Introduction

Against the backdrop of a rapidly increasing female prison population and concern at the significant number of women with mental health problems held in custody, criminal justice liaison and diversion (CJLD) schemes have been tasked with diverting offenders* with mental health needs away from the criminal justice system into the care of health and social services. This briefing paper presents key findings from an evaluation conducted between January 2006 and March 2007 of 10 CJLD schemes. The evaluation aimed to provide a qualitative and quantitative description of the schemes and the extent and nature of the service they provided for women offenders with mental health needs.

Three areas were addressed by the evaluation:

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

The schemes included in the evaluation reflect different types of liaison and diversion services. They were located in police stations and magistrates’ courts, rural and urban locations, include schemes with and without psychiatric input and those which used proactive and reactive methods of working (checking for evidence of mental health problems or relying on custody staff and other criminal justice practitioners to make referrals).

For each scheme the evaluation:

- reviewed operational policies and protocols, where available
- compiled socio-demographic and an assessment outcome data profile for offenders assessed by the scheme (based on routine monitoring and case file data for 2005)
- collated information about multi-agency involvement to map local service provision and examine the links between the scheme and other agencies
- conducted interviews with key professionals (scheme staff and others from police, courts, probation and receiving services) and women service users
- placed scheme activity in context through examination of local arrest and sentencing data.

* This briefing paper has used the term ‘offenders’, but includes those who come into contact with the criminal justice system because they are suspected of committing an offence.
Policy context

Diverting offenders with mental health needs away from the criminal justice system into the care of health and social services has been a policy aim for some time. As far back as 1992, the Reed Review of Health and Social Services for Mentally Disordered Offenders (the Reed report) recommended that there should be nationwide provision of properly resourced court assessment and diversion schemes to achieve this goal.

Prison exacerbates mental ill health, heightens vulnerability and increases the risk of self-harm and suicide. In addition, mental health services within prison are unsuitable and inadequate for dealing with prisoners with chronic and severe mental health conditions. Recent developments in this area include a government review of services for offenders with mental health needs conducted by Lord Keith Bradley, and the forthcoming publication in 2009 of the first offender healthcare strategy. There are also efforts afoot to improve and standardise the provision of court assessment, liaison and diversion services through the introduction of service level agreements (SLA) between magistrates’ courts and mental health services. Pilot projects using SLAs are currently being undertaken in the south-west of England and north-west London.*

Baroness Corston conducted a review of vulnerable women in the criminal justice system. This highlighted the failure of the NHS to properly resource schemes to divert women with mental health needs away from prison and into community-based healthcare. The Women’s Offending Reduction Programme (WORP) sought to develop more appropriate community interventions for women to encourage their diversion at pre-court and pre-sentence stages of the criminal process and the greater use of community disposals. In addition, the Gender Equality Duty (April 2007) placed a legal obligation on public bodies to show that they were promoting equality of opportunity between men and women through the Equality Act 2006. The implications for criminal justice agencies included recognising and catering for the potentially different needs of male and female offenders.

What we know about the female offending population

Most female prisoners are serving short sentences for non-violent crimes and over a third have no previous convictions. The majority (66%) are mothers, yet the small size of the female prison estate means that many are held far from home making it difficult to maintain regular family ties, which can have damaging consequences for their children and for the women’s mental health. Ensuring that community-based disposals are available wherever possible for women with mental health issues could help to reduce the number serving these short prison sentences.

Mental ill health is high among women offenders. Female prisoners are twice as likely as males to have had contact with mental health services prior to their imprisonment. They are also more likely than male prisoners to suffer from functional psychosis and neurotic disorders such as depression, anxiety and phobias. Two-thirds of women prisoners have been assessed as having a neurotic disorder. Approximately 50% of women prisoners were receiving prescribed medication such as anti-depressants and anti-psychotic medicine. A more recent study has reported that women in custody were five times more likely to have a mental health problem than women in the general population.

Nearly a third of women prisoners self-harmed in 2003 compared to only 6% of men, and while women comprise a minority (6%) in the prison population, they accounted for 46% of all self-harm incidents. Furthermore, nearly half of female remand prisoners had attempted suicide in their lifetime compared to a quarter of male remand prisoners. There were 54 self-inflicted deaths of women prisoners between 2000 and 2005 and the majority of prisoners who commit or attempt suicide have a history of mental disorder.

Substance misuse is common, with female prisoners more likely than men to be dependent on opiates. In a sample of 301 women from 10 prisons, 34% reported hazardous levels of drinking in the year before prison and 43% reported use of crack cocaine and 44% use of heroin in that time frame. Over a quarter (27%) had used heroin and 9% had used crack cocaine while in prison. Unsurprisingly, there is also a high degree of comorbidity: one study found that 83% of female remand prisoners and 70% of female sentenced prisoners had two or more mental disorders. Other issues include experience of violence: 50% of women prisoners have experienced domestic violence and about a third have been sexually abused.

* For more details contact Offender Health at the Department of Health.
Current provision of CJLD schemes in England and Wales has been described as patchy and service quality as variable.\(^4,21\) It is argued that a lack of central co-ordination or strategic planning means many schemes fall short of the service recommendations detailed above.\(^24\) Here we describe the structure, operation and throughput of 10 schemes with specific focus on the service provided for women, and provide recommendations for improving practice.

The schemes

Historically, the schemes were set up in response to the Reed report (1992) and related Home Office circulars. They have, however, developed and re-configured over time and according to local circumstances. But while there are common core elements of provision, there is no standard model in terms of remit, staffing, funding and service delivery (see Table 1 overleaf).

Schemes can be categorised as either court or police station depending on whether their core function is to provide a screening and mental health assessment service to courts or to the police. They were funded jointly by health and social services (5), health (3) or social services (1) and by health, social services and probation (1). Only five schemes had active steering groups, incorporating staff from the key agencies (courts, probation and mental health services and the police). Five schemes were integrated into community mental health services.

Targeting offenders

Generally the schemes saw whoever was referred to them, accepting that some referrals would be inappropriate. They tried to exclude those whose primary problem was substance misuse. This was, however, difficult when receiving referrals from non-specialists in mental health such as custody staff. Activity data suggest that about a third of all schemes’ contacts were diagnosed as having substance misuse rather than mental health problems and just over a quarter were designated as ‘No Further Action’, suggesting no mental health issue was identified. Only two schemes reported a more targeted approach. Scheme 1 focused on those committing serious violent offences and Scheme 3 on those who had treatable mental disorders (under part 3 of the MHA). These schemes had fewer contacts than those that did not target.
having problems filling vacancies for approved social workers. Approved mental health professionals are expected to have a key role in the delivery of CJLD schemes to courts and police stations with the introduction in November 2008 of the new Mental Health Act 2007.

Psychiatric input – links to inpatient facilities

Only a minority of schemes’ contacts were recommended for formal assessment under the MHA, and all of the schemes reported problems

### Table 1 Overview of schemes

<table>
<thead>
<tr>
<th>Scheme 1</th>
<th>Scheme 2</th>
<th>Scheme 3</th>
<th>Scheme 4</th>
<th>Scheme 5</th>
<th>Scheme 6</th>
<th>Scheme 7</th>
<th>Scheme 8</th>
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* Scheme 1 operates for ½ day per week. All other schemes operate five days per week.

### Staff composition

None of the schemes were composed of multidisciplinary staff, as recommended by the Offender Mental Healthcare Pathway, while half had no administrative support. Schemes were most often led by community psychiatric nurses. One scheme had a lone worker and under half had input from psychiatrists. Only one scheme had any formal links with learning disability services (approximately 2% of contacts across all schemes were deemed to have learning disabilities). At the time of the evaluation, two of the schemes were linked vacant.

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gaining access to inpatient beds. The shortest time frame for access to a bed was a day and the longest was four months. Three schemes had psychiatrists attached to their team. Others (e.g., Scheme 4 and Scheme 6) could call upon duty psychiatrists when diversion under the MHA was considered likely. Only Scheme 9 had clear arrangements for psychiatric input, where about one day per week of psychiatric time was provided to the scheme, with scope for on-call advice at other times. Elsewhere, psychiatric input was more sporadic. For example, the psychiatrist attached to Scheme 10 was also the medical director for the Trust, which made providing cover to the scheme difficult. At Scheme 2, support from the local forensic psychiatrists was a result of goodwill rather than any formal agreement. In Scheme 5, the worker used various strategies to get access to psychiatric services, including sending clients to Accident and Emergency.

**Coverage and capacity**

Coverage of the magistrates’ courts or police stations was influenced by hours of operation, the number of staff and other activities undertaken by the schemes, which took time away from core activities. None of the schemes were able to offer out-of-hours or weekend cover.

The schemes were involved in a range of activities in addition to providing screening and assessment services, without receiving any additional resources (see Box 1 below). They were increasingly being asked to gatekeep requests for psychiatric reports and attend multi-agency public protection arrangements (MAPPA) meetings and five schemes carried out casework. They also accepted referrals from probation and social services and five schemes provided training to police, magistrates or probation to promote their service and to help improve the recognition of mental health problems among offenders. These activities are important but they had an impact on how work was managed, and with limited resources there were instances where referrals could not be dealt with because of time constraints.

**Proactive or reactive**

Only half of the schemes described their screening in the courts or at police stations as proactive. This is cause for concern because women have been described as less vocal and more withdrawn in their presentation than male offenders and are thus more likely to be missed. Good practice points described by schemes working proactively included checking the names of those held in custody against their client

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**Box 1 Additional activities of the schemes**

| Scheme 1 | Care co-ordination |
| Scheme 2 | Training non-specialists |
| Scheme 3 | Multi-agency public protection arrangements (MAPPA) meetings, training non-specialists, care co-ordination, prison liaison |
| Scheme 4 | Gatekeep requests for psychiatric reports at magistrates’ courts, training magistrates |
| Scheme 5 | Gatekeep requests for psychiatric reports at the magistrates’ youth courts and crown courts, contribution to pre-sentence reports, training police and probation |
| Scheme 6 | MAPPA meetings |
| Scheme 7 | Care Programme Approach meetings, MAPPA meetings, act as appropriate adult, training police and probation |
| Scheme 8 | MAPPA meetings, care co-ordination, prison liaison |
| Scheme 9 | Care co-ordination, training to non-specialists, prison liaison |
| Scheme 10 | Care co-ordination |
database to identify individuals who had contact with mental health services, and checking types of medication listed on prisoner files or the police log of a prisoner’s belongings for anything related to mental health conditions.

**Relationship with referrers – police and court staff**

Relationships with police and court staff had improved greatly over time. An initial reticence, particularly from the police, declined as they became used to having a range of civilian staff in the custody suite. However, there were instances where a change of custody staff could disrupt those working relationships. Without exception, police respondents were positive about the schemes and reported good working relationships, noting the input the schemes had in improving the duty of care to detainees.

**Links with drug arrest referrals schemes**

There was potential for overlap in service provision between CJLD and drug arrest referral schemes (DARS), which are also located in police stations and courts. The coverage provided by DARS was much greater than the mental health screening schemes – all the DARS offered weekend and out-of-hours coverage. Mental health teams were in some respects the poor relation. While generally there was co-operation between the schemes, this was mainly based on ad hoc, informal working relationships rather than any official arrangement at management or commissioning level; there is clearly scope to improve links between these screening services and work towards a more formal integration of drug and mental health services. This is important given the potential for comorbidity of substance misuse issues, mental health problems and other social care needs.

**What services were available for women?**

We focused on three issues with respect to services for women. These were:

- services offered by the scheme for women at the point of contact
- types of mental health and other community-based services for women to which the schemes could refer clients
- training for CJLD workers about women offenders with mental health needs.

**Services offered by the schemes to women**

Women offenders were in the minority as clients and gender-specific services at the point of contact were few. The most frequently mentioned service that staff noted (and that women offenders wanted) was same-sex screening and assessment. This was often, but by no means always, feasible. Two schemes had no female staff at the time of the evaluation.

**Mental health and other support services for women offenders**

Information about services in each area, based on scheme and stakeholder knowledge, suggests that at most sites the ideal composition of single sex inpatient and community-based mental health and support services for women does not exist. It remains the aspiration of guidance and best practice documents rather than a reality. There were limited services for women with mental health needs (both inpatient and community-based) and no consistency of provision across the schemes. Additionally, the contacts between the schemes and other services did not tend to be underpinned by any formal inter-agency protocols or referral arrangements.

Schemes located within forensic or community-based mental health teams had access to the range of mental health services the teams provided. They did not, however, have privileged access to services. Scheme 2 was unique in its service model for women, having a secure facility for women, an inpatient unit in the community for women and supported accommodation to help community reintegration.

Signposting or providing clients with information about local services was more common than active referral. Several schemes reported a women’s service in their locality providing access to a range of advice and support in a women-only environment. There was also a range of drop-in and day centre activities run by voluntary organisations and advocacy groups. Women’s Aid was often mentioned as a local service for those experiencing domestic violence. Drug services for those with dual diagnosis or any service specifically for women drug users was lacking. While many of the relationships with other services worked well, these were often achieved by the skilful building of informal links and were not underpinned by formal protocols, making them vulnerable to staff mobility.
Linking with women’s prisons

A common problem was the relatively poor links schemes had with women’s prisons. Two related issues were noted: the geographic dispersal of the women’s estate meant it was often impractical to arrange visits and the infrequency of contact made it difficult to build up working relationships with prison health teams. This has implications for transferring mental health assessment information from the scheme to the prison and vice versa on release. Although there are standard procedures for the notification of a prisoner’s risk of suicide and self-harm, other information about mental health may be lost. Scheme 9 had appointed a prison link worker for women. Her role was to ensure continuity of care and access to services on leaving prison. She also tried to help women stay in contact with families and carers through practical help such as arranging transport for visits.

Guidance and training

Despite the emphasis on guidance and training for those working with women offenders with mental health needs,10, 21 only two schemes reported receiving any gender-specific training and this was focused on self-harm. None of the schemes had received guidance on dealing with eating disorders or sexual abuse.

User involvement

There is an increasing emphasis on the centrality of the service user in mental health policy21 and regular consultation with service users is recommended as a routine factor in service planning.23 None of the schemes in our sample had any routine procedures for collating feedback from their service users or any recent findings from user consultations. Our own limited endeavours show that it was difficult for the women to differentiate the service input they had from different health and criminal justice agencies, which has implications for any future methods schemes may use to collect service users’ opinions. The interviews we undertook with service users (11 in all) did however show that women were generally positive about the service provided by the schemes and gained valuable help and support from the receiving agencies. The following interview extracts show the importance the women placed on having someone at court or in the police station who had time to listen to their concerns and who had some understanding of what they were going through:

‘I thought it helped me more, because then other people get to understand from my point of view, rather than just going in there and they don’t understand everything. I mean, at least people then have, you know, realise reasons why you get yourself into trouble… if I could kiss that man, I would, from the [CJLD scheme], you know, I would, he done wonders for me… and he actually sat down and he listened to me, you don’t get many people like that.’

Wilma, 23 years old

‘Just being able to go in and speak about anything really and knowing that it ain’t going to go any further. It’s private and confidential. Nobody else needs to know about it. He’s always saying, it stays in the room that we’re in. It’s just nice to know that he’s not in judgement.’

Emily, 24 years old

Below, Gale, 25 years old, describes her situation before and after intervention by the CJLD scheme which led to a transfer to a mental health facility:

‘I feel better here [in the secure unit] because in jail I had the voices really bad and I was trying to pretend to everybody I am all right. I was making a joke with it because me voices kept saying ‘out the window’ and I said ‘you’re telling me to go out the window’ and I was making a joke of it. And I was making out I was all right to everyone because I didn’t want anyone taking the piss out of me… And I had never been to jail before so I was trying to make out I was all right when I wasn’t. Where here I have been able to get better and tell the truth.’

Resources

As a general point, all the schemes talked about operating with very limited resources. The following extract from an interview with a steering group chair and commissioner of forensic services is used to illustrate the issues faced by many schemes:

‘It’s way under capacity… it’s very difficult to keep it on the commissioning agenda because you are going through this tiering on the commissioning side. You are in there
with all the other service programmes, like cancer, like heart diseases, all the other bits and pieces... They all get dealt with first. Mental health comes way down the commissioning list and within mental health you have all those targets that you are performance-managed... Court diversion has not appeared in that. It barely got a mention in the criminal justice care pathway... never mind a target."

CJLD schemes' data findings

Data quality

We collated local police arrest and sentencing data and scheme monitoring data from 2005 to provide an indication of the need for CJLD schemes for women offenders in different areas. From the outset it was clear that the extent and quality of routine monitoring data would vary. An earlier Nacro survey22 found that one in five schemes did not collect service level activity data, while two-fifths did not record details of clients’ gender. As anticipated, much of this activity data was paper-based.

The quality and consistency of activity data was generally poor and monitoring systems were inadequate. The minimum data set proposed for this study (see Box 2, page 11) represented common core data that were available across the schemes, according to screening and assessment tools. However, only four schemes routinely transferred these data onto an electronic database, three had no electronic data at all, two gave us partial electronic data and one scheme could provide no activity data. As a result, the proportion of missing data was high, particularly on items such as primary diagnosis and referral recommendations. Criminal justice outcomes were not easily available at eight of the schemes. Likewise, the outcome of referrals to community services were not recorded routinely.

This meant that we were unable to draw any conclusions about the recommendations made to the court by CJLD schemes for women offenders and the proportion of recommendations taken up by courts, or the proportion of successful referrals from CJLD of women to hospital and community-based mental health services and criminal justice system interventions. These kinds of outcome data were not recorded routinely by most schemes, making it very hard to judge the effectiveness of the schemes. What we can say about the CJLD contacts and referral sources is limited. This dearth of monitoring data is an important finding in its own right.

Nature and extent of contact by CJLD schemes

We can say that the schemes were seeing on average 2% to 3% of the total number of offenders passing through the police station and courts. This suggests a considerable level of unmet need. Surveys of the offender population have consistently found a high proportion with mental health problems.15

There were 2,155 adult referrals to the nine CJLD schemes between January and December 2005, ranging from 16 to 688 referrals per scheme (the mean was 239). Around three-quarters of referrals during this period were made via police custody (n=1,123; 52%), probation (n=289; 13%) or the courts (n=192; 9%).

Four schemes operated at the police station.* Between January and December 2005 these police force areas came into contact with a total of 49,666 arrestees. During the same period the CJLD schemes received 1,492 referrals, but not solely from custody suites – equivalent to 3% of the arrestee population at these sites. The rate of contact was similar for female suspects (3.5%).

The level of contact with the arrestee population varied by area from 4.7% in Scheme 9 to 1.4% in Scheme 10.

At all nine CJLD sites it was possible to gather comparable data on court activity (though only six operated as court-based schemes). During 2005, 85,493 defendants were sentenced by the courts. The schemes in these areas received 2,155 referrals – equivalent to 2.5% of the population processed by the courts. As with the arrestee data, the rate of contact was almost identical for female defendants (2.6%), but with the level of contact varying considerably between areas, from 0.8% in Scheme 1 to 4.9% in Scheme 7, this scheme also engaged the highest proportion of female defendants (7.7%).

The most common reasons for making a referral were unspecified mental health concerns (n=500),
self-harming (n=355), substance use (n=28) or other reasons (n=184). The available activity data from the nine sites suggests that less than one-third (n=648) of those referred to CJLD schemes during 2005 had previous contact with psychiatric services. In some cases CJLD workers completed a full assessment with the referrals they saw (n=820; 38%); however, we cannot be certain of the extent to which this happened, as details on the type of assessment undertaken were often missing.

Over half the adults referred to the CJLD schemes were assessed as requiring further intervention (n=1146; 53%). Table 2 illustrates how substance use (n=362), SEMI (serious and enduring mental illness, such as schizophrenia and bipolar/manic depressive psychosis) (n=187) and depression (n=142) were the most common forms of primary diagnosis made by CJLD workers following assessment of need. The high rate of CJLD referrals being identified with substance misuse problems indicates some duplication of effort or the potential for dual diagnosis of substance misuse and mental health problems. This reinforces the need to establish links between CJLD schemes and DARS.

### How did the women seen by the CJLD schemes differ from the men?

It is important to consider whether women’s experiences of the CJLD schemes differed from men’s and to understand what factors were important in shaping these experiences. There were a limited number of variables, for which we had reasonable data, which we could hypothesise as being potentially important factors (see Table 3 overleaf).

The women seen by the schemes were more likely than men to be white; to have been arrested/charged with a public order or violent offence (but not section 136 detainees); and, to

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**Table 2: Primary diagnosis for CJLD referrals requiring further intervention (%) (n=1146)**

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<tr>
<th>Diagnosis</th>
<th>%</th>
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<td>Serious and enduring mental illness</td>
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<tr>
<td>Depression</td>
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<td>Other</td>
<td>11%</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>11%</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>6%</td>
</tr>
<tr>
<td>Low level mental health needs</td>
<td>5%</td>
</tr>
<tr>
<td>Dual diagnosis</td>
<td>3%</td>
</tr>
<tr>
<td>Learning disability</td>
<td>2%</td>
</tr>
<tr>
<td>Missing</td>
<td>2%</td>
</tr>
<tr>
<td>Self-harm</td>
<td>1%</td>
</tr>
</tbody>
</table>

---

* The reason for referral was not recorded in 51% of cases (n=1089).
** Data on previous contact with psychiatric services was not recorded in 44% of cases (n=956).
*** Data on referral recommendations were missing (including not known and not assessed) in 25% of cases (n=545).
have been diagnosed with a substance use issue. They were less likely to have previous convictions or have been diagnosed with SEMI than their male counterparts. This is in contrast to research showing a higher prevalence of mental illness (including psychosis) among female prisoners compared to male prisoners, and suggests some degree of unmet need and missed opportunities for the mental health screening of women in contact with the criminal justice system.

### Recommendations

Below we outline some recommendations, based on our research, for how schemes might improve their service for women offenders with mental health problems.

### Resources

- The schemes are clearly under-resourced and the entire criminal justice system would benefit from greater investment in them. Their profile might be raised if schemes were directly commissioned by primary care trusts and had clear performance targets from the Department of Health. For this to happen there needs to be good evidence about throughputs and impact, and this information will only be available if there is investment in the administrative infrastructure of CJLD schemes.

- Providing services for a higher proportion of those in need is in part a question of resources. The schemes simply do not have the capacity to provide sufficient coverage. However, a higher proportion of the population in need could be located if schemes’ times of operation were more closely synchronised with the times of peak demand, such as evenings and weekends.

- If more resources were made available, CJLD schemes should aim for a more proactive working style by, for example, checking custody records and prisoner escort record forms for evidence of mental health issues and/or previous contact with mental health services, rather than relying on referrals from custody staff.

### Informed gender practice

- Proactive screening may be particularly important for identifying women with mental health problems because they may be less obvious to the non-specialist. However, women who appear challenging can also be extremely vulnerable.

- Wherever possible, the service user should have the choice of speaking with a female member of staff. Schemes could encourage the recruitment of female staff by offering, for example, job shares and part-time appointments.

### Table 3 Female and male contacts seen by the CJLD schemes

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity (white)</td>
<td>96% (361/377)</td>
<td>91% (1481/1637)</td>
</tr>
<tr>
<td>Mental status (single)</td>
<td>74% (218/293)</td>
<td>79% (1132/1436)</td>
</tr>
<tr>
<td>Homeless</td>
<td>14% (24/167)</td>
<td>17% (133/766)</td>
</tr>
<tr>
<td>Has previous convictions</td>
<td>65% (107/166)</td>
<td>80% (544/681)</td>
</tr>
<tr>
<td>Violent offender</td>
<td>17% (55/325)</td>
<td>14% (193/1369)</td>
</tr>
<tr>
<td>Public order offender</td>
<td>15% (50/325)</td>
<td>9% (116/1369)</td>
</tr>
<tr>
<td>Section 136 detainee</td>
<td>1% (3/325)</td>
<td>1% (16/1369)</td>
</tr>
<tr>
<td>Has previous contact with mental health services</td>
<td>94% (149/159)</td>
<td>93% (498/537)</td>
</tr>
<tr>
<td>Mental health need (SEMI)</td>
<td>8% (25/325)</td>
<td>14% (194/1371)</td>
</tr>
<tr>
<td>Substance misuse problem</td>
<td>38% (125/325)</td>
<td>29% (394/1371)</td>
</tr>
</tbody>
</table>
Improving working relationships and communication between the schemes and prison inreach teams in female prisons is also a priority. Initially, this may simply be a matter of establishing links with other CJLD schemes to ensure a local (to the prison) team can provide support to the offender until they are released and move back to their area of residence.

Links with community-based services could also be improved. Signposting is limited and thus developing more formal referral links with appropriate local agencies (including the voluntary sector) could result in better attendance at follow-up services in the community among CJLD clients. Schemes should map out women’s organisations that offer counselling, women’s centres, women-only hostels, supported accommodation and drug projects, crisis centres and services that engage with sex workers. The Griffin Society* has a resources database which may be useful. Any gaps that exist in provision, for example a lack of women-only inpatient facilities, should be raised with commissioners.

**Performance monitoring**

- The minimum data set defined for this study to monitor scheme activity (set out in Box 2 above) could be achieved easily (all the schemes collected these data as part of routine screening and assessment procedures) if resources were available for administrative support, including database construction and management.

**User engagement**

- Strategies for user engagement are at a rudimentary level and should be developed.

**Publicity**

- The work of the CJLD schemes needs to be publicised via leaflets and posters at police stations and in courts and given to defence solicitors to ensure that all criminal justice professionals, offenders and detainees are aware of the services they provide.

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**Box 2  Recommended minimum data set**

<table>
<thead>
<tr>
<th>Data element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of referral and assessment</td>
</tr>
<tr>
<td>Age, sex and ethnicity of client</td>
</tr>
<tr>
<td>Source of referral (e.g., police, court, probation)</td>
</tr>
<tr>
<td>Housing, employment and relationship status of client</td>
</tr>
<tr>
<td>Current offence and previous convictions</td>
</tr>
<tr>
<td>Reason for referral</td>
</tr>
<tr>
<td>Previous contact with mental health services</td>
</tr>
<tr>
<td>Primary diagnosis</td>
</tr>
<tr>
<td>Referral recommendations</td>
</tr>
<tr>
<td>Criminal justice outcome</td>
</tr>
</tbody>
</table>

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*www.thegriffinsociety.org*
References

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- To subscribe to the RAC newsletter please email newsletter@ltd.ac.uk

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

Do you need this leaflet in another format?
Ring 020 7840 7220.

Nacro’s Mental Health Unit
Nacro believes that responses to offenders with mental health needs should focus on their care and treatment rather than on punishment. To help bring about this change, Nacro campaigns for:
- more effective working partnerships between agencies
- the development of specialist skills in the criminal justice system
- better information sharing
- the education and training of staff so that they have the skills and encouragement they need to work with a group who can be difficult and unrewarding.

Nacro’s Mental Health Unit has been working to tackle problems faced by offenders with mental health needs since 1990. We work with government agencies at a national and local level to develop more effective ways to deal with offenders with mental health needs. We provide a range of services: information and advice; policy development and other consultancy services; and training. We also run a major annual conference on mental health and crime.

Nacro has a specialist mental health website which offers information and support for practitioners and policy makers working in the field of criminal justice and mental health. To find out more, visit the website or contact the Mental Health Unit on 020 7840 1209 or email mentalhealth@nacro.org.uk.

www.nacromentalhealth.org.uk

ICPR
The Institute for Criminal Policy Research (ICPR) carries out multi-disciplinary research into crime and the criminal justice system. We produce work which is independent and objective. Our key audiences are managers and practitioners within the criminal justice system, other professionals working with offenders, and politicians and their advisors. Our research approaches incorporate both quantitative and qualitative methods. Our main areas of research include:
- the quality and effectiveness of public services and resources (including police, probation and services for offenders and drug users)
- the causes, consequences and prevention of offending
- public attitudes towards crime and sentencing, the police and community safety.

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