Findings of the 2004 survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales.

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Introduction

Nacro’s Mental Health Unit (MHU) has been working with agencies at a national and local level, for over 15 years to develop more effective ways of working to improve services for mentally disordered offenders (MDOs). This survey is carried out by Nacro on an annual basis on behalf of the Home Office to map Court Diversion/Criminal Justice Mental Health Liaison schemes nationally.

In carrying out this survey Nacro is not attempting to evaluate the effectiveness of such schemes, but to gain a better understanding of which areas of England and Wales have some form of diversion/liaison scheme for people coming into contact with the criminal justice system who have, or are suspected of having, mental health needs. We also make some comparisons about the way the schemes operate.

There is currently a proposal under consideration by the Department of Health and Home Office to undertake a national independent evaluation of Criminal Justice Liaison Schemes in relation to women offenders with mental health needs. The purpose of this would be to identify what kind of approaches, services and arrangements are the most successful in terms of identifying female offenders with mental health problems as early as possible and helping them access services and support appropriate to their needs. If this evaluation takes place it is intended that the findings of the Nacro survey will inform the selection of the sample of schemes that is to be investigated in depth.

Methodology

A questionnaire (see Appendix 1) was sent out in November 2004 to the 143 contacts associated with court diversion work held on our database following our survey of 2003. The questionnaire was based on the 2003 survey with the addition of some new questions and opportunities for schemes to give information about any problems being experienced.

Those who had previously completed a survey in 2003 received a new survey which included the details they provided last year for updating and amendment in order to encourage returns.

The aims and objectives of the survey were:

- To update our database of schemes
- To find out if there were any changes in funding, staffing or operation within the last year
- To find out if schemes would be willing to participate in any future evaluation commissioned by the Home Office and Department of Health

We received 64 returns from this survey after sending out a reminder letter and extending the deadline for returns from 17th December 2004 to 14th January 2005. This compared to 68 returns we received in 2003. The rate of returns was improved marginally by chasing up schemes by telephone. On attempting this we found that many schemes did not return the survey for a variety of reasons, including general pressure of work, staff sickness and lack of interest. It might also be the case that staff within the NHS suffer from ‘survey fatigue’ due to the amount of questionnaires they are sent both within the NHS and from other organisations.

30% of the returns we received were from schemes which had not sent back a survey in 2003. A follow up phone call to schemes we had not heard from in some time revealed that some no longer exist due to lack of funding or a lone member of staff leaving the post with no replacement being found. Schemes are particularly vulnerable to closure if they have no operational protocol in place and/or no MDO steering group overseeing the work of the scheme.

The results of the survey have been collated under the following headings: operational procedures, staffing and funding, data collection, steering groups and agreed policies and recommendations.

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2 In 1999 there were roughly 150 court diversion schemes in England and Wales. Since that time we estimate that there has been a slight drop off in the number of schemes after the end of Home Office pump priming of schemes between 1994 - 1997.
Key Findings

- All schemes surveyed felt confident that the courts followed their recommendations to divert people to hospital, but some said courts were less likely to follow recommendations to treat in the community.

- 25% of schemes surveyed said they had seen a decrease in staffing levels in the last year. 30% of schemes cited staffing issues as a barrier to their scheme operating. Despite this, operational hours for most schemes had remained unchanged from the previous year. A third of schemes were operating with only one member of staff.

- 50% of schemes had no sessional input from either a psychiatrist or a psychologist and, unsurprisingly, 41% of schemes reported difficulties in obtaining psychiatric reports.

- 72% of schemes cited lack of beds as a barrier to their scheme operating successfully.

- Almost a quarter of schemes felt that mentally disordered offenders were a low priority for agencies in their area.

- 34% of schemes said their area was using the police station as the sole ‘place of safety’ (section 136, Mental Health Act, 1983). Of these 40% had no jointly agreed policy on section 136.

- 78% of schemes collected statistics. 50% of schemes that were collecting statistics did not collect data on ethnicity and 42% did not collect data on gender.

- 36% of schemes did not have a policy on information sharing.
What was Found

Operational Procedures

Respondents were asked how many days per week their scheme operated. 78% of schemes were operating 4-5 days per week and a further 8% were operating 6-7 days per week. Operational hours had stayed the same over the last year for most schemes. 75% of schemes had a written operational protocol on the day to day running of their scheme.

Respondents were asked where their schemes operated. 19% were covering the magistrates’ courts only, with 19% covering police station, crown court, magistrates’ court and probation offices and 19% covering police station, crown court, magistrates’ court, probation offices and prison. 51% of schemes had links with the local prisons.

Funding and Staffing

Respondents were asked how their scheme was funded. 38% of schemes surveyed were funded solely by NHS Trust monies. 20% were jointly funded by social services and the NHS Trust. 12.5% had some funding input from probation. The remainder were various combinations of healthcare, social services, police and prison. This does not vary greatly from the funding data in the 2003 survey. 27% of schemes cited lack of funding as a barrier to their scheme operating (see Case Studies A and B).

Levels of funding had mostly stayed the same (in line with inflation) as the previous year, but some schemes had seen their funding decrease (Figure 1). Reasons given for this were wide ranging: monies were not forthcoming from the Primary Care Trust; there was a large trust wide funding deficit which had a knock-on effect for the scheme; resources had been diverted to prison in-reach. One scheme was unable to get a response from the NHS Trust which was responsible for providing nursing cover for the scheme. Another scheme was not operating at all because the holding cells at the magistrates’ court had been condemned.

Case Study A

Doncaster Mental Health & Criminal Justice Liaison Service

Funding has decreased for this scheme as money has been diverted to prison in-reach through the secondment of a CPN until January 2005. The scheme produced a report in June 2003 in which they said they hoped to integrate the scheme and the prison in-reach team by developing a Forensic Team. However this has not been possible and the Criminal Justice Liaison Service now seems compromised by the need to provide prison in-reach. The reduction in staff numbers on the scheme may have led to the reduction in numbers of assessments being carried out over the last couple of years.
Case Study B

Dorset Forensic Service

There is no one to complete the Nacro survey questionnaire as bids for funding for a Criminal Justice Liaison Scheme have been rejected by their NHS Trust several times.

Where levels of funding had increased, schemes told us this enabled them to cover more locations, improve their working environment (e.g. purchase IT equipment, fax machines) and to increase the staff on their team. Some schemes which had realised an increase in funding wanted to point out that this was not necessarily a large amount and that they still needed additional funding in order to increase staff on the team. (see Case Study C)

![Figure 1: Has the level of funding for your scheme changed in the last year?](Image)

**Case Study C**

**Gateshead MDO Liaison Scheme**

This scheme won the Court Escort and Court Custody Award from the Butler Trust for their work at Gateshead Magistrates’ Court. They are trying to restart their steering group and hoping to expand the team from one CPN. They are looking at getting a further nurse seconded to work with the existing CPN.
31% of schemes were operating with one worker or less than 1 whole time equivalent (WTE), most often a community psychiatric nurse. When schemes are operating like this they are more vulnerable to becoming unsustainable and having a lone worker can also prevent development of the scheme. If the member of staff leaves the post sometimes they are not replaced and the work cannot continue. Since last year there have been a number of schemes where this has occurred. For example, a mental health worker no longer covers Hammersmith probation offices; in South Shields a nurse who covered the magistrates’ court left and was not replaced; in Calderdale the nurse moved on and now the court rings the local Arrest Referral Worker if they suspect a person has a mental health problem. The Arrest Referral Worker’s role is to identify problematic drug misusers and, as such, no expertise in mental health issues is required by the postholder. We were also made aware of a pilot scheme in Avon & Wiltshire that had been discontinued and to our knowledge there are no schemes covering North Wales.

42% of schemes, however, had three members of staff or more. We were pleased to note that five (8%) schemes had a probation officer as part of their team and four of these had some funding from probation services. 47% of schemes had at least 0.5WTE of an Approved Social Worker and 34% had 0.3 WTE or more administrative support. Approximately half the schemes were led by general psychiatry and half by forensic. Three schemes had learning disability workers, 3 had drug/alcohol workers but none had any input from an Occupational Therapist. Nacro’s experience whilst carrying out local development work in various areas has shown us that services can be accessed more easily where a scheme is made up of staff from a variety of agencies. MDOs often present a complex set of needs which cannot be resolved via one agency. Individual professionals and agencies might gate keep access to scarce resources/services, but by having a service that encompasses all elements of health, social services and criminal justice agencies this fosters a greater sense of collaborative working which in turn provides a better deal for the service user.

14% of schemes had an even ratio of male to female staff. 34% had a 2:1 or greater ratio of male to female staff on their team. 33% had a 2:1 or greater ratio of female to male staff on their team.

In the last year 25% of schemes said their staffing had decreased. 20% had seen their staffing increased, with 52% having the same level of staffing.

38% of schemes had sessional input from a psychiatrist, 3% from a psychologist and 9% from both. 50% of schemes did not have sessional input from either. Of those that did have sessional input from a psychiatrist, 46% had four hours or more a week.

Most schemes were reactive (69%) in that they only assessed people who were referred to them, 22% were proactive and 8% said they were both
proactive and took referrals. 77% said the assessment process would normally take 'less than or up to 24 hours'. Only one scheme said the assessment process would take over 7 days.

The majority of referrals came from police (17%) or the courts (14%), but many schemes cited more than one agency (55%) as being their main referrer.

Lack of beds, difficulty in obtaining psychiatric reports and not enough staff were the three major barriers which prevented schemes from being as effective as they would like (see Figure 2). Almost a third of schemes cited other problems. Among these a recurring theme was a lack of accommodation specifically for MDOs. Other problems were; inconsistent staffing; some services rejecting referrals from the scheme; being a lone worker preventing the development of the court side of the service; unwillingness of courts to consider alternatives to custody; reluctance to use section 35 (MHA – remand to hospital to obtain a psychiatric report) directly from court to secure beds; no local medium secure unit; and a lack of interest or reluctance from general psychiatry to get involved (see Case Study D).

Case Study D

South Western Magistrates’ Court

This scheme is not currently operating. It has had no nurse cover since November 2004 and no general psychiatrist since December 2003. The Bench Legal Manager said she has been unable to get any response from the NHS Trust which has provided the cover in the past.
Figure 2: What are the barriers to your scheme operating?

- Lack of beds
- People unaware of scheme/low referral rate
- Problems working with other agencies
- Lack of funding
- Lack of training
- Not enough staff
- Geographic difficulties
- No protocols
- Difficulty obtaining psychiatric reports
- Lack of CMHTs
- Information Sharing problems
- No steering Group
- MDOs a low priority for agency in area
- No answer
- Other
**Data Collection**

78% of schemes collected statistics. 58% of these schemes recorded all their statistics by gender, 50% recorded all their statistics by ethnicity and 43% by age. 39% of schemes recorded all their statistics by gender, ethnicity and age. 50% collected information on recommendations to the court.

66% of schemes were able to provide us with the number of mental health assessments they carried out in a given year. The highest percentage of women being assessed by a scheme was in Leicester (49% of assessments were of women in 2002), with the lowest percentage being 5% (2004) in Redbridge.

In some areas the numbers of referrals seemed low considering the geographical location of the scheme e.g. Inner City London. This could point to problems in the identification of cases or the scheme suffering from a low profile leading to key agencies being unaware of its existence.

48% of schemes said their figures were passed onto an MDO steering group. 36% passed the information onto funders. Statistics were also made available to strategic planners/commissioners, County steering groups, clinical managers and agencies on request. 5% said that their statistics did not go anywhere. Some schemes collected statistics but had not had time to collate them while others had stopped collecting statistics pending the introduction of new information technology systems.

All schemes surveyed said the courts would follow their recommendations to divert to hospital in over 90% of cases although they were slightly less likely to follow their recommendation to treat in the community.
Steering Groups and agreed policies

64% of schemes have a steering group to oversee their work. However some schemes had doubts about the value of the steering groups. One scheme stated one of the barriers to working was,

“limited commitment from participating agencies supposedly involved in the steering group”.

Respondents were asked whether they had any agreed operational protocols and or policies with other agencies (see Table 1). 66% of schemes had a policy on section 136 of the Mental Health Act 1983, which was an improvement on last year’s survey results (56% had no policy), although some schemes did say that they did not get involved with the section 136 work. Some schemes also said that although their scheme did not have a policy they referred to the policy that their NHS Trust had drawn up.

36% said they had no policy on Information Sharing – this had not changed in the last year.

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<thead>
<tr>
<th>Table 1: - Does your scheme have a protocol/policy on:</th>
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<tr>
<td>Working with the police</td>
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<tr>
<td>Information Sharing</td>
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<tr>
<td>Operational protocol</td>
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<tr>
<td>Section 136, Mental Health Act 1983</td>
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<td>Learning Disabilities</td>
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<td>Conveying to hospital</td>
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<td>Dual diagnosis</td>
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<td>Dangerous &amp; Severe personality disorder</td>
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<td>Identifying and responding to the needs of female offenders</td>
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<tr>
<td>No answer</td>
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<td>Other</td>
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Other policies that schemes work to included agreements with local prisons, policy on Mental Health Act assessments and ordering of psychiatric reports.

Schemes were asked where the designated ‘place of safety’ was for people detained under section 136 of the Mental Health Act 1983 (see Table 2).
We were disappointed that a third of schemes said their area was using the police station solely as the 'place of safety'. In fact, in one area the 'place of safety' had been the psychiatric hospital but had since reverted to the police station. The Mental Health Act 1983 Code of Practice (The Stationery Office, 1999) states that it is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital rather than at a police station. A police station is likely to be appropriate if the person is acting violently at the time of detention, is known to be violent, or when the person is under the influence of alcohol or drugs.

Only 23% of schemes had been subject to some form of evaluation since their establishment.

This year we asked whether service users had an opportunity to feedback or make a complaint about their experience of the scheme. 80% of schemes said this was possible. A further 30% of schemes actively sought views from service users on the running of their scheme.
Conclusion

Court diversion has been a much-neglected area over the last few years when compared to the focus placed on other recent initiatives such as prison mental health in-reach and Crisis/Assertive Outreach teams. Although there is limited research into the outcome of admission through these schemes, it is Nacro’s experience that where such schemes exist they are effective at diverting people from custody where appropriate and referring people to suitable services in the community.

In 1992 the Reed Review of Health and Social Services for mentally disordered offenders and others requiring similar services said:

“There should be nationwide provision of properly resourced court assessment and diversion schemes and the further development of bail information schemes... The longer term future of many schemes is not yet assured but experience increasingly suggests that, where diversion schemes became established, these come to provide a broader multi-agency focus which, of itself, can make effective disposals easier.”

The publication of our survey findings coincides with the publication of the Department of Health document ‘Offender Mental Health Care Pathway’ which is intended to guide the practice of those who deliver services and to support decision making for commissioners. This guidance is written on the premise that areas have a Criminal Justice Liaison Team with inputs from an Approved Social Worker (ASW), Registered Mental Nurse (RMN), psychiatrist, psychologist and learning disability specialist. In reality, Nacro has found that, thirteen years on from the Reed report, the national picture is far from that ideal. Many areas have no provision at all. Many others rely on one lone worker, most often a community psychiatric nurse (CPN). There is no advice in the document for those areas that do not have a Criminal Justice Liaison Team either on how to set one up or on what alternative arrangements may be in place to effect a mental health assessment. Lack of, or poor quality, guidance in this area can all too often lead to serious failures in service provision. We therefore recommend the following:

1. It is Nacro’s view that all magistrates’ courts, police stations, prisons and probation offices should have access to a court diversion/Criminal Justice Liaison Scheme in order to more easily access psychiatric assessment for offenders suspected of having a mental disorder. These schemes should be integrated into mainstream services rather than existing as ‘add on’ arrangements with few links to strategic planning. In areas where there are no Court Diversion/Criminal Justice Liaison schemes a needs assessment should be carried out. At the very least a protocol should be drawn up which will set out how agencies should work together to provide the necessary services and

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3 Dr David James et al (2002), Outcome of psychiatric admission through the courts, RDS Occasional Paper No 79, Home Office
3 Review of health and social services for mentally disordered offenders and those requiring similar services, Department of Health, Home Office; HMSO 1992
4 Offender Mental Health Care Pathway, Department of Health 2005
organise psychiatric reports for mentally disordered offenders.

2. Money should be ring-fenced for the creation and maintenance of these schemes and where possible joint funding between criminal justice and healthcare/social services should be encouraged, with the intention of creating robust multi-disciplinary teams. This funding should not be time limited.

3. The Department of Health should effect an increase in the number of psychiatric beds available and not simply leave it to the discretion of NHS Trusts.

4. All schemes should have an operational procedure in place so that all those involved know how the scheme works. In addition, all schemes should have a policy on information sharing or adhere to a Trust-wide policy. Nacro has produced a good practice guide for practitioners working with mentally disordered offenders on this subject. There will undoubtedly be instances when exchange of information about a person is either in the public interest or for reasons of public or personal safety. But without the clarity and direction afforded by a protocol or guidelines the judgement call about this is left to practitioners which is, in Nacro’s opinion, insufficient. It is also likely that such exchanges of information will not be formally recorded or justified.

5. Schemes should make sure that their contact details and information about schemes are widely disseminated so as to increase awareness of the service provided.

6. All schemes should link in with County-wide MDO groups and strategic arrangements for mental healthcare in their area and should have access to mainstream mental healthcare provision.

7. Schemes should collect data, broken down by gender, age and ethnicity, to identify need in order to improve the services the scheme offers.

8. Nacro carries out some local development work, for example, we are currently working with the Warrington Criminal Justice Liaison Team to review their operations. However, more schemes would benefit from a review of some kind as the overall picture nationally has not been evaluated. An evaluation of the overall effectiveness of Court diversion/Criminal Justice Liaison Mental Health Schemes in England and Wales should be commissioned.

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Information Sharing Challenges and opportunities: A guide to sharing confidential information concerning mentally disordered offenders is available from Nacro’s Publications department 020 7840 6427 or see [http://www.nacro.org.uk/publications/mentalhealth.htm](http://www.nacro.org.uk/publications/mentalhealth.htm)
Nacro’s Mental Health Unit aims to improve responses to mentally disordered offenders (MDOs) and to reduce levels of offending by providing a co-ordinated range of development, information and consultancy services to the various agencies that are involved in providing services for offenders with mental health needs across the criminal justice, health and social care sectors. The key aim is to help them to develop effective policy and practice. Should you require any further information or if you have any comments on this survey, please contact Lucy Smith on 020 7840 6718 or email lucy.smith@nacro.org.uk.
Appendix 1

SURVEY OF LIAISON/ASSESSMENT & DIVERSION SCHEMES

Please note that this is an abridged version of the actual survey questionnaire.

PART A Contact Details

PART B Operational Procedures

What type of scheme are you running?
Which locations does your scheme cover?
Who is your scheme funded by?
Has the level of funding changed in the last year?
Staff make-up of the scheme (including gender breakdown)
Has the total staff complement changed in the last year?
Do you have sessional input from psychologists or psychiatrists?
What are the operational hours of the scheme?
Have the operational hours of the scheme changed in the last year?
Is your scheme proactive (do you screen ALL people held at the courts/police station)
or reactive (do you only screen people who are referred to you?)?
How long does it take to complete the assessment process?

PART C Data Collection

Do you collect statistics annually?
What do you collect statistics on?
Which year is the most recent year you have statistics for?
Total number of mental health assessments carried out for that year.
Where do these figures go?
What, if any, are the barriers to your scheme diverting people from custody?

PART D Steering Groups and agreed policy

Is there a steering group for your scheme?
Name of steering group
Please give contact details for the steering group
What agreed policies does your scheme have in place with other agencies?
Where is your designated “place of safety” under s136 of the Mental Health Act, 1983?
Has your scheme been evaluated externally?
If yes, by whom?
Is there an opportunity for people using the scheme to provide feedback and/or make
a complaint?
Do you seek views from service users on the running of your scheme?
Would you be willing to participate in the forthcoming Department of Health/Home
Office evaluation?