was already under some sort of mental health treatment at the time of the court case. Of those currently under treatment, 36% had a treatment condition attached to their community order vs. 10% of those not currently in contact with services.

The second predictor of a treatment condition was whether the crime was a sexual offence; being convicted of a sexual offence increased the probability of received a treatment condition by two to four times. Of those currently under treatment, 59% of sexual offenders received a treatment order vs. 32% of non sexual offenders. For those not currently in treatment, 39% of sexual offenders received a treatment order vs. 10% non sexual offenders.

For those currently under mental health treatment at the time of their court case, the existence of an alcohol abuse problem reduced the probability of a treatment order by a factor of three; 35% with no alcohol abuse received a treatment order vs. 12% with alcohol abuse. For those not currently in contact with mental health services, a history of previous contact doubled the probability of a court mental
health condition; 17% of those with service contact history vs. 9% with no treatment history.

Ross and Lawrence (ibid) concluded that an offender’s treatment history was the primary consideration for the imposition of a treatment condition attached to a community sentence; those currently under treatment were four times more likely to receive such and order and those with past contact twice as likely. They hypothesised that this could be for a number of reasons: current treatment could indicate severity of disorder or need; sentencers may feel the imposition of a treatment condition to act as an official ‘endorsement’ of an existing plan of care; or they may be less concerned about the demands imposed by the treatment order, relative to the gravity of the offence. However, the authors also noted that, for offenders currently under treatment, it may be that courts were more likely to have either sought, or automatically be provided with, expert clinical advice in comparison to people not in contact with services whose disorder could then possibly be missed.

With regard to the predictive power of sexual offences in the application of community treatment orders, two possible explanations were given. Firstly, that the application of a community order with a treatment condition was viewed by sentencers as a viable alternative to imprisonment in terms of assessing the likely risks involved and/or, secondly, that sexual offending was, in itself, regarded as a form of mental disorder, a view which may depend on the nature of the expert advice given to the court.

Both alcohol and drug abuse were found to reduce the likelihood of a treatment order being imposed. This may reflect a sentencer’s need to choose whether to deal with the mental health problem or the substance misuse, or may also reflect the problem of finding services willing to deal with dual diagnosis clients. Perhaps most interestingly, the researchers found that no offender demographic factors were predictive of treatment orders being imposed or not. The offenders in their dataset reflected a typical offending population in the middle stages of a criminal career. Most were young adult men, but there were also significant numbers of young adult women. Almost all had previous CJS contact but there were no differences in whether or not a treatment order was applied relative to their age, gender or ethnicity.

Ross and Lawrence (ibid) concluded that, while courts play a central role in the management of people with mental health problems who offend, defendants themselves actively influence outcomes through the choices they make about treatment and the way those choices are represented in court. The role of substance misuse is a critical consideration for the CJS, given the difficulty of accessing dual diagnosis services in the community and that “therapeutic jurisprudence can only be effective if the courts are able to provide or support access to interventions which meet the needs of the offenders.”

Skeem and Louden (2006) examined published and unpublished evaluations, between 1975 and 2005, relating to adults with mental illness under probation. All articles were in English, and the majority related to the United States of America. The study was prompted by concerns that people with mental illness under probation supervision were significantly more likely than those without to have
their probation or parole revoked for violating conditions or for committing new offences (e.g. Porporino & Motiuk, 1995). They sought to answer three questions: firstly, what are the risk factors for people with mental illness failing community supervision; secondly, what interventions have been tried to ensure the success of supervision; and, thirdly, how effective have such interventions been.

The review concluded that the links between mental illness and supervision failure were complex and multi-faceted. Links could be either (i) direct, for example a result of overt illness behaviour; (ii) indirect, for example where aspects of an illness adversely affects a person’s ability to comply with probation conditions e.g. maintaining employment; or (iii) spurious, caused by factors relating to both illness and antisocial behaviour more generally, for example poverty and poor social networks. Increased rates of failure may also be attributable to professionals monitoring more closely offenders with mental illness, who often have co-existing substance misuse issues, thus any breach of conditions may be more easily or quickly picked up.

With regard to what interventions had been tried with this group, the review identified a number of service initiatives, including speciality mental health caseloads in probation, reduced caseload numbers, sustained staff training, team and multi-agency working and the use of problem solving strategies which pre-emptively identify obstacles to compliance. The reviewers found that research into which of these interventions was effective was limited, with few evaluations of services. Some evidence existed for the value of speciality vs. traditional caseloads in probation in linking offenders with treatment services, improving their well-being, and reducing the risk of probation violation. They concluded that the current evidence suggests that speciality probation services are “on the cusp of qualifying as promising practice”, requiring robust evaluation through independent studies with gold standard research methodologies.

To further examine the promise of speciality probation services, Skeem, Emke-Francis and Louden (2006) conducted a national survey in the United States of America, comparing the supervision approaches of a matched sample of 66 speciality and 25 traditional probation agencies. The survey aimed to quantify and make sense of the two different approaches to supervising people with mental illness. This was done by identifying speciality probation services, assessing their unique ingredients, describing their heterogeneity and assessing their perceived practicality and effectiveness. The survey comprised a telephone interview and the completion of a comprehensive case management questionnaire, returned by post.

Analysis focused on identifying features that both distinguished speciality from traditional agencies and were shared by, or relatively common to, most speciality services. Three groups of features were examined. Firstly, structural characteristics; speciality agencies largely had exclusive mental health caseloads, with fewer probationers per member of staff. Staff were also likely to be more higher trained than in traditional agencies. Secondly, case management style; traditional agencies emphasised mixed caseloads, referral to external specialist services and probationer compliance whereas speciality agencies focused on staff expertise and highly involved relationships with mentally disordered offenders. Speciality agencies scored significantly higher with regard to their active links with treatment providers, case managers and other third parties. Thirdly,
implementation of treatment mandates; speciality agencies were more likely to focus on monitoring both medication and treatment attendance. Speciality agencies were also more likely to endorse problem solving strategies than traditional agencies. This could include planning joint strategies with treatment providers rather than just using providers as a source of information to inform proceedings for breaching orders.

The authors concluded that, although probation agencies differed in their approaches to supervising mentally disordered offenders, it was possible to categorise services as speciality or traditional, based on the features described above. Speciality agencies were identified by exclusive mental health caseloads; meaningfully reduced caseload numbers; sustained officer training; a management style which involves integration of internal (probation) and external (treatment and other) resources to meet service users’ needs; and problem solving approaches to address treatment non-compliance. Problem solving was characterised by having fair, two-way conversations about non-compliance and its likely causes; generating alternative strategies; and mutually agreeing a plan to solve the problem and thus generate compliance. Specialist probation staff were less likely than traditional staff to use reminders of the rules or threats of imprisonment to increase compliance. They noted that further research was required to determine whether a problem solving approach and, more generally, the establishment of ‘firm but fair’ relationships could reduce perceptions of coercion felt by mentally disordered offenders within the CJS. They also noted the need for prospective outcome studies to determine whether speciality agencies ‘work better’ than traditional agencies and, if so, which elements most contribute to the success.

Davis et al. (2008) conducted a review of literature around the effectiveness of community orders, concluding that evidence in the area was variable, with few gold standard experimental studies published. Findings from the largely quasi-experimental and non-experimental studies which were available provided strong evidence that community-based cognitive/behavioural programmes and some types of drug treatment do work to reduce recidivism. Available evidence did not support the effectiveness of domestic violence programmes, unpaid work, education and basic skills training and intensive probation as methods of reducing re-offending. Similarly, the limited amount, and poor quality, of current research led the authors to conclude that there was currently a lack of conclusive evidence on the impact upon re-offending of anger management, probation and alcohol and mental health treatment.
3.3 Community services for women who offend

Baroness Jean Corston was commissioned to undertake an examination into women who were vulnerable to offending (Home Office, 2007). In her report, Corston considered the needs of women “inappropriately placed in prison”, i.e. those who did not need to be in prison to protect the public, and “those outside who were at risk of offending”.

Corston noted fundamental differences between men and women who offend, or are at risk of offending. For example women with histories of violence and abuse are over-represented within the CJS and can be described as victims as well as offenders; women commit more acquisitive crime than men but have lower involvement in serious violence, criminal damage and professional crime; relationship problems feature strongly in women’s pathways into crime; coercion by men can form a route into criminal activity for some women; women prisoners are far more likely than men to be primary carers of young children, making the prison experience significantly different for women than men; women tend to be located further from their homes than male prisoners, to the detriment of maintaining family ties, receiving visits and resettlement back into the community; prison is disproportionally harsher for women because prisons and the practices within them have, for the most part, been designed for men; and 30% of women in prison lose their accommodation while in prison. Because of these differences, treating women in the same way as men does not result in equal outcomes, thus a different approach to at risk women is required.

Corston (ibid) made 43 recommendations, of which 40 were accepted by government and a cross-departmental Criminal Justice Women’s Unit was established. Time limited funding was made available to 45 voluntary sector organisations working with women offenders and those at risk of offending. The focus was on diversion from custody, with organisations providing support for those who could have been remanded in custody awaiting trial, as well as supporting community sentences.

Patel and Stanley (2008) undertook a review of the community order and suspended sentence order for women. With regard to use of the MHTR, they identified that only 109 women in England and Wales had received a MHTR throughout the whole of 2006, out of a total of 20,922 Community or Suspended Sentence Orders (0.5%).

The Criminal Justice Joint Inspectorate (CJJI; 2011) published a thematic report into alternatives to custody for women. The review aimed to consider the extent to which non-custodial options were put forward, and taken up, in respect of women offenders.

As part of their review, the CJJI examined the case files of 107 women offenders which confirmed the vulnerabilities identified earlier by Baroness Corston. Fifty four percent were considered to have mental health problems; 51% took illegal drugs; 59% had problems with alcohol; 34% were vulnerable to self-harm; and 24% vulnerable to suicide. Additionally, 73% had been victims of domestic abuse; 18% had been perpetrators of domestic abuse; and 60% had financial problems.
A review of relevant literature for the report highlighted that more women than who are sentenced to immediate custody received sentences of less than 12 months (74% vs. 63%); most women sentenced to immediate custody were serving sentences for non-violent offences; women offenders had highly complex health, substance abuse, relationship and social needs; and over half the women in prison had dependent children. Women make up around 5% of the overall prison population but, because of shorter average sentence lengths than men, constitute 9% of prison receptions. Similarly, a high proportion of women in prison are there having been re-sentenced for a breach of a community order or licence conditions; in 2006, 50% of all new receptions at HMP Holloway were for such breaches (Home Office, 2007).

The CJJI undertook fieldwork for their thematic review in the last quarter of 2010. At that time, they found considerable activity at regional level, following central leads from the Ministry of Justice, with probation trusts working well with partner organisations to develop a strategic framework for women offenders. However, the CJJI noted that a significant culture shift was still needed at practitioner level for women’s issues to be treated differently, with a need to develop more meaningful outcome measures in relation to women’s progress.

The CJJI praised the development of women’s community centres, based on a ‘one stop shop’ model of holistic support and access to a range of services. Such centres were regarded as a valuable ‘safe space’ which, if used effectively, could play an important role in securing women’s engagement to address their offending and promote compliance with community sentences or licence conditions. When sentencers knew about such centres, they found them credible, although links with probation trusts were variable and, therefore, their facilities were not always valued or taken full advantage of by offender managers. Again, the need to develop meaningful outcome data was highlighted, not least with regard to evidence of positive outcomes increasing centres’ prospects of achieving ongoing funding.

With regard to unpaid work and accredited programmes, the CJJI noted a lack of women-specific provision for both but, where women-only groups were run, they were often successful. The lack of a critical mass of numbers in any particular locality for specialist offending behaviour programmes, for example for women sexual offenders or perpetrators of domestic abuse, meant that such courses were generally unavailable. Women’s centres were regarded as an under-used resource for unpaid work opportunities. England has six women-only approved premises and CJJI visits to three of those led to a conclusion that such residential facilities provided a credible and sustainable to custody, with residents benefitting from meaningful relationships with staff which contributed to increased confidence and the making of positive life choices.

The CJJI examined the links that probation trusts have put in place with community partners to address women’s needs, finding that examples of successful partnerships between probation trusts and other agencies were operating to support women in the community. The most successful partnerships were characterised by open communication, shared objectives and a common understanding of the needs of the target group. The most successful women’s centres were noted as being well integrated into their local community with a range
of service providers conveniently providing services to a hard to reach group from one location. However, links with mental health services providers were variable, in spite of the high level of acknowledged need in this group. Some of this inadequate service provision appeared to relate to different definitions of mental health need across different agencies. Thus women offenders or those at risk of offending may be vulnerable due to their mental health status, but not necessarily have problems so severe as to constitute mental illness at a level which would warrant input from statutory services. Urban areas generally fared better with regard to mental health service availability, but often links were reliant on offender managers’ local networks and contacts rather than being embedded at a more strategic level. Services for drug and alcohol issues were thought more satisfactory, but a lack of awareness around the links between alcohol and offending led to more acceptance by offender managers of alcohol use, with interventions viewed as supportive rather than more directly focused on the priority of reducing reoffending.

The CJJI found sentencers generally amenable to non-custodial disposals for low risk women offenders, with the proviso that a failure to comply with community penalties would ultimately lead to a short custodial sentence. Conditional cautioning, which occurs out of court, was also in use with women with low level offences although the CJJI thought that continued use of conditional cautioning was a missed opportunity for the alternative handing of low level offending; such a course of action could both prevent eventual imprisonment and introduce offenders to a women’s centre, giving access to a range of support. Bail decisions generally took into account issues with dependent children, with the Crown Prosecution Service objecting to bail in the cases of serious, or repeat, offenders. Sentencing guidelines are offence, rather than gender specific, but mitigating services, often linked to women’s complex domestic lives, can be taken into account, allowing sentencers to apply different approaches to women’s cases. Pre-sentence reports are important in this area, allowing both risks and needs to be set out to guide decision making around appropriate disposals. Reports examined for the thematic review were found to be variable in terms of quality and the adequacy with which women’s complex needs had been identified.

With regard to management of women’s community orders and licences, the CJJI was concerned that inadequate attention was paid to women’s potential to cause serious harm, with risk management plans poorly integrated with sentence plan objectives. Home visits allowed a woman’s progress in relation to her vulnerabilities to be monitored effectively, but were under-used. Additionally, opportunities to work cohesively and co-operatively with partner agencies were missed, especially with the women’s community centres. Offender management was often process driven, rather than individually tailored. Training initiatives designed to increase offender managers’ awareness of women’s vulnerabilities, complexity and diversity of need, and to encourage more holistic and creative ways of working were welcomed by the CJJI. Effective engagement often began with a period of early ‘stabilisation’ at the start of a community order, with work undertaken to encourage compliance with conditions to avoid early breaching for manageable infractions of conditions. When breaching became a serious option, the CJJI praised offender managers for efficient actions made on the basis of flexible and realistic judgements in most cases. Sentencers regarded custodial sentences as a response to breaches as an action of last resort.
4 The Mental Health Treatment Requirement – Fit for Purpose?

As noted above, evidence around best service and treatment models for the community management of mentally disordered offenders is currently incomplete. Proof of the efficacy of some commonly used offending behaviour programmes is lacking (e.g. Davis et al., 2008); similarly, there is a need to conduct prospective outcome studies to firmly establish the evidence for specific models of service and intervention, for example speciality probation supervision for offenders with mental health problems (Skeem Emke-Francis & Louden, 2006).

As noted above, the prevalence of mental health problems in people in contact with the criminal justice system in the community is higher than in the general population, thus it may perhaps be reasonably expected that, when courts are given a discrete power to mandate people with identified mental health problems to engage with specified aspects of mental health treatment, such an order would be widely used.

In April 2005, the Community Order became the single, generic community sentence available to the magistracy and judiciary as an alternative to imprisonment. The Community Order was designed to bring under one umbrella order what previously would have been different orders, allowing sentences to be tailored to an individual’s needs. The order allowed for the imposition of between one and all of 12 discrete requirements:

1. **Supervision**, by the probation service;
2. **Compulsory unpaid constructive community work**, up to a maximum of 300 hours;
3. Participation in **specified activities** such as improving basic skills (such as literacy) or making reparation to the people affected by the crime;
4. **Prohibition** from undertaking specific activities;
5. Undertaking **accredited programmes**, which aim to change offenders’ behaviour;
6. **Curfew**, where an offender can be ordered to stay at a particular location for certain hours of the day;
7. **Exclusion**, where an offender can be excluded from specified areas;
8. **Residence** requirement, where an offender may be required to live in a specified place, such as an approved hostel;
9. **Attendance centre**. Offenders under the age of 25 may be required to attend a particular centre at a specified time for between 12 and 36 hours, over the course of their sentence;
10. **Drug rehabilitation**, which includes both testing and treatment, and can last for between six months and three years; again this can only be imposed with the consent of the offender;
11. *Alcohol treatment*. The offender must agree to this treatment and it must last for at least six months; and

12. *Mental health treatment* (MHTR), which can only be awarded with the consent of the offender.

A MHTR can last up to three years and currently needs to be conducted under the direction of an appropriate medical practitioner or a chartered psychologist and managed by an offender manager. Treatment can be as an in-patient (not high security), or provided in an out-patient/community setting. For a court to award a MHTR, they currently require evidence from a Section 12 (Mental Health Act 1983) medical practitioner that a person’s mental condition is susceptible to treatment, yet not so severe as to warrant a hospital or guardianship order.² The court needs to be satisfied that the treatment required is available, and that the offender has expressed a willingness to comply.

Whilst, on the face of it, the MHTR would seem to provide a mechanism through which to engage people with mental health problems in contact with the criminal justice system with treatment services in the community, rather than custody, the small number of published examinations to date of the uptake of the MHTR reveals a rather different situation.

Seymour and Rutherford (2008) examined the use of the new Community Order, with specific reference to the uptake of MHTRs. They noted that the vast majority of Community Orders comprised one or two requirements; most commonly supervision (37%) and unpaid work (31%). By contrast, five of the other 12 requirements: MHTRs, residence, attendance, prohibited activity and exclusion made up less than one percent of total use. During 2006, only 725 MHTRs were issued across England and Wales, out of a total of 203,323 requirements across 121,690 Community Orders. This meant that MHTRs comprised only 0.36% of the total number of Community Order conditions.

The authors noted wide regional variation in the use of MHTRs; seven out of 42 probation areas were responsible for 55% of all MHTRs issued in 2006, despite the fact that these areas accounted for only 36% of the total number of all 12 requirements issued nationally. Twenty of the 42 probation areas issued fewer than 10 MHTRs; eight areas less than 5; and two areas used a MHRT only twice. With regards to ethnicity, 28% of MHTRs were issued to non-white ethnic groups; 12% were issued to black or black-British offenders, the group which received the MHTR proportionally more often than any other. Women were as likely as men to receive an MHTR, but more likely to receive drug supervision requirements (*ibid*). Khanom, Samele and Rutherford (2009) updated those figures, noting that only 686 MHTRs commenced in the year to 30 June 2008, out of 221,700 requirements overall; thus MHTRs constituted 0.31% of the total. In the same period 12,347 drug rehabilitation orders and 3,846 alcohol treatment requirements were ordered.

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² Clause 62 of the Legal Aid, Sentencing and Punishment of Offenders Bill which would remove the requirement for a report to be from a S12 approved doctor is currently before Parliament (House of Lords 2nd reading 21.11.11).
In 2008, the National Audit Office published a report into the supervision of Community Orders (NAO, 2008). They saw Community Orders as having joint benefits; firstly, offenders were punished but, secondly, they enabled offenders to stay with their families. A comparison between actual and predicted reconviction rates showed that community sentences could reduce reconvictions proportionally more than custodial sentences.

The report noted that the use of certain Community Order requirements did not correspond with the profile of the underlying drivers of offending behaviour, particularly substance misuse and mental health problems. Comparing figures from an external examination of a sample of OASys scores with national use of Community Order requirement percentages, the report recorded a 45% incidence of alcohol use among offenders, ‘matched’ by 1% of alcohol treatment requirements. Similarly, an incidence of 43% of mental health problems was addressed by less than 1% national use of the MHTR. The best fit was between drug misuse and the drug rehabilitation requirement; an incidence of 23% was matched by 6% of the relevant requirement. Possible explanations for this were given as:

- An offender’s needs may not be the cause of offending behaviour, therefore a sentencer may be unlikely to consider the need to address it as part of the punishment;
- Not all needs require intensive intervention and lower level treatment may be accessible without necessitating a mandated treatment requirement;
- Needs may be already being addressed, either from an earlier sentence or from treatment from another provider; indeed the NAO, in their case file examination, found no instances whereby a MHTR instigated mental treatment where none had previously existed; and/or
- Courts may impose sentences/requirements different to those proposed by an offender manager.

The NAO report also noted that a MHTR was more costly than other awards. Costing work undertaken for the report indicated that work with offenders with mental health problems cost an average of £3,703 in probation staff costs alone, compared to £650 for stand-alone supervision. Drug rehabilitation orders were calculated at £1,920 and alcohol treatment requirements £1,670. An additional issue in the successful delivery of all requirements, but perhaps most marked in the use of MHTRs, is the need to develop good relationships between offender manager and client and between offender manager, other agencies and client. In 32% of the 302 case files the NAO reviewed for their report, the offender manager changed during the course of the order, offering a challenge to success.

The NAO report addressed the issue of the capacity of probation trusts to undertake supervision of Community Orders. High caseloads were associated with negative impacts upon the motivation of probation staff, possibly undermining the quality of supervision. In the five probation areas examined for the report, the mean caseload, per offender manager, was 44 less complex cases and 34 more complex cases.
Seymour and Rutherford (op.cit.) outlined a number of difficulties in issuing MHTRs which may explain their limited take-up by sentencers. The problems were identified from an assessment of available data and were noted as informing the design and development of new empirical research by the then Sainsbury Centre for Mental Health, latterly the Centre for Mental Health.

Firstly, legislative obstacles were acknowledged, including the Criminal Justice Act’s (2003) definition of mental disorder for the purposes of a MHTR whereby a disorder was to be not so great as to require detention under mental health legislation, yet severe enough as to require and ‘be susceptible’ to treatment. Seymour and Rutherford point out that previous research into people in contact with a criminal justice mental health team found that, in practice, most had previous contact with mental health services, but had been assessed as having either a minor or an untreatable problem, thus not fitting the current criteria for a MHTR.

Secondly, they note that the requirement for suitable treatment to be available is problematic, as lack of access to services for offenders with mental health problems is a known difficulty, with perceived or lived stigma adversely affecting engagement. Thirdly, problems around obtaining a mental health assessment from a named consultant are acknowledged. Many people in contact with the criminal justice system do not have their mental health problems adequately identified in a timely manner (e.g. Shaw et al., 2009; McKinnon & Grubin, 2010) thus, if an assessment is not arranged and conducted, a MHTR cannot be issued. Even if an assessment is arranged, it may not be possible to access services unless the assessor has connections with local service providers.

A fourth difficulty surrounds the complexity of issues presented by many offenders who commonly have mental health problems with accompanying substance misuse issues. This can introduce a circularity which ultimately may lead to a person’s mental health and/or substance misuse needs not being addressed adequately or appropriately. Seymour and Rutherford reference the voluntary sector service provider, Turning Point, who note

“…support is not offered for mental health needs until after drug treatment has ended or may not be offered in cases in which mental health needs are only identified once treatment has started. Some areas don’t take people with mental illness because these clients are assessed as not being able to cope with the available treatment.”

In 2009, Khanom, Samele and Rutherford (op.cit.) reported on the follow-on research from Seymour and Rutherford’s preliminary paper, making recommendations designed to increase the use of the MHTR, where appropriate. Their research aimed to identify how an offender is issued with a MHTR, the decision making behind sentencing and how MHTRs work in practice, describing the key professionals and agencies involved and the processes and procedures by which it is carried out. Interviews were carried out with 56 criminal justice and health statutory and third sector professionals involved in MHTRs across nine London boroughs.
A number of key themes emerged. Many professionals interviewed had a “striking lack of awareness of the MHTR”, with few having direct experience of its implementation. A number of magistrates interviewed felt that the mental health training they had received was minimal. Some court staff felt a MHTR was of no use when someone was already known to mental health services, feeling it would be a duplication of effort; in contrast, others acknowledged that a MHTR could be a useful tool to re-engage someone who had lost contact with services. Those working in courts which had liaison and diversion schemes felt less inclined to use MHTRs as a tool for engagement, identifying that as a role of the diversion team. Interviewees were mixed in their views of the usefulness of MHTRs, stating that they were rarely informed of the outcomes of cases after court appearances, so they were unclear about ‘what works’. Some staff expressed a lack of clarity about who would be considered the ‘right person’ for a successful MHTR.

Professionals expressed uncertainty around the types and degrees of mental health problems which could be dealt with using a MHTR. Whilst the relevant legislation delineates an upper limit of applicability, i.e. those who warrant detention under the Mental Health Act, no lower limit of severity is detailed, other than a person’s condition must be ‘susceptible to treatment’. Some felt that, if a person’s problems were severe, the demands of compliance to an MHTR would be too great, all but guaranteeing failure. All psychiatrists interviewed (n=3) stated that a MHTR was only suitable for those with severe and enduring mental illness, for example schizophrenia and bipolar disorder. They stated that they would not recommend it for those with mild to moderate problems such as depression and anxiety who they felt would be better supported in primary care. Many sentencers felt that a diagnosis of personality disorder was not suitable for the application of a MHTR, as such conditions were considered untreatable. Commonly, it was regarded that probation staff would be most likely to raise the issues of someone’s mental health issues and that sentencers would rarely consider mental health issues of their own accord.

In accord with Seymour and Rutherford (op.cit.), Khanom et al. explored the difficulties around obtaining a formal psychiatric report to support the recommendation of a MHTR. Lengthy delays in obtaining reports could lead to delays in sentencing. Delays were cited as related to finding a psychiatrist suitable and willing to provide a report, meeting the associated costs, with additional difficulties if the person did not residing in the area served by the court where the offence was committed. Probation staff interviewed were especially critical of defence solicitors involving “random psychiatrists who make a diagnosis but cannot offer treatment because they are acting in a private capacity”, thus failing to fulfil the required criterion regarding availability of treatment. The quality of reports was also criticised, with many incomplete or inappropriate in terms of fulfilling the criteria for MHTRs; however, psychiatrists interviewed defended their own and their colleagues’ practices, noting that requests for reports were often vague, with no mention of its particular purpose in terms of decision making around MHTRs.

Once a MHTR has been instituted, professionals’ biggest concerns, other than probation staff, were around why, when and how to breach clients who failed to comply. Generally, professionals agreed that failure to attend appointments would constitute a breach but there was no agreement around whether non-compliance in
a legal sense extended to concordance with medication. Some probation staff felt that increased risk could be a justification for breaching someone if they failed to take medication whereas others argued that non-compliance related to missed appointments without good reason, but not missing medication. Poor communication between the health provider and probation staff was cited as a reason of uncertainty around a person’s level of compliance where a lack of detailed care/treatment feedback affected a probation officer’s ability to breach a client for non-compliance or indeed encourage them for positive engagement.

What to do with a person if they did return to court having breached their order was an issue of concern to many staff, especially court staff and sentencers. Legislatively, in the case of a breach, a court is required to make a community order more onerous or impose a custodial sentence. Where this may be a straightforward response to breaches of other community order requirements, i.e. the failure to complete unpaid work, for mental health requirements, the response was thought to be much more complex. Professionals described a clear ‘Catch-22’ situation whereby they initiate a MHTR because someone is ill and, by doing so, they avoid sending an unwell person to prison. If the person is then unable to comply with the requirement because of their illness, they are breached and courts are faced with doing the very thing they wished to avoid in the first place.

Khanom et al. made a number of recommendations from their work. They recommended that central government and the National Offender Management Service (NOMS) needed to provide practical guidance for professionals on how to construct and manage MHTRs; primary care trusts should engage with criminal justice agencies and commission services enabling courts to issue MHTRs; court staff, including sentencers and solicitors, should be trained in mental health awareness and sentencing options; local protocols between courts, probation and health services should be developed to enable the appropriate use of MHTRs; requests for psychiatric reports should be clear in stating their purpose and the information required to inform decision making; liaison and diversion schemes should be involved in MHTRs; NOMS should clarify circumstances which constitute a breach of a MHTR and advise agencies how they should respond; use of MHTRs should be consistent nationally and outcomes measured; and an extensive survey of psychiatric morbidity among offenders serving sentences in the community should be commissioned by Government to identify what proportion of people on community sentences have what kind of mental health problems to inform the development of services based on actual need.

Mair and Mills (2009) examined the first three years of the generic Community Order sentencing option, noting that six of the 12 possible requirements were rarely used: mental health treatment, alcohol treatment, residence, exclusion, prohibited activities and attendance centre. They suggested a number of possible reasons for this lack of use, including a lack of availability of resources; a lack of knowledge on the part of sentencers; lack of knowledge on the part of probation staff; failures by probation staff to keep sentencers aware of what is available; a desire by probation staff to work within their ‘comfort zone’; a failure to think creatively and innovatively on the part of sentencers and/or probation staff; probation staff not being able to make full offender assessments prior to sentence due to heavy workloads; confusion as a result of potential duplication (e.g.
exclusion and prohibited activity); uncertainty about how some requirements are monitored; influence of local probation policy decisions; and/or a lack of resourcing leading to waiting lists that discourage use of some requirements. To inform their work, the authors interviewed a number of probation officers about their experiences of the Community Order.

In relation to the limited use of the MHTR, one probation officer commented that

"a significant issue for the criminal justice system [is] that the threshold for mental health services is too high in my view ... At the assessment stage, if mental health services are saying no, then there’s no service to provide, so you can’t use the requirement anyway. And I think many of the offenders would consent to treatment ... but they’re just not being offered the service, it’s as simple as that really. And I think, you know, it’s the most significant issue facing the criminal justice system.”

A second officer noted

“I don’t believe we can go down a mental health requirement at the moment. From my understanding, it’s very difficult, because although it’s available it’s almost impossible to propose because you need a named psychiatrist; we’d monitor the order, we’d breach it and all that kind of stuff, but you’d need a named psychiatrist and that’s almost impossible to get. It’s much easier to sentence under the Mental Health Act and stuff like that.”

Other probation officers considered that mental health workers were ‘not interested’ and ‘reluctant to have anybody tied up to an order’.

Bradley (2009) spoke to service users about community sentencing as part of his review of people with mental illness and learning disabilities in the CJS. He noted that they supported the concept of community sentencing, but recognised issues around the overriding concern to manage any potential risks to individuals and society; inconsistency in approach to community sentencing across the country; the need for better engagement between service users, carers and professionals to ensure best treatment options are available; an unwillingness for defence lawyers to recommend Community Orders to their clients if the length of such an order would exceed a likely custodial sentence; and a need for sentencers to better understand the options available. A cost-benefit analysis conducted for the Bradley review estimated that as many as 2,000 prison places per year could be saved in relation to a change in sentencing practices for people with mental health problems receiving short custodial sentences. This could possibly create net savings of £40 million per year (ibid). Bradley recommended that

- The DH and HM Courts Service should commission further research into the use of MHTRs;
- A service level agreement should be developed between HM Courts and Probation Services and the NHS to ensure the availability of the necessary mental health provisions for Community Orders; and
- The DH and HM Courts Service should issue clear guidance for sentencers and probation staff regarding the use of MHTRs.
Gillham, Manjunath, Napper, Samele and Taylor (2011) presented preliminary findings of their ongoing research into formal inter-agency working with mentally disordered offenders through the use of the MHTR at the International Association of Forensic Mental Health Services conference, 2011 (personal correspondence). The team conducted 99 separate interviews; 46 with offender managers, 28 with offender-patients subject to a MHTR; and 25 with clinicians.

Offender manager concerns centred around issues related to managing a client’s potential instability (particularly related to increased risks associated with substance misuse) and an acknowledgement of a ‘culture clash’ between health and criminal justice agencies whereby probation supervision was ‘all about rules’ compared to the more voluntary/choice oriented ethos of engagement with mental health services. Participants expressed that this could be addressed by regular mental health/probation service contact and communication. Positive points of MHTRs were noted as it involving active processes with clients, enhancing their understanding of their mental health needs; the opportunity to address wider deficits, for example parenting or relationship skills; and a sense of flexibility and partnership in the interactions between all involved. Importantly, in the current climate of cuts to public services, offender managers noted that, if a MHTR was awarded, that meant that suitable mental health resources had been identified and allocated, thus the problems around trying to independently plug a service user into community services were avoided.

Similarly, clinicians commented that MHTRs could have the positive effect of ‘including the excluded’ in mental healthcare, as services were mandated to provide treatment to those who may otherwise ‘fall through the net’. The MHTR also gave clinicians an enforcement tool, a little ‘extra weight’ to keep clients engaged. The resultant inter-agency working was noted as a positive for this potentially complex client group; however the setting up of open communication required effort on all sides with the client regularly acting as the conduit through which information between probation and mental health services was passed on, often in an ad-hoc manner.

Negatives were noted as a current lack of knowledge about the requirement, due to its limited take-up and problems around the actual mechanics of setting up and running the MHTR. And, just as the element of enforcement was seen by some clinicians as a positive, others regarded it as a negative consequence of a MHTR, standing in the way of an open therapeutic relationship. Clinicians acknowledged the limits to any useful intervention on their part with certain clients, for example those without clear disorders, or those clients whose behaviour is largely impulsive and negatively affected by substance misuse. Additionally, there are no statutory or automatic review periods for MHTRs; however offender managers can suggest the conduct of a review to sentencers.

Service users interviewed expressed some concerns and uncertainties around their MHTR; they noted that it was often unclear what the order meant, and what people’s expectations of them were. This was experienced as stressful, hard to manage and sometimes stigmatising. However, they also expressed the view that the MHTR could act as a framework through which they could achieve stability over aspects of their life which had previously been unstable, for example limited contact with services, unstable accommodation and finances etc. The MHTR was
seen as introducing active processes into their supervision by their offender manager, turning it into a broader relationship, rather than just a straight forward supervisory process. For it to be most successful, the researchers found that service user consent had to be real, rather than people feeling ‘badgered into’ consenting as the ‘least worst’ available option, given their situation.

Overall, the study concluded that the MHTR did have value, but needed modification to maximise its potential for positive outcomes. They recommended guidance for health service commissioners to increase their understanding of health services’ role in the process, to lead to adequate resource allocation and appropriate systems, infrastructure and service level agreements. Importantly, an increase in the number of MHTRs will, in no small way, be dependent on mainstream, not just forensic or offender, mental health services increasing their willingness and capacity to engage with the process. Widespread training among key players, from court staff, to sentencers, through to offender managers and clinicians, is needed to ensure people understand what it is and what it can achieve. Success will be largely predicated on close and functional relationships between offender managers and health staff.
Findings from OHRN fieldwork and alternatives to custody questionnaire

Our fieldwork in this area covered three main topic areas:

1. The types of statutory and third sector health and social care services currently available services for people with mental health problems in contact with the CJS;

2. Changes to these services required to facilitate an increase in community disposals in lieu of short custodial sentences for this client group - a professional ‘wish-list’; and

3. Respondents’ experience of MHTRs in terms of examples of good practice and an examination of barriers and facilitators to implementation.

5.1 Question 1: Statutory and third sector health and social care services currently available services for people with mental health problems in contact with the CJS

Data for this question were gathered from the site visits to liaison and diversion pathfinder schemes, the follow-up questionnaire and additional phone interviews with other professionals identified through the initial data collection. The results therefore come from a combination of differently formatted responses thus are discussed as a whole without the imposition of any formal quantitative analysis which would inevitably be incomplete and therefore potentially misleading.

There was marked homogeneity with regard to referral patterns to statutory services. Most commonly respondents said they referred clients to: community drug and alcohol services; community mental health teams; open, low and medium secure in-patient settings; dual diagnosis services; GP services; crisis teams; assertive outreach services; and prison in-reach and primary healthcare teams.

Less frequently mentioned services included: specialist in-patient settings e.g. learning disability, acquired brain injury; forensic psychiatry services; Improving Access to Psychological Therapies (IAPT); community learning disability services; early intervention teams; child and adolescent mental health services; and complex care treatment teams.

The questionnaire prompted respondents to name services that they found particularly helpful with their client group. Contact details for such services are noted in Appendix 2. It was outwith the resources available for this report to contact these services individually to discuss their work and identify any apparent examples of good practice; rather, their contact details are included to allow
professionals to contact the provider to compare practices, share ways of working etc.

We asked respondents to discuss their contact with third sector services and their role in supporting the needs of their CJS clients. Services which were most valued were those providing ‘hands-on’ support to clients. Commonly mentioned were third sector substance misuse services; housing agencies and supported housing schemes; welfare rights services; and counselling services.

Contact details for a range of third sector services which respondents thought to be particularly useful are included in Appendix 3.

We also asked respondents to provide details of any community statutory or third sector services in their area which provided input specifically for women (Appendix 4) or people from black and minority ethnic groups (Appendix 5).

In work that we are undertaking separate to this report, we obtained a directory of statutory and third sector health and social care services which had been compiled by a service user group in Preston, Lancashire. No similar volumes were submitted to this review.

Interestingly, that one directory alone gave details for a greater number and wider range of services than we gathered from our entire questionnaire returns nationally. This logically indicates that it would be a point of good practice for all liaison and diversion services to compile and keep up to date such a directory, to help them make the best and most creative use of what is available in their local area. The process of compiling the directory could be used as an opportunity to make contact with each service to discuss their work and agree referral parameters and reasonable service expectations for clients identified via the CJS.

5.2 Question 2: Changes to community services required to facilitate an increase in community disposals in lieu of short custodial sentences for this client group— a professional ‘wish-list’.

For this question, we asked respondents to think about service users who currently received short term custodial sentences but potentially could be alternatively managed in the community, considering what changes to current provision, in terms of service type or volume/availability would be required to meet the increased demand.

A number of respondents noted that the range of services currently available to them was generally adequate and suitable, but that service capacity was definitely an issue, thus any policy directive reducing the use of short term custodial sentencing would put more strain on a system already facing demands beyond the limit of available resources. Access to all types of mental health service was commonly regarded as too slow, with clients losing the momentum to engage in the gap between being seen in the CJS and then receiving an appointment for mainstream services. Increased capacity for nurse prescribing was mentioned as a
possible mechanism to increase flexibility of service response to people’s changing needs, reducing delays in treatment.

A need for improved out of hours cover and drop-in services by both mainstream and criminal justice mental health teams was identified. Greater capacity overall was felt to contribute positively to the ability to supervise people with mental health problems more closely and proactively than is often possible at present; this was felt to be particularly important in promoting public confidence in the community management of offenders with mental health problems. Allied to this was the ability for services to offer intervention early in the offending cycle, thus reducing the likelihood of sustained criminal behaviour was mentioned by a number of interviewees.

The concept of ‘one stop shop’ services was mentioned by a number of respondents, acknowledging the multi-layered nature of offenders’ health and social care needs. Such services were noted as having advantages for clients because of the convenience of access to a number of services in one place, thus likely promoting concordance and stability. Such services were also useful for promoting inter-agency working, due to the increased opportunities for, and convenience of, joint working and information sharing. The most commonly held view was that such services should be focussed on ‘revolving door’ clients with low level mental health needs, accompanied by complicating factors such as substance misuse, personality disorder and/or chaotic lifestyles. The ‘one stop shop’ suggestion overlapped with the desire for services to develop more formal integrated offender management units and ways of working.

Increased primary care provision was mentioned by a number of respondents, in terms of increased access to short term interventions, e.g. IAPT and cognitive behaviour therapy interventions. Personality disorder services, especially at primary care level were mentioned by several interviewees as currently inadequately resourced.

A common theme running through people’s responses to this topic area was the need for guidance for practitioners – from national government departments, from commissioners and from regional and local strategic managers. Additionally, the need for sustained training for CJS staff to encourage them to maintain a psychologically informed approach to all aspects of their work to increase both the identification of people with mental health problems and to understand how such problems impact upon their behaviours around concordance with treatment and compliance with criminal justice sanctions was universally acknowledged.

A number of respondents noted a need for increased accommodation provision, both in terms of spaces in approved premises but also more general housing availability through councils, private landlords and/or housing associations. Similarly, a need was identified for increased opportunities to refer clients for structured vocational activities to contribute to structure in their lives, reducing chaos and opportunities for offending.

As mentioned by a number of other reviews in this area (e.g. Bradley, 2009), the current and future development of targeted and cost effective service provision for offenders in the community would be greatly enhanced by the conduct of a national, comprehensive mental health prevalence and needs survey.
5.3 Question 3: Mental Health Treatment Requirements: examples of good practice and an examination of barriers and facilitators to implementation.

Our fieldwork interviews and questionnaire responses confirmed the findings of the two main reviews into the use of the MHTR discussed earlier in this report (Seymour & Rutherford, 2008; Khanom, Samele & Rutherford, 2009).

A number of respondents discussed the fact that, at present, a MHTR needed to be administered under the supervision of a named psychiatrist or a psychologist. They noted that this was not reflective of how community mental health teams (CMHTs) operate generally, whereby a CMHT client may never routinely have contact with either type of professional. A change to include the wider range of professionals, for example the nurses and social workers which make up the bulk of the CMHT workforce would make a team’s response to MHTRs more manageable and flexible. Maintaining the need for the requirement to be overseen by a psychiatrist or psychologist may contribute to delays which courts may well not be prepared to tolerate, thus lessening their appetite to consider a MHTR for the individual in question, and potential future cases.

A liaison and diversion team based in London noted that CMHTs would need to adapt their current referral procedures to incorporate timely responses to MHTR referrals to ensure that there was a recognised pathway for them to be accepted and processed through current CMHT Single Point of Access (SPA) procedures.

One interviewee, with practical experience of the set-up and management of MHTRs, iterated all the barriers to implementing good practice identified in the earlier reviews. Firstly, the issue of trying to identify an appropriate consultant in an offender’s health service catchment area, based on his experience of such professionals frequently refusing to become involved in the process of setting up a MHTR. This was attributed to a number of factors including professionals’ lack of knowledge of the MHTR and what it would involve; the oversight of MHTRs being viewed as more of a burden than any benefits it could bring; concerns about the levels of responsibility involved; a philosophical/professional preference to engage with a patient in a therapeutic, rather than ‘coercive’ manner, a concern experienced by the interviewee as being most acute in professionals with limited/no forensic mental health service experience; and a professional unwillingness to be ‘dictated to’ by others (sentencers, offender managers) for aspects of a patient’s behaviour that were outside of the professional’s reasonable sphere of influence. Our respondent noted that many of these objections arose quite simply from a lack of education and training in the application of MHTRs commenting that, from his experience, other mental health professionals would find that MHTRs were “very facilitative, if they did but know it”.

A second barrier noted concerned a lack of clear direction or parameters as to what constituted ‘mental health treatment’ under the terms of a MHTR, given the likely complexity of offenders’ health and social care needs. Mental health treatment overlaps with other requirements, most obviously interventions for substance misuse. This, in practice, leads to the need to work effectively in multi-agency
partnerships to prevent either repetition of effort or problems remaining unaddressed as they fall between the gaps between services.

Thirdly, issues around the provision of the report to sentencers examining whether a MHTR was appropriate were identified. As mentioned elsewhere, there is little point in a report being done by someone other than the person who is to become the responsible clinician as a criterion for the issuing of a MHTR is that treatment is both required and available; thus, if the report is written by someone who does not have the resources to provide a service, for example an independent psychiatrist engaged by a defence solicitor, that is, in itself, insufficient for the court to include a MHTR as part of a Community Order. The cost of reports was mentioned as an additional factor; requesting psychiatric reports for court is an expensive business.

Fourthly, the actual mechanics of local multi-disciplinary working need to be robust to allow a MHTR to be delivered and supervised appropriately. The provision of effective treatment outwith a custodial or in-patient setting for people with complex and inter-connected health and social care needs, mandated by court, requires a structure which is not necessarily automatically in place when a MHTR is under consideration. Liaison and diversion teams have close links with the workings of courts, but generally seem to operate very separately from mainstream mental health services; more could be done to ensure diversion teams are best placed to ‘bridge the gap’ through initial caseload management and then onward referral to mainstreams CMHTs when both client, and the management of the MHRT, are stabilised.

One team said they had undertaken a service audit of their practices around the management of MHTRs which had identified a need for clear guidance for both probation and health staff and improved communication pathways. Other recommendations for good practice from their local audit included routinely recording details of MHTRs in Care Programme Approach (CPA) documentation; regular reviews and updates to CPA files; invitations to CPA meetings to be sent to offender managers and attendance encouraged; documented evidence of regular contact between probation and mental health services; consent around information sharing; and routine joint visits/meetings, including home visits.

Another professional, managing a liaison and diversion team in the South East, commented that it could be hard to reach consensus of opinion between courts and mental health services about which service users would be appropriate for MHTRs. He noted that some professionals viewed offender-patients as problematic, feeling that a MHTR would ‘saddle’ them with a challenging client. Again, the current requirement for a named responsible psychiatrist or psychologist was noted as difficult in terms of likely availability of a willing clinician with capacity. He agreed that other clinicians could manage MHTRs perfectly adequate, if legislation allowed, although acknowledged that sentencers would require further education as to how such an arrangement could work safely.

A clinician based in a London magistrate’s mental health court scheme noted that the sentencers she worked with them had an appetite to use the MHTR more frequently, but a major stumbling block was the ability to identify a CMHT willing to take on a new client with a MHTR. Those in established contact with a CMHT fared a better chance of a MHTR; therefore in practice, MHTRs were not being used as a
mechanism to put people into contact with services who otherwise would not be treated.

One respondent suggested a working model whereby, if courts started to award an increased number of MHTRs, the management of these would be incorporated into the mental health clinics which were already operational based at probation trust offices. This was noted as potentially simplifying the process of inter-agency working, promoting concordance with the order as a client could be seen by both probation and mental health staff at the same location, at the same time. Thus, the management of their Community Order requirements would be streamlined and professionals, and clients, would have regular, shared, face-to-face conversations about progress.

A senior probation officer with specific interest and experience working with, and developing policy for, mentally disordered offenders, noted that changes to probation officer training over a number of years, away from the traditional social worker role to one of offender manager had left many probation officers deskilled and “scared of mental health” issues. He commented that probation staff had forgotten how to liaise with other organisations, saying that probation services “went a bit control and command for a while”, during which time probation officers “lost their ability to leave the office”. He also noted that the unqualified grade of staff, Probation Service Officers, who worked with lower risk offenders, were similarly not confident and felt unskilled working with mental health issues.

The same respondent went on to note that MHTRs were not the only tool available to sentencers and probation staff when working with offenders with mental health problems; another of the 12 possible Community Order requirements, specified activity, could also be used to ensure offenders accessed brief interventions for mental health problems, particularly at primary care level. Examples given included completion of IAPT interventions and/or completion of the computer based Beating the Blues cognitive behavioural programme for the treatment of depression (www.beatingtheblues.co.uk). He noted that such work was now underway in at least two London Boroughs. Similarly, in one London probation area, a holistic offender health clinic was being piloted whereby offender-patients were helped to register with local primary care services, access dental care and could be assessed on-site by a dedicated mental health clinician.

Several staff we interviewed noted that MHTRs were hampered by the high thresholds of illness/need operated by many CMHTs; whilst offenders’ health needs were often complex, their mental health issues were often at primary, rather than secondary, care level, automatically excluding them from specialist teams. Professionals described daily frustrations attempting to get CMHTs to accept referrals from liaison and diversion services and noted that this was further compounded when teams saw an MHTR as an additional responsibility/burden to manage.

Respondents to the questionnaire were asked what actions could potentially increase the uptake of MHTRs; comments overwhelmingly referred to the need for the issuing of national practice guidance; more awareness training for sentencers; mental health awareness training for probation staff; and closer inter-disciplinary practices around the management of offenders’ needs.
6 Discussion

The fieldwork we conducted for this report confirmed the findings of much of the review literature currently available. We engaged with dedicated and enthusiastic staff who offered meaningful insights into the structural, practical and ethical issues which impact upon their working lives on a daily basis.

Managing people with mental health problems who are in contact with the criminal justice system is a time and resource consuming activity. At its most challenging, services are hampered by working in isolation, interacting with criminal justice staff who are poorly informed about the needs of mentally disordered offenders, and only able to offer or access limited therapeutic services not fully fit for purpose as alternatives to more punitive sentencing options.

At its most effective, mental health and criminal justice staff, especially offender managers and sentencers, offer an integrated response to clients’ multi-faceted needs, offering flexibility of approach, informed by shared goals of improving outcomes for individuals and society. All the staff and teams we engaged with were clear about the value of multi-disciplinary working and evidenced the fact that they engaged positively and proactively with both third sector and statutory health and social care services in their area.

The Mental Health Treatment Requirement of the Community Order has not, to date, been wholly adopted as a viable mechanism through which to manage mentally disordered offenders in the community. Its shortcomings have been detailed in two review and preliminary research documents (Solomon & Rutherford, 2007; Khanom, Samele & Rutherford, 2009) and the issues identified by the authors of those reports were confirmed as still current by the fieldwork for this report.

Despite this, we feel it is too early to abandon the MHTR as unworkable; rather it is time to proactively manage the process from early identification of potential suitable recipients through to successful completion of mandated engagement with mental health treatment services.

Liaison and diversion staff, and other interviewees, noted that sentencers only infrequently consider the use of MHTRs. It was also noted that most requests for assessments for MHTRs came from probation officers. To us, this situation where access to mental health services seems to be largely dependent on the actions of non-clinicians (sentencers and offender managers) seems counter-intuitive. Primarily, it is too dependent on individual levels of training and/or comfort in working with mental health issues in groups of staff for who such matters are not necessarily their core concern.

We believe that liaison and diversion schemes should specifically and proactively identify suitable clients for MHTRs when they conduct their first assessment and then pass that information to the court, rather than assume the more passive role of waiting for the possibility to be raised elsewhere. Locally agreed protocols should be in place across all concerned agencies which detail an acceptable timetable from identification of a person potentially suitable for a MHTR, through to formal
assessment and application of the requirement as part of a Community Order. Such protocols should clearly establish the types and degrees of mental health problems which should be considered in relation to MHTRs, ensuring that these include, rather than exclude, the types and severity of needs that clients routinely present with. Expected care pathways to ensure engagement with services should be clear, practical and possible. Mandated review periods should be instigated, with reports of progress proactively made available to sentencers.

Critically, the current Catch-22 situation whereby sentencers are unlikely to award a MHTR to people already in contact with mental health services for fear of duplication of effort yet rarely use the requirement as a way of starting engagement with services in those with no current contact needs to be urgently resolved. Proactive case-seeking at first screening/assessment by liaison and diversion schemes should address this matter as a priority issue. To both reduce delays and to more accurately reflect the type of client who could potentially receive an MHTR, we believe that the relaxation of the requirement for a report from a Section 12 approved doctor and clinical oversight by a psychiatrist or psychologist will make the order more ‘user-friendly’ and more aligned to the delivery model of the majority of community mental health teams.

In our previous report (OHRN, 2011) we suggested that liaison and diversion schemes should carry caseloads. We repeat that recommendation here, with the expectation that a proportion of MHTRs will be managed within these caseloads, at least initially, followed by hand-over of care to mainstream services when both the client and the supervision of the MHTR have stabilised.

Where clients have mental health needs which require primary, rather than secondary, care input, this could be offered on a short term basis as part of the liaison and diversion team caseload. This would avoid a commonly reported time-consuming problem, that of trying to get CMHTs to accept those clients with lower level mental health needs. The retention of primary care clients on caseloads could also be used to explore the use of the specified activity requirement available as part of a Community Order to ensure completion of short-term evidence-based treatment interventions, for example IAPT or self-guided care.

To be successful, MHTRs require pro-active supervisory relationships and it is suggested here that this could be achieved through an increase in “one stop shop” service models. Earlier in this report, we described research which indicated early promise in the operation of speciality probation provision which hypothesised the potential benefits of smaller caseloads of clients with mental health problems being managed by better trained staff, offering consistency of approach through open, but firm, staff-client relationships. This could be achieved through the direct secondment of an offender manager to the liaison and diversion team’s MHTR case identification and management work commitment, as described above.

Alternatively, mental health staff could incorporate active engagement with MHTR management and treatment provision through the mental health clinic arrangements which currently exist nationally, based in probation trust premises. This type of service co-location and integration should serve to increase both the quantity and quality of inter-agency communication, improving engagement with, and from, the client, reducing uncertainty around what a person’s MHTR requires of
them. This moves the client-professional staff relationship to a higher level than merely supervision for criminal justice purposes and should better inform and manage the processes around non-compliance, with the intention of reducing the likelihood and/or need for formal breach procedures.

To achieve positive change to current services, we offer the following recommendations.
7 Recommendations

Re: Mental Health Treatment Requirements

1. A national study examining the mental health prevalence and associated health and social care needs of offenders managed in the community should be commissioned by Government to inform the development of future services for this group;

2. The Department of Health and Ministry of Justice should produce national guidelines regarding the use of the MHTR for sentencers, criminal justice clinicians and probation services;

3. Mental health awareness training should be mandatory for offender managers and sentencers;

4. NHS service providers and commissioners should embed resources for the assessment, management and reporting of MHTRs within both liaison and diversion and community mental health services at primary and secondary care levels;

5. Liaison and diversion teams should, as part of their initial screening and assessment of clients in police custody or magistrates’ courts routinely and specifically assess an individual’s suitability for an MHTR as part of any likely Community Order, with protocols in place to inform sentencers of the outcome of that specific assessment;

6. Such assessments must be informed by locally agreed cross-agency protocols around who is suitable for a MHTR (in terms of type/severity of mental disorder);

7. The requirement for an initial assessment report to be conducted by a section 12 approved doctor should be removed;

8. The requirement for a MHTR to be overseen by a psychiatrist or a psychologist should be removed in favour of enfranchising a wider group of mental health professionals;

9. Local protocols should detail expected timescales between identification of potential MHTR recipients, formal assessment and award of the Requirement to prevent delays in treatment and/or timely conclusion of criminal justice procedures;

10. MHTRs should be pro-actively managed through multi-agency working arrangements, as part of a “one stop shop” model or other co-located service initiatives e.g. probation-based mental health clinics or offender managers seconded to liaison and diversion team caseload management duties;

11. All MHTRs should have mandated review periods, with protocols to ensure sentencers are informed of progress and outcomes.
Re: Alternatives to custody

1. Local service commissioners should work with practitioners to identify unmet needs and manage gaps through the commissioning of new services or the re-negotiation of current services to ensure that provision reflects need as accurately as possible;

2. All liaison and diversion and criminal justice mental health services should maintain an up to date directory of community statutory and third sector services in their area; and

3. Liaison and diversion services and criminal justice mental health teams should proactively liaise with community providers to forge positive working relationships and formal protocols for onward referral of their clients to other providers.
8 References


9 Appendices

9.1 Appendix 1: Questionnaire

Scheme Name:

Contact details of person filling out the questionnaire

Name: 
Mailing Address: 
Work Phone: 
Mobile Phone: 
Fax: 
Email: 

1. What statutory health and social services do you frequently refer people to? (e.g. Substance misuse, Learning Disabilities, types of mental health service, other)

please list the type of service and give a little detail about what particular services they offer your clients

2. Of the statutory health and social services available in your area, which do you believe to be innovative and/or particularly useful and why?

give a brief description of why you think a service is useful and where possible, please provide contact details for a named person at each service
3. What third sector voluntary services do you frequently refer people to and give a little detail as to what they can offer your clients. (e.g. help with housing, benefits, any specialist support services, community based health services)

*please list the type of service and give a little detail about what particular services they offer your clients*


4. Of the third sector voluntary available in your area, which do you believe to be innovative and/or particularly useful and why;

*give a brief description of why you think a service is useful and where possible, please provide contact details for a named person at each service*


5. Do you have access to any services specifically for women in your area? If yes, what do they offer your clients?

*Please describe the services and provide contact details.*


6. Do you have access to any services specifically for Black and Ethnic Minorities in your area? If yes, what can they offer your clients?

*Please describe the services and provide contact details.*
7. Is your team involved in the assessment for/management of mental health treatment requirements?

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7.2 If no, please detail any issues that contribute to this.

8. Are mental health treatment requirements regularly used in your courts?

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8.2 If no, why not?

9. What do you think could be done to improve the uptake of usability of mental health treatment requirements?

10. If more people were to be awarded community sanctions rather than short periods of imprisonment, what additional community services (in terms of new services, or increased capacity of existing services) do you think would be required?

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If you have any questions or concerns please contact Heather Noga, Offender Health Research Network, University of Manchester. Email: [heather.noga@manchester.ac.uk](mailto:heather.noga@manchester.ac.uk)
Appendix 2: Examples of useful statutory services

- Mersey Care NHS Trust Asperger’s Team offer formal assessment, support, treatment and guidance for service users and carers (0151 737 4805);
- Mersey Care NHS Trust Forensic Personality Disorder and Assessment Team assesses for the presence of personality disorder and offers treatment/intervention (0151 431 5112);
- RESETTLE is a Liverpool-based community risk assessment and case management service for released high risk offenders (0151 494 4390);
- The Joint Homelessness Team, Westminster, London, offer regular surgeries in day centres and will see people released on bail requiring follow-up (020 7534 6711);
- The Early Intervention Team (EQUIP; East London NHS Foundation Trust) offer assessments and support for clients and undertakes court-requested psychiatric reports and assessments for MHTRs, for young people (14-35) experiencing psychosis (020 8525 1115);
- Reading Crisis/Home Treatment Team offers a 12 hour/day multi-disciplinary service for assessment, crisis intervention/support over the phone, home visits and medication reviews. Their extended working hours allows service users to be referred after a charging/bail decision has been made and someone has been released from police/court custody (0118 960 5000);
- South West Yorkshire NHS Trust Early Intervention Team provides bio-psychosocial care for individuals age 14-35 experiencing first onset psychosis. The team has close links with youth offending services, criminal justice agencies and prisons/YOIs. Focus is placed on maintaining social networks, employment and education to maximise a person’s potential (01924 516162).
- Blackpool Crisis Resolution Home Treatment team acts as a gate-keeping service to in-patient care, attending custody settings and contributing to information gathering out of hours (01253 306280);
- Lancashire Care NHS Trust Early Intervention Service undertake thorough assessments of those who may be developing a psychotic illness, offering quick responses to referrals (01254 226310);
- Burnley Integrated Offender Management Unit (REVOLUTION) offer a multi-agency approach to engaging offenders with a view to increasing access to services and support, whilst contributing to the reduction of crime (contact Safer Lancashire on 0845 053 0000).
- The Early Intervention Team, Liverpool, serves young people (14-35) experiencing psychosis (0151 330 8136);
- The Liverpool Homeless Outreach Team serves homeless people with severe and enduring mental illness (0151 330 8028); and
- Inclusion Matters (Liverpool) – free NHS service via GP referral providing talking therapies for common mental health problems (0151 228 2300).
9.3 Appendix 3 – Examples of useful 3rd sector services

- SAFELINE therapeutic counselling services, Warwick (01926 408315);
- Mayday Trust supported housing provider, Rugby (01788 568176);
- The Lucy Faithfull Foundation works with male and female sexual offenders and their families (01527 591922);
- The Providence Row Link Worker Scheme supports criminal justice and mental health clients in a number of areas e.g. housing, benefits, improved engagement with statutory services in East London (020 7920 7335);
- Together Forensic Mental Health Practitioners support clients with community orders managed by London Probation Trust (020 7780 7300);
- Off-Centre young people’s project, Hackney, provide counselling, guidance and activities for those aged 11-25 (020 8986 4016);
- Hillside Clubhouse, Islington, is a transitional employment programme facilitating supported access to voluntary/paid employment for people with mental health issues (020 7700 6408);
- Reading Volunteer Centre offer voluntary work placements (0118 957 4123);
- Faith, Reading, provide emergency food parcels, including upon release from prison (0118 950 9693);
- Julian Housing, Norwich, offer help to people with mental health problems at risk of losing a tenancy (01603 767718);
- The Matthew Project, Norwich, offer services to young people with drug and alcohol problems (01603 626123);
- Bernsali Housing, Barnsley, offer help and advice around tenancies and homelessness (01226 775555);
- Living Room Project, Stevenage, offers support for people abusing alcohol (01438 355649);
- The Salvation Army run the Bridge Project in Blackpool offering support attending appointments, assisting with housing and benefit applications, providing a drop-in service, counselling and general well being service (01253 299835 or 626114);
- Freeflow Counselling Service, Burnley, offers a free and confidential counselling service to men and women above 16 years old in a safe and supportive environment, (01282 450545);
- Maundy Grange, Accrington offer counselling, emotional and practical (food parcels, soup kitchen) support (01254 917707);
- Christians Against Poverty, Bradford, provide debt advice (01274 760720);
- Rethink, Liverpool, offer support with benefits, housing, finances and advocacy (0151 250 6200);
9.4 Appendix 4 – Examples of services for women

- The Liverpool Turnaround Project caters for women in the CJS (0151 728 9532);
- Women Ahead one stop shop for vulnerable women, Tower Hamlets, offers a range of support needs (020 7422 0901);
- Together Women’s Project, Sheffield, serves difficult to engage women with chaotic lifestyles and complex needs (0114 275 8282);
- Clean Break, a pan-London women’s theatre and education service offer courses and self awareness groups for women (020 7482 8600);
- The Matrix Project, Norwich, supports sex workers (01603 751717);
- Preston Women’s Refuge serves women affected by domestic violence (01772 201601);
- Cranstoun Women’s Groups, Lemington Spa, aid in recovery from drug abuse (01926 885176);
- CRY Salis, Lemington Spa, run women’s groups (01926 682217);
- ISIS, North London, offer a drug service for women (020 7272 1231);
- Door of Hope, London, work with sex workers (0207 729 7982);
- Open Door, London, work with sex workers (020 7683 4601);
- Safe Exit, London, work with sex workers (020 7392 2977);
- Haven, Whitechapel, London, work with women that have been abused (020 7247 4787);
- Eaves is a pan-London service for vulnerable women (020 7735 2062);
- MIND day services, Black Country, offer specialist women’s services e.g. yoga groups (0121 565 2788);
- The Rahab Project, Reading, part of PACT (Parents and Children Together), offer advocacy and support for sex workers (0118 941 8005);
- Berkshire Women’s Aid, provides support to women who are suffering/have suffered domestic violence (0118 950 4003);
- Leeway Domestic Violence Service, Norwich (0845 241 2171);
- The Survivors, Norwich, for female victims of childhood sexual abuse (07796 296922);
- Stevenage and N Herts Women’s Resource Centre offer gender specific support including social and therapeutic interventions (01438 742742);
- Watford Women’s Group offer one to one and group support with issues like domestic violence, housing, finances, benefits, legal issues etc (01923 816629);
- The Sunflower Centre, Hemel Hempstead, protect and support those affected by domestic violence with a tailor made individualised service (01442 270679).
9.5 Appendix 5 – example useful services for black and minority ethnic service users

- Mothertongue, Reading, offer multi-ethnic counselling, interpretation services and cross cultural support (0118 957 6393);
- Hibiscus, a pan-London service, supports women from BME backgrounds, especially Eastern European (020 7278 7116);
- The Vietnamese Mental Health Service, Tower Hamlets, offer one on one and group support for Vietnamese and Chinese people experiencing mental ill health (020 7234 0601);
- Praxis, London, provide one to one advice, casework and support to access health services and advocacy, employment, housing (020 7729 7985);
- The African Caribbean Counselling Service, West Bromwich, offer leisure services, advice and training (0121 612 6813);
- Norwich and Central MIND inclusion project offer employment related workshops and training for people from BME backgrounds (01603 432457);
- Norwich and Norfolk Racial Equality Council support equal rights for BME people (01603 611644);
- Asian Men & Women’s Support Service, Derby (01332 604098);
- Derby Asian Women’s Training Association, provide education and training opportunities (01332 363179);
- Karma Nirvana, Derby, is a specialist South Asian women’s project providing support to those experiencing domestic violence (01332 604098; Honour Network Helpline 0800 5999 247);
- The Hope Centre, Preston, offer assistance with domestic violence, honour based violence and forced marriages (01772 201301);
- Nilaari, Bristol, offer drug and alcohol services (0117 952 5742).
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