

# Diversion

## A better way for criminal justice and mental health

© Sainsbury Centre for Mental Health 2009

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying or otherwise without the prior permission of the publisher.

ISBN13: 978 1 870480 78 9

### **Published by**

Sainsbury Centre for Mental Health

134-138 Borough High Street

London SE1 1LB

Tel: 020 7827 8300

Fax: 020 7827 8369

[www.scmh.org.uk](http://www.scmh.org.uk)

**Sainsbury Centre for Mental Health** works to improve the quality of life for people with mental health problems by influencing policy and practice in mental health and related services. We now focus on criminal justice and employment, with supporting work on broader mental health and public policy. Sainsbury Centre was founded in 1985 by the Gatsby Charitable Foundation, one of the Sainsbury Family Charitable Trusts, from which we receive core funding.

Charity registration no. 1091156

A company limited by guarantee registered in England and Wales no. 4373019

Design: [www.intertype.com](http://www.intertype.com)

Printing: Nuffield Press, UK



# Contents

	Acknowledgements	<b>4</b>
	Executive summary	<b>5</b>
<b>1:</b>	Introduction	<b>8</b>
<b>2:</b>	Evidence on outcomes and effectiveness	<b>12</b>
<b>3:</b>	Site visits	<b>23</b>
<b>4:</b>	Value for money	<b>33</b>
<b>5:</b>	Conclusions	<b>50</b>
<b>6:</b>	Recommendations	<b>52</b>
	References	<b>60</b>



# Acknowledgements

This report was written by Michael Parsonage, with support from Husnara Khanom, Max Rutherford, Mamta Sidhu and Chloe Smith. We are extremely grateful to Linda Bryant (Together), Lucy Smith (Nacro) and Mark Sergeant (Mersey Care NHS Trust) for expert advice.

We would like to thank all the diversion schemes that participated in our survey and the managers and practitioners who gave generously of their time.



# Executive summary

Many people in the criminal justice system have complex mental health and other needs which are poorly recognised and inadequately managed. Too many end up in prison, a high-cost intervention which is inappropriate as a setting for mental health care and is ineffective in reducing subsequent offending.

Mental health diversion schemes operate at the interface between criminal justice and mental health. They seek to ensure that people with mental health problems who come into contact with the police and courts are identified and directed towards appropriate mental health care, particularly as an alternative to imprisonment.

This report assesses the case for diversion for offenders with mental health problems from a value for money perspective. Reliable quantitative information on the performance of diversion schemes is in short supply. To assess the costs and benefits of diversion we undertook:

- A review of published evidence, including studies from other countries;
- Site visits to 16 diversion schemes in England;
- An analysis of value for money based on the evidence gathered.

The evidence we have collected indicates that well-designed arrangements for diversion have the potential to yield multiple benefits, including:

- Cost and efficiency savings within the criminal justice system;
- Reductions in re-offending;
- Improvements in mental health.

Taken together, these benefits constitute a powerful case for diversion on value for money grounds.

There is a particularly strong case for diverting offenders away from short sentences in prison towards effective treatment in the community. Diverting people towards effective community-based services will improve their mental health. It can also reduce the prevalence of other risk factors such as substance misuse and improve the effectiveness of interventions aimed at other influences on offending.

Even on conservative assumptions, it is estimated that this will lead to savings in crime-related costs of over £20,000 per case, including savings to the criminal justice system of up to £8,000 and benefits from reduced re-offending valued at around £16,000.

But existing arrangements seriously under-perform in delivering these benefits. In the absence of a clear national policy framework, diversion services have developed in a piecemeal and haphazard way. Many schemes are insecurely funded and there is an unacceptably wide degree of variation in their ways of working.

The coverage of schemes is patchy: some areas have no arrangements at all. Others have only minimal coverage. We estimate that just one-fifth of the potential national caseload is seen and even cases of

severe mental illness are often missed because many schemes rely on police or court staff to identify individuals who may need their support.

Many schemes take a modest view of their role. They focus on assessing people with mental health problems and signposting them towards appropriate services. They do not seek to influence decisions taken within the criminal justice system on charging, remand or sentencing. This is a missed opportunity.

Little is done to ensure that offenders who are signposted towards appropriate services effectively engage with them on a continuing basis. In the absence of assertive interventions, drop-out rates are likely to be high. This substantially reduces the benefits of diversion.

Significant change is needed in national policy and local delivery to improve value for money and to capture more of the undoubted benefits of diversion. We recommend:

- 1** A Diversion and Liaison Team for people with mental health problems who come into contact with the criminal justice system should be established in every primary care trust (PCT) area in England. These teams should be supported by a national statement of policy and associated implementation guidance.
- 2** Commissioners of diversion and liaison services should wherever possible consider the scope for using voluntary sector agencies.
- 3** The services to be provided by diversion and liaison teams to criminal justice agencies should always be specified in contracts or service-level agreements.
- 4** Every diversion and liaison team should be overseen by a cross-agency management group.
- 5** Diversion and liaison services should always be commissioned on the basis of joint funding from mental health and criminal justice budgets.
- 6** Diversion and liaison teams should be organised to support offenders with mental health problems at all stages of the criminal justice pathway.
- 7** The Government should consider setting up a small number of pilot projects to explore different models of pre-arrest diversion.
- 8** Diversion and liaison teams should extend the use of pro-active methods of identifying potential clients, including 100% screening of selected groups of offenders.
- 9** Diversion and liaison teams should work more closely with drug interventions programme teams in identifying potential clients.
- 10** The Government should consider the scope for improving the identification of mental illness by police officers, court officials and other criminal justice staff.
- 11** All diversion and liaison teams should develop and agree plans for the provision of training in mental health issues for criminal justice staff.
- 12** All diversion and liaison teams should provide recommendations as well as information to criminal justice agencies, in relation to decisions on charging, remand, sentencing and disposal.
- 13** All diversion and liaison teams should undertake outreach work as a core part of their business to ensure that their clients engage satisfactorily with local services.

- 14** Commissioners and managers of all community-based mental health services should ensure that a potential client's offending history does not act as a barrier to receipt of these services.
- 15** PCTs and other commissioners should actively explore the scope for using voluntary sector agencies to provide support for offenders with multiple 'sub-threshold' needs.
- 16** The Department of Health and PCTs should develop new methods of primary care support for offenders with complex needs and other similar groups.
- 17** In appropriate circumstances, criminal justice agencies should make greater use of conditionality in decisions relating to charging, remand and sentencing as a means of promoting engagement with mental health services by offenders.
- 18** More use should be made of the Mental Health Treatment Requirement as a sentencing option.
- 19** The Government should commission a programme of research studies on diversion and liaison, based on high-quality research methods, to improve our knowledge of effectiveness and cost-effectiveness.
- 20** The Government should collect and publish much more information on unit costs in the criminal justice system.
- 21** The Office for National Statistics should undertake one or more surveys of mental ill health among *all* offenders.



# Introduction

A high proportion of offenders have mental health needs. The criminal justice system is not always well placed to handle the complex problems that this can create. An important role at the interface between criminal justice and mental health is therefore assigned to diversion, loosely defined as a means of ensuring that people with mental health problems who enter the criminal justice system are identified and directed towards appropriate mental health care, particularly as an alternative to imprisonment.

This report provides an assessment of the current arrangements for diversion in England and Wales. Its perspective is analytical rather than descriptive, with a particular focus on value of money. The questions it addresses include:

- What do the current arrangements for diversion achieve in terms of outcomes and effectiveness?
- Do these benefits outweigh the costs of diversion?
- How can value for money be improved?

The findings of our analysis have been made available to the official review of diversion conducted by Lord Bradley, which was commissioned by the Secretary of State for Justice in December 2007 and reported to ministers early in 2009.

## What is meant by diversion?

There is no universally agreed definition of diversion and the term has come to be used in a number of different senses as schemes for diversion have developed and evolved over the last 20 years. A brief review of the concept may therefore be helpful, particularly as a means of clarifying the coverage and focus of this report.

First, a distinction may be drawn between diversion as an *outcome* and diversion as a *process*. Essentially this is a distinction between ends and means. Diversion in the former sense relates to an intended set of aims or objectives, for example reducing re-offending and improving mental health, while diversion in the latter sense refers to the activities and interventions which are used to achieve the desired objectives.

A further distinction is between diversion *away from* something and diversion *towards* something else. Diversion as an outcome is generally taken to mean diverting someone away from criminal activity and towards improved mental health and a better overall quality of life. Diversion as a process means diverting someone away from the criminal justice system or from prison and towards community-based mental health treatment and other support services.

Finally, there is a distinction between diversion *from* the criminal justice system and diversion *within* the criminal justice system. The initial focus of diversion schemes in this country was largely on taking prisoners with severe mental illness out of the criminal justice system altogether and into hospital.



However, only a minority of offenders with mental health problems are sufficiently ill to require hospital treatment and so increasing attention is now given to diversion within the criminal justice system, particularly from options which involve the use of custody to sentences which allow supporting mental health care to be provided to offenders in the community.

Schemes also play a wider role in offering support and liaison, both to offenders with mental health needs and to the agencies involved with them. This is to ensure that offenders are treated appropriately and effectively as they move through the criminal justice system. Schemes are therefore often described as diversion and liaison schemes. We regard liaison as a form of diversion, particularly in the outcome sense (i.e. steering people away from crime and towards better mental health) and the liaison role is covered throughout the analysis in this report.

### All-stages diversion

Drawing on this broad definition including liaison, it is clear that people can be diverted at *any* stage of their route through the criminal justice system. In order to capture this perspective, Sainsbury Centre has developed an all-stages model or framework for diversion, which provides an overview of the many different points at which people can be diverted during their ‘pathway’ through the criminal justice system (Sainsbury Centre, 2008a). The model, summarised in Figure 1 on page 11, is divided into three broad sections, with a total of seven stages. A more detailed version of the model is available on the Sainsbury Centre website ([www.scmh.org.uk](http://www.scmh.org.uk)).

### The focus of this report

The focus of this report is very largely on diversion at the key decision-making stages of the criminal justice system. These stages cover the critical steps after an offence has been committed, when a series of decisions are taken within the criminal justice system on charging, remand, sentencing and disposal. It is in this territory that mental health diversion and liaison schemes concentrate their efforts, working with the appropriate criminal justice agencies (the police, Crown Prosecution Service, the courts etc.) in order to strike an appropriate balance between the administration of justice and the meeting of mental health needs.

It should also be noted that the coverage of the analysis in this report is restricted to adults only, i.e. people aged 18 and over. It does not therefore deal with diversion for children and young people, on which Sainsbury Centre is currently conducting separate work in conjunction with the Department of Health and the Youth Justice Board.

### Research methods

A recurring theme of this report is that there is a serious shortage of reliable quantitative information on the workings of diversion schemes, particularly in relation to their outcomes, effectiveness and cost-effectiveness. As a further complication, there is a great deal of variation between schemes, for example in their size and composition, objectives and methods of working. In other words, there is no single, preferred model of diversion on which analysis can readily be brought to bear.

Faced with these problems, we decided to approach the analysis from a number of different angles. We undertook three separate but related strands of work:

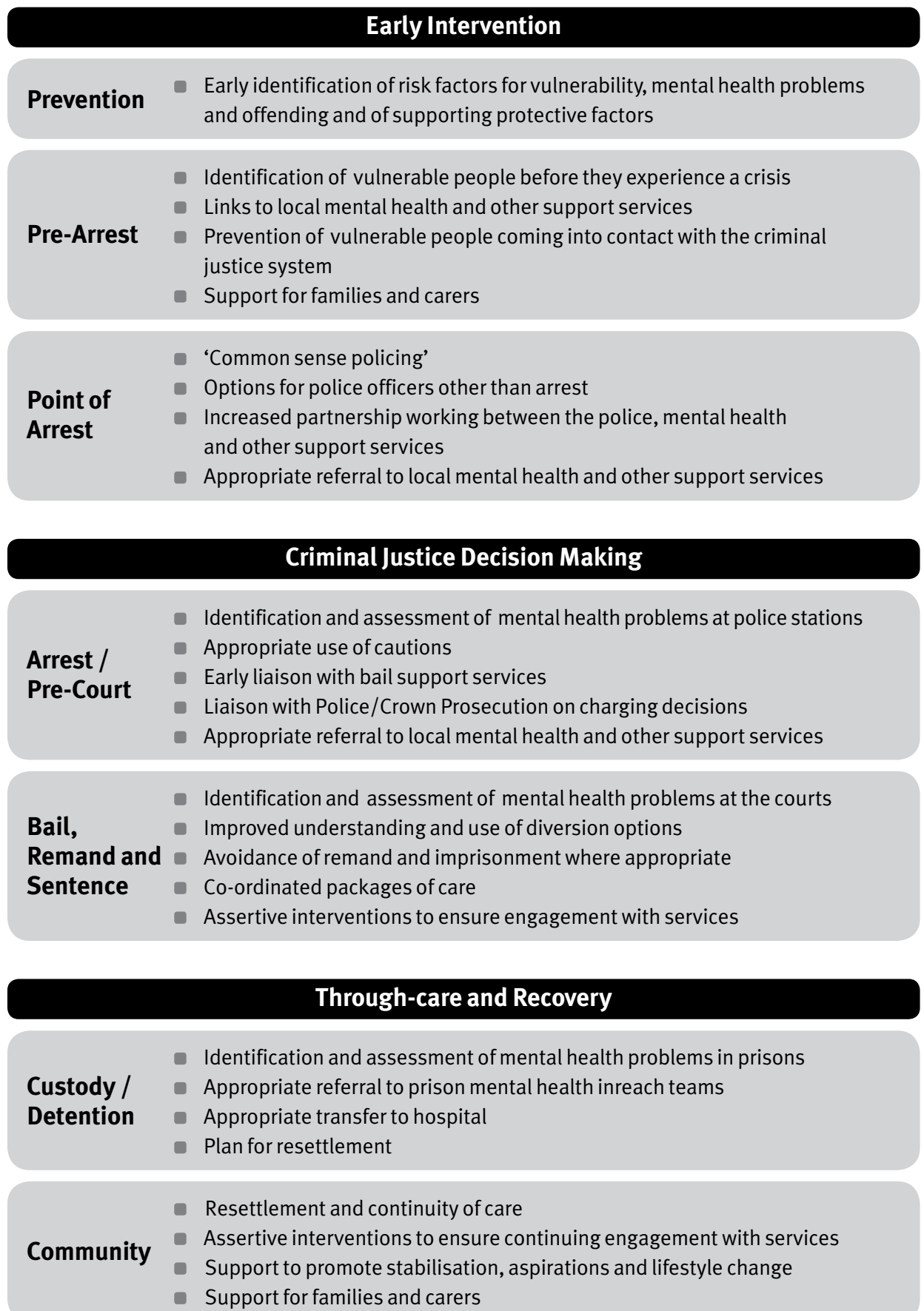
- A review of published evidence on diversion, including international studies as well as those relating specifically to this country;
- The collection of information directly from diversion schemes, based on site visits to a sample of 16 schemes around the country;
- An analysis of value for money based on costing, modelling and related techniques.

## The Bradley Review

Preliminary work on the analysis described in this report had already begun when the setting-up of Lord Bradley's review of diversion was announced at the end of 2007. Following this announcement, we spoke to Lord Bradley and his team at an early opportunity to inform them of the work we were undertaking and we have subsequently made available our findings as they have emerged. This report may therefore be seen both as an input to the Bradley review and as an independent analysis of diversion undertaken as part of Sainsbury Centre's criminal justice programme.

There are a number of major differences in scope and coverage between our review and Lord Bradley's. The Bradley review has explored diversion at all stages of the offender pathway, whereas our focus is on a restricted number of these stages. Lord Bradley's review covers diversion for children and young people as well as adults, whereas we look at adults only. The Bradley review also covers offenders with learning disabilities as well those with mental health problems. Finally, our report is an analysis of the case for diversion, with a particular focus on value for money, whereas Lord Bradley has been charged with making recommendations for national policy and practice.

Notwithstanding these differences, we very much hope that our report and Lord Bradley's will together contribute to wider public debate on the important issue of diversion for offenders with mental health problems and also to the development of the offender health and social care strategy being prepared by the Government for publication later this year.

**Figure 1: All-stages diversion model** (adapted from Sainsbury Centre, 2008a)



## Evidence on outcomes and effectiveness

There is now a sizeable international literature on the subject of diversion for offenders with mental health problems. One recent review lists over 500 published references, the majority relating to the US (Hartford *et al.*, 2004).

Much of this literature is relatively recent in origin, reflecting the fact that in most cases the development of organised schemes for diversion is itself a fairly new phenomenon. In the United States, for example, an important institutional innovation has been the development of dedicated mental health courts. There are now over 150 of these around the country, yet the first US mental health court only opened in 1997 and even by 2001 there were fewer than two dozen in existence. Similar developments can be observed in Canada and Australia, where mental health courts were introduced in 1998 and 1999 respectively.

In England and Wales, the first organised scheme for diversion was established as a pilot in 1989 and was followed by a fairly rapid albeit piecemeal expansion of such schemes in the early to mid 1990s, initially supported by joint Home Office and Department of Health funding.

In all these cases, the interest of policy makers, researchers and practitioners in diversion reflected a growing awareness and concern at the over-representation of people with mental health problems in the criminal justice system, particularly the rising numbers in prison where little or nothing was being done to address their health needs.

Published evidence about diversion has two major limitations. First, much of it is descriptive rather than evaluative: it focuses more on what diversion schemes do than on what they achieve, particularly in terms of longer-term outcomes and cost-effectiveness. There are relatively few studies which evaluate the impact of diversion schemes using high-quality research methods, ideally including such design features as the use of control groups, a longitudinal element, proper costings and quantified measures of outcomes.

Second, there is a great deal of variety in the way that diversion schemes operate, both between countries and within them. Diversion can apply at a number of different points in the criminal justice pathway. Yet even at specific points of intervention, such as decision making by the courts, schemes are highly diverse in their organisational form, scale, objectives, methods of operation and the groups they target. Such diversity inevitably makes it difficult to draw generalisable conclusions on what works, particularly when combined with the need to allow for contextual and institutional differences between countries when making international comparisons.

Subject to these limitations, this chapter looks at the published evidence on diversion, dealing first with the evidence from other countries (principally the United States, which accounts for the great bulk of the international literature) and second with studies relating to diversion in this country. It highlights key findings on outcomes, effectiveness and cost-effectiveness rather than providing descriptive accounts of individual schemes.

## International evidence

In the US stricter sentencing imposed since the mid-1980s has led to a huge increase in the overall size of the prison population, from 0.5 million in 1980 to over 2.3 million today, equivalent to more than 1 in 100 of all American adults (Aizenman, 2008). Between 6% and 15% of all prisoners have a severe mental illness (Lamb and Weinberger, 1998) and it is now more common for someone with such a condition to be found in prison than in a psychiatric hospital. This striking finding first came to national attention in a 1998 *New York Times* front-page story entitled ‘Prisons replace hospitals for the nation’s mentally ill’ (Butterfield, 1998).

People with severe mental illness are more likely to be imprisoned in the US than individuals without mental health problems for the same offences, and they are often held in prison for longer periods (Lamberti *et al.*, 2001). Their condition tends to worsen in prison because of poor treatment. Fewer than 15% of inmates who report mental illness receive any treatment at all (Ditton, 1999). On release they are often unable to access services in the community because of the reluctance of health care providers to take them on (Regan, 2001). Re-offending rates are high, with 49% of federal prisoners with severe mental illness having three or more prior arrests compared with 28% of those without mental illness (Ditton, 1999). There are repeated references in the literature to defendants with severe mental health problems going through a revolving door from street to court to cell and back again without ever receiving adequate care.

In response to this large and growing problem, recent years have seen a substantial surge in diversion programmes in the US, supported in part by federal funding. In nearly all cases the focus of these schemes is on people with severe mental illness (with or without co-occurring substance misuse) who have committed minor offences. The programmes include a variety of police-based pre-arrest or pre-booking schemes (diversion at initial contact with the police before formal charges are brought) and also court-based schemes mainly in the form of dedicated mental health courts (diversion after arrest and charging).

### Police schemes

It is estimated that about 7% of all police contacts in the US involve people with severe mental illness (Deane *et al.*, 1999) and that 16% of such contacts result in arrest (Sheridan and Teplin, 1981). The police typically face two main problems in handling these contacts. They lack knowledge about mental illness and effective interventions, and there is a lack of communication with mental health service providers.

Various models have been developed to address these difficulties. They include a crisis intervention team (CIT) model, first implemented in Memphis, Tennessee, in which volunteering police officers receive special training in mental health issues. Other models involve partnerships between law enforcement and mental health workers, such as the psychiatric emergency response team (PERT) or mobile crisis team (MCT) model. In these, outreach teams consisting of specially trained police officers and mental health professionals work together in crisis situations. There is also a community service officer (CSO) model, in which social workers are employed as civilian police employees and work alongside regular police officers in responding to possible mental health emergencies.

These various police-based models have not been compared in controlled studies, but one survey reported higher levels of perceived effectiveness among police officers using the CIT approach

compared with other models (Borum *et al.*, 1998). Another study looked at arrest and referral rates at three sites, each of which was using a different model (Steadman *et al.*, 2000), and reported that:

- All three models resulted in arrest rates for people with severe mental illness coming into contact with the police that were lower than the national average figure of 16%.
- The lowest rate of arrest was achieved by the CIT model (2%, compared with 5% for the CSO model and 13% for the MCT model).
- The CIT model also resulted in more cases of people with severe mental illness being taken to a treatment location (75%, compared with 20% and 40% for the other models). This higher rate of referral was attributed in part to the existence in the CIT site of a mental health emergency facility which operated a 'no refusal' policy for police cases.

Some evidence on longer-term outcomes is provided in a multi-site study of diversion which included three pre-arrest schemes as well as a number of court-based programmes (Steadman and Naples, 2005). The study measured outcomes after three and twelve months for 635 individuals who were diverted by the various schemes and also for 625 people with severe mental illness identified at the same point in the criminal justice process who were not diverted.

It showed that people who were diverted spent more days in the community (i.e. not in prison or other institution) during the 12-month follow-up period, had lower re-arrest rates, made more use of a range of community-based mental health services and also scored better on an index of psychological symptoms than those who were not diverted. These findings are positive but should not be over-interpreted, as the differences in outcomes were in some cases relatively small and may also partly reflect differences in the characteristics of the diverted and non-diverted groups that were not fully allowed for in the study.

## **Court-based schemes**

Court-based diversion schemes have expanded considerably in the US in recent years. This is mainly through the proliferation of specialist mental health courts, which are now the dominant diversion model in most American states. These courts are part of a wider movement of 'therapeutic jurisprudence', aimed at reducing arrests and imprisonment by addressing the psychosocial needs of specific groups of offenders, and their introduction has followed the widespread adoption of drug courts in the US during the 1980s.

In the absence of a national blueprint for good practice, mental health courts differ considerably in terms of eligibility criteria, methods of resolving criminal charges and sanctions for non-compliance. But all of these courts and other court-based diversion schemes can be characterised as performing a number of common functions, including:

- The screening and assessment of detainees;
- A negotiation for community-based treatment as an alternative to further involvement in the criminal justice system;
- Referral to local services.

This section summarises findings from the relatively limited number of research studies that have sought to evaluate the impact and effectiveness of court diversion programmes using quantified outcome measures.

The Broward Mental Health Court in Florida was one of the first mental health courts to be set up in the US. An early evaluation examined its effects on the use of mental health services, based on a

comparison with service use by a matched group of defendants with mental health problems tried in a traditional court (Boothroyd *et al.*, 2003). Among the 121 defendants whose cases were heard in the mental health court, the proportion using services increased significantly during an 8-month follow-up period (from 36% in the eight months before their court appearance to 53% afterwards). By contrast, the likelihood of service use among the sample of 101 defendants in the comparison group remained virtually unchanged (28% pre-court appearance, 29% post-court appearance). Defendants in ordinary courts were 50% more likely to stop receiving treatment after their court appearance relative to defendants in the mental health court. The study also found that, among those getting treatment, the volume of services received increased on average by 62% following a mental health court appearance but decreased by 18% among those served by the traditional court.

Involvement with the mental health court thus increased the likelihood of engagement in the mental health treatment system and led to higher levels of service use. Yet a sizeable minority of those using the mental health court failed to engage with services despite a directive to do so. This finding was attributed partly to the non-coercive nature of the court, including an absence of sanctions for non-compliance with its directives, and also to the limited availability of local services.

Two mental health courts were set up in Seattle in 1999 and a study published in 2003 has described some early indicators of effectiveness, covering not only the use of mental health services but also some quantitative measures relating to recidivism such as re-arrest rates and time spent in prison (Trupin and Richards, 2003). Information was collected pre- and post-court appearance for a sample of 96 defendants who used the mental health courts and also for a comparison group of 128 defendants who opted out. The findings were generally positive, with the estimated effects on relevant criminal justice and mental health indicators of effectiveness being described as “medium or medium to large in magnitude” in most cases. In particular, “evidence for increased treatment referral and engagement was unequivocal”, with the linkage to services reaching around 90% among defendants using the mental health courts compared with 54% among those who opted out. Weaknesses of the study include relatively small sample sizes and also a degree of non-comparability between the opted-in and opted-out groups; in particular, the latter tended to have committed less serious offences and may therefore have been facing less severe sanctions if convicted after a trial.

A study published in 2005 examined re-arrest rates and linkages to mental health services among 368 offenders with severe mental illness who were served by a mental health court in Clark County, Washington, established in 2000 (Herinckx *et al.*, 2005). It used a ‘before and after’ study design, with data on outcomes being collected for 12 months before enrolment in the court and 12 months afterwards. It found that the number of participants who committed crimes fell by 46% in the year after their court appearance. The total number of crimes committed fell by 75% and the number of probation violations fell by 62%. These are clearly substantial reductions, but in the absence of comparable data for a matched control group it is not possible to say with any certainty how much of the change was directly attributable to the diversion programme, particularly as the study found that the likelihood of re-arrest was not significantly associated with increased intensity of mental health service use.

A mental health court was opened in Brooklyn, New York, in 2002 and outcomes were evaluated for a small sample of 37 early participants (O’Keefe, 2006) using a 12-month ‘before and after’ design. Information was collected on a wide range of outcomes, including recidivism, homelessness, psychiatric hospitalisation, substance misuse and psychosocial functioning. Improvements were reported in all of these areas, including:



- The number of participants arrested at least once fell by 41% comparing the 12 month periods before and after enrolment;
- The average number of days spent homeless fell from 60 to 35;
- The proportion of participants admitted to a psychiatric hospital fell from 50% to 19% (viewed positively as a sign that participants were actively engaged in community-based treatment).

The study also noted “dramatic decreases in drug and alcohol use” and improvements in “psychosocial functioning”. Again, these positive findings need to be interpreted with caution because of limitations in study design, in particular small sample size and absence of a control group for comparison.

A study published in 2005 examined the efficacy of a mental health court in California which diverts participants to treatment in the community using an assertive outreach model of case management (Cosden *et al.*, 2005). A total of 235 people were randomly assigned either to this model or to ‘treatment as usual’ (i.e. adversarial court proceedings followed by standard care as offered by the local mental health services) and assessed over a two-year period. It found that for some offenders, particularly those with serious drug and alcohol problems as well as mental illness, neither method of treatment was found to be effective. A majority in both groups averaged fewer days in prison, made more use of mental health services and demonstrated improvements in psychosocial functioning after entering treatment than before. But those participating in the mental health court supported by assertive outreach showed greater improvements in most outcomes.

A multi-site study including three US court-based diversion programmes (Steadman and Naples, 2005) collected data on a range of outcomes after three and twelve months for a large sample of individuals who were diverted and for a comparison group who were not diverted. The combined results for the three court-based programmes show that those individuals who were diverted had lower re-arrest rates during the 12-month follow-up period, spent more days in the community and made more use of a range of mental health services. There was, however, no difference in evidence of psychological symptoms after 12 months between the diverted and non-diverted groups.

The same study also collected some information on costs (Cowell, Broner and Dupont, 2004). It provides an insight into whether diversion is not only effective but also cost-effective. It collected data on criminal justice costs (prisons, courts etc.) and on mental health service costs (psychiatric hospitals, community-based mental health teams etc.). For each of the three court-based diversion programmes it found that criminal justice costs, particularly prison costs, were lower per head among the diverted group than among those who were not diverted, and conversely that mental health service costs were higher. In two of the three sites, these cost differences more or less exactly offset each other, with the result that total costs were broadly the same for diverted and non-diverted participants. In the third it was found that diversion led to a net cost saving, because of a particularly large fall in prison costs. Combined with the evidence on outcomes for the same three schemes, this suggests a positive conclusion on cost-effectiveness, as diversion was found to be cost-neutral or cost-saving compared with non-diversion, while outcomes were on balance clearly better.

Some further evidence on the cost impact of diversion is provided in a recent study of a mental health court in Allegheny County, Pennsylvania (Ridgely *et al.*, 2007). This followed up a sample of 365 diverted offenders for one year and a smaller sub-sample for two years and carried out cost comparisons both on a ‘before and after’ basis and with a hypothetical control group. It found that diversion was broadly cost-neutral after one year, with higher spending on mental health services being offset by lower prison costs. However, it also found that after two years diversion became significantly cost-saving, as continuing reductions in prison costs were now found to be accompanied



by lower spending on mental health services, particularly hospital inpatient care. Subject to some weaknesses in the research design, this study confirms a positive verdict on cost-effectiveness, with the further possibility that the economic case for diversion is stronger, the longer the time period over which it is assessed.

In addition to these studies of court-based diversion schemes in the United States, we found one published study from Australia which includes information on outcomes (Skrzypiec, Wundersitz and McRostie, 2004). It relates to a mental health court in Adelaide that commenced operation in 1999. The study examined changes in offending behaviour, using a 'before and after' design. It found that offending fell substantially over a one-year period after participation in the mental health court compared with a similar period pre-enrolment. In the year before enrolment, the 157 participants in the study committed a total of 348 offences. In the following year the number of offences fell to 116. About two-thirds of participants did not offend at all in the post-enrolment period, while the number committing three or more offences fell from 31% in the pre-enrolment year to 9% in the subsequent year. The biggest fall in the numbers offending was among those who had previously committed the most serious offences. No information is provided on mental health-related outcomes in this study and the lack of a control group for comparison means that its evidence on reduced offending should be regarded as mainly indicative.

## Evidence from England and Wales

The first organised scheme for diversion in England and Wales was implemented as a pilot in 1989. Following the 1992 Reed review of health and social care for mentally disordered offenders (Department of Health and Home Office, 1992) and associated Home Office guidance (Home Office, 1990 and 1995), there was a substantial expansion of such services. Ten years later, about 150 diversion programmes were in existence around the country.

Most of these schemes were set up in magistrates' courts, but some based their operations in police stations. The earliest schemes tended to be led by psychiatrists. They focused mainly on identifying cases of severe mental illness among those coming into contact with the criminal justice system and bringing about their transfer to psychiatric hospitals. However, as only a relatively small proportion of offenders with mental health problems were found to be sufficiently ill to require admission to hospital, many schemes came to focus more on a liaison function, signposting people to mental health and other services in the community (and in prisons). Over time, this has become the predominant form of activity for most schemes, and, as an associated change, an increasing number are now led by nurses rather than psychiatrists.

### Form and function of diversion schemes

The workings of these schemes have been described and reviewed in a number of studies, including periodic surveys by Nacro, and also in a recent audit of schemes using a checklist developed for the Department of Health and Ministry of Justice by researchers at Portsmouth University (Pakes and Winstone, 2006). It is clear from those studies that, despite the expansion of schemes since 1989, coverage remains well short of the nationwide network recommended by the Reed report. Of the 47 prisons in England and Wales that take unsentenced prisoners, less than one-fifth have court diversion schemes covering all the courts they serve (Birmingham, 2001). In a recent review of NHS commissioning only 2 out of 23 primary care trusts surveyed knew about diversion schemes in their area (HM Inspectorate of Prisons, 2007).

Many schemes are small-scale and insecurely funded. For example, Nacro's most recent survey found that well under half of all schemes had three or more members of staff and nearly a third were operating with either one worker or less than one whole time equivalent, usually a community psychiatric nurse (Nacro, 2005). Only about half of all schemes had any input from a psychiatrist. A quarter of schemes said they had seen a decrease in staffing levels in the previous year, often as a result of reductions in funding.

In the absence of a clear national policy framework or blueprint for diversion and liaison services, schemes have developed very much from the bottom up, driven by local needs, circumstances and interests. This has resulted in a high degree of diversity in their structures, methods of working and management systems. A 2005 government-commissioned review found that: "the majority of the schemes did not have clear aims, objectives and targets and there was no performance management of the schemes" (Centre for Public Innovation, 2005). The main focus tends to be on meeting practical needs on a case by case basis, with success being heavily dependent on the energy and commitment of the individual professionals involved.

Successful diversion is increasingly hampered by difficulties in access to NHS beds. The number of people admitted to hospital for treatment from the courts fell by 44% between 1993 and 2004 (HM Inspectorate of Prisons, 2007). In Nacro's most recent survey, 72% of those responding cited lack of beds as a barrier to their scheme operating successfully (Nacro, 2005). Links with community-based services are also variable. One survey found that, while some schemes had clear pathways identified for referral, the majority had poor or weak integration with local mental health services (Centre for Public Innovation, 2005).

## **Evidence of outcomes and effectiveness**

Most diversion schemes collect some statistics relating to their caseload and activity, but there is no standard minimum data set in operation across the country. Routinely collected information on outcomes and effectiveness is largely non-existent and in consequence all schemes find it difficult to evaluate their success.

Evaluation is further hindered by a shortage of research findings derived from well-conducted studies. This section summarises the results from those studies which have been undertaken in relation to three areas of potential success for diversion and liaison services.

### **1 Improvements in the identification of mental illness among people coming into contact with the criminal justice system**

Earlier and better identification of mental illness is an important objective of all diversion and liaison schemes. Ideally this would be achieved by assessing all individuals coming through the criminal justice system. This is rarely possible in practice because of resource constraints. Many schemes operate on a reactive basis, relying on referrals made by non-medical personnel, usually police or court staff. This entails two risks: that those responsible for making the referrals identify mental illness where it does not exist ('false positives'), and that they fail to identify mental illness where it does exist ('false negatives').

The limited available evidence on false positives indicates a broadly acceptable range of figures. A study of a police-based scheme in London found that 90% of all referrals were correctly identified as having serious mental illness (James, 2000). In another police-based scheme, in Birmingham, the corresponding figure was 85% (Riordan *et al.*, 2000). A study of a court-based scheme in Sussex found that 70% of referrals merited a clinical diagnosis (Kingham and Corfe, 2005).

Evidence on the more serious problem of false negatives is also limited but it is less encouraging. A study of a court diversion scheme in Manchester found that only 14 of 96 defendants from overnight custody with serious mental illness were detected by court staff and referred to the diversion programme (Shaw *et al.*, 1999). The relatively low rates of referral reported by some schemes, sometimes related to their small scale of operation, suggest that significant numbers of people with mental health problems are not being identified for one reason or another. The number of individuals referred to a Birmingham police scheme represented only 0.6% of total arrests over the study period (Riordan *et al.*, 2000). This is less than half the prevalence rate for serious mental illness among those arrested by the police as reported in other studies (Robertson, Pearson and Gibb, 1996).

Some studies report more positive evidence on identification. There was a four-fold increase in compulsory admissions to psychiatric hospital from one court after the introduction of a diversion scheme, attributed to better identification (James and Hamilton, 1991). Of those compulsorily admitted to hospital through another court scheme after a period on remand, 39% had not been recognised as ill at the remand prison (Hudson, James and Harlow, 1995).

Improvements in identifying mental ill health have come about through the greater use of screening procedures by diversion schemes, usually by examining files for identifying markers such as previous contact with mental health services. Better identification can also result from allowing referrals from multiple sources, including self-referral, and from introducing diversion schemes at multiple points in the criminal justice system, most obviously at police stations as well as courts. Where this has been done, it has been found that a police-based service can identify seriously ill people who would otherwise be returned uncharged to the community and would not therefore have received an assessment by a court scheme (James, 2000). This study suggested that intervening at this early stage could have a preventive impact on further offending.

## **2 Improvements in the criminal justice process for offenders with mental health problems, such as quicker handling of cases**

There are various ways in which diversion and liaison schemes can support criminal justice agencies and improve the general efficiency of the criminal justice system, including:

- Increasing awareness of mental health issues among criminal justice staff;
- Reducing the risk of dangerous or disruptive behaviour in custody through the correct or earlier identification of mental health problems among prisoners;
- Reducing the use of remand, for example by speeding up the transfer of severely ill prisoners to hospital or helping those with less serious mental health needs to remain in the community on bail;
- Reducing delays in the provision of psychiatric assessments;
- Reducing the need for unnecessary formal psychiatric court reports. This may in turn reduce the need for unnecessary remands in custody, which often arise because the court is waiting for a psychiatric report;
- Facilitating non-custodial sentences for offenders with mental health needs in appropriate cases, thereby reducing the demand for prison places.

Little research evidence is available on the scale of these potential benefits. The main exception is in relation to the use of remand. Various studies have compared samples of cases admitted to hospital through court diversion schemes with those that arrived through remand prison assessment (James and Hamilton, 1991; Joseph and Potter, 1993; Exworthy and Parrott, 1993; Pierzchniak, Purchase and Kennedy, 1997). These studies show similar results, with time from arrest to hospital admission being

reduced substantially for those seen by diversion schemes, from around seven weeks to just one week on average.

Two pilot projects (in West London and in the South West of England) to establish service-level agreements between the courts and the NHS on the provision of mental health services are currently in progress. Both focus on the provision of psychiatric advice to the courts. They aim to speed up court procedures and reduce the amount of time that defendants with mental health problems are remanded in custody. A baseline study for the pilot in the South West (Hean, Warr and Staddon, 2008) has shown that:

- It currently takes eight weeks on average for a full psychiatric report to be prepared;
- Nearly all requests for reports result in at least one court adjournment (and sometimes up to five adjournments);
- Half of defendants are kept in custody awaiting reports, even though only about a third subsequently receive a custodial sentence.

### **3 Improvements in longer-term outcomes, particularly in terms of better mental health and reduced re-offending**

Few studies have sought to assess the longer-term outcomes of diversion and liaison schemes in this country. Most of these suffer from weaknesses in research design, such as small sample size, limited coverage of outcome measures and absence of a control group for comparison purposes.

An early study followed up 65 offenders admitted to hospital through a court diversion scheme. It found that 23% had derived no mental health benefit from their admission (often because they absconded), 32% derived “some benefit” and 45% “benefited markedly” (Joseph and Potter, 1993). Those who did not respond well to treatment tended to be those who had higher rates of criminality and a previous compulsory admission to hospital.

Another early study of court diversion conducted a 12-month follow-up of 82 diverted individuals, including 21 who had been admitted to hospital (Rowlands *et al.*, 1996). It found that 38% gained no benefit from intervention at court, either because they absconded from hospital or because they did not keep out-patient appointments. Those who were admitted to hospital tended to benefit more than those who were not. Re-offending occurred in 18% of cases.

One study followed up 65 offenders at six months after diversion into the community and 22 at one year (Chung *et al.*, 1998 and 1999). The quality of life of these individuals was found to be significantly lower than that of the general population and there was little change in their psychiatric condition. Contact with health professionals fell substantially over time. Even after six months the numbers in contact with their GP had fallen by half and those consulting hospital doctors by over two-thirds. It was suggested that this reduction in seeking professional help was more the result of transient lifestyles than of any improvement in mental health.

Loss of contact with mental health services was also examined in a study which followed up a small sample of offenders seen by a court diversion scheme in Manchester (Shaw *et al.*, 2001). Half of the sample were diverted to hospital inpatient care from the courts and of these at least one-third had lost contact with psychiatric services at 12 months follow-up. The other half were referred from the courts to psychiatric community teams or hospital outpatient clinics, but less than one-third attended their first appointment and of these almost one-third had become disengaged from services within 12 months. These rates of attendance are much worse than the corresponding rates for GP referrals

among the general population. The study suggested that more effective outreach services are needed to help people with serious mental illness to engage with services following a court appearance.

Some adverse findings are also reported in a follow-up study of 232 individuals who underwent assessment by a court-based criminal justice mental health team in 2001/02 (Green, Smith and South, 2005). Many of the sample were found at their assessment to have substance misuse problems, to be homeless and to have a history of psychiatric contact. But for most, their mental health problems were not of sufficient severity to merit diversion to hospital. Only a minority (20%) were assessed as having severe mental illness.

The study mapped service contact, housing and offending in the 12 months following assessment and compared this to the 12 months prior to assessment. It found increased levels of service contact but also increased levels of offending and no decrease in homelessness. Particularly for those with minor mental health problems, intervention by the court-based team appeared to bring few benefits, partly because local services were limited in what they could offer this group and also because engagement with services was hampered by the chaotic lifestyles of many clients.

Finally, a comprehensive study of hospital diversion, funded by the Home Office, compared outcomes for a sample of 214 cases admitted to hospital through court diversion schemes with those for a matched sample of 214 compulsory admissions from the general population under the Mental Health Act (James *et al.*, 2002). The main findings were strongly positive. In particular, the diverted group:

- Were just as likely as the comparison group to complete their admissions;
- Had similar lengths of stay in hospital;
- Were no more likely to be violent or to engage in substance misuse in hospital;
- Achieved a similar improvement in mental health by the time of discharge;
- Were not re-admitted any more quickly.

The diverted group were more likely than the comparison group to be convicted in a two-year period after discharge, but there were nevertheless significant reductions in numbers of convictions during this period compared with the two years before admission. The re-conviction rate among the diverted group in the two years after discharge was only 28%, compared with general re-conviction rates, at the time of this study, of 56% among discharged prisoners and 58% among offenders placed on community penalties (James *et al.*, 2002).

## Conclusions

Published evidence on the effectiveness of diversion for offenders with mental health problems is limited in quantity and quality.

The diversity of schemes in this country and elsewhere further reduces the scope for clear-cut conclusions.

However, evidence from other countries (mainly the US) suggests that both police-based and court-based diversion schemes can improve outcomes for offenders who have a severe mental illness.

These improvements cover a range of outcomes, including better mental health and reduced re-offending. There is no evidence that diversion results in any increased risk to public safety: diversion schemes focus largely on people who have committed relatively minor offences and international evidence shows that re-offending either remains the same or is reduced as a result of diversion.

There is some evidence that diversion is cost-saving, particularly over the medium and longer term. Combined with the evidence on outcomes, this implies that well-designed programmes provide good value for money.

The largest and best-designed research study undertaken in the UK (James *et al.*, 2002) also gives a positive verdict on diversion for those with severe mental illness.

There is as yet insufficient evidence to support any firm conclusions on the impact of diversion and liaison services on mental health and re-offending outcomes for people with mild to moderate mental health problems.

A key determinant of success among all groups is that schemes ensure continuing engagement with local services. Assertive interventions may be needed to achieve this, given the multiple needs and chaotic lifestyles of many clients.



## Site visits

To supplement our review of published literature, we undertook a series of visits to diversion and liaison schemes around the country during the summer of 2008. We collected information on 16 schemes in all, based partly on semi-structured interviews with scheme managers and partly on written reports, statistical returns, observations and other relevant material provided by the schemes.

The purpose of this exercise was primarily to focus on the schemes' potential impact, effectiveness and outcomes. For this reason, the schemes we visited were not a random sample but were specifically chosen, on the basis of advice from Nacro and other experts, as leading examples of established schemes with potentially good data. We asked scheme managers not just about what their services were doing in terms of processes and activities but also about what they thought they achieved in terms of specific benefits and improvements, quantified wherever possible.

Given the well-documented limitations of information systems in this area, we did not expect to make any major progress in the quantitative assessment of effectiveness, particularly for longer-term outcomes. Much useful information was nevertheless collected and the main findings from our site visits are summarised in this chapter. Where relevant quantitative information was obtained, use is made of this in Chapter 4.

We are extremely grateful to all the schemes which agreed to participate in our survey (none refused) and to the individual scheme managers and practitioners who gave generously of their time in the interviews and in dealing with other requests. We were strongly impressed by the professionalism, expertise and commitment of all those we met.

### Overview of the schemes

Eleven of the 16 schemes in our sample were court-based, three were based at police stations and two provided an integrated service at more than one point within the criminal justice system. Thirteen schemes were run by the statutory sector and three by the voluntary sector. Of the statutory sector schemes, six were provided by forensic psychiatric services (specialist teams working with offenders with severe mental health problems). Ten schemes were wholly funded by the NHS, one by social services, one jointly by the NHS and social services and four received some funding from criminal justice agencies.

### Staffing

The schemes varied in size from 0.5 to 6.0 whole time equivalent front-line workers. Staffing was largely provided by mental health nurses and – to a lesser extent – social workers. Few of the schemes had any dedicated input from psychiatrists, though a larger number did have access when necessary. The average number of cases handled by the schemes was in the range of 150 to 250 a year per full-time worker.



## Client characteristics

Clients seen by the schemes were predominantly young men, usually single, unemployed, reliant on state benefits and with a previous criminal record. Many were also insecurely housed and with drug or alcohol as well as mental health problems. In short, they are people with multiple needs. The proportion with severe mental illness was generally in the range of 10% to 25%. This implies that a significant proportion of a typical scheme's caseload is comprised of people with mental illness of insufficient severity to guarantee access to the specialist mental health services provided by the NHS. Dealing effectively with these 'sub-threshold' cases was seen by many schemes as a particular challenge.

Partly because of the relatively low numbers of clients with severe mental illness, the predominant activities of all the schemes we visited were assessment and liaison, rather than diversion in a narrow sense. A number expressed the view that offenders with mental health problems, unless very seriously ill, should go through the criminal justice system like everybody else and face the consequences of their actions. The team's role was to ensure that offenders received appropriate mental health care along the way, as they progressed through the system.

## Reputation among criminal justice and mental health agencies

All of the schemes we visited seemed to be highly valued and respected by the criminal justice agencies with which they worked. One scheme mentioned that their impact was somewhat dependent on the whim of the court clerk, which meant that they often faced barriers when for example requesting adjournments. This was, however, very much the exception. In other cases, we were told that the setting-up of a scheme had initially been met with suspicion by some police or court staff but that these concerns quickly dissipated once the scheme was actively working.

By contrast, a number of NHS-led schemes commented adversely on a lack of acknowledgement or support from the mental health trust where they were employed or based. Little interest seemed to be shown in what the schemes were doing or how well, leading to a sense of neglect and isolation. Such concerns were compounded in many cases by uncertainty over future funding.

## Variation between schemes

Finally, even on the basis of a non-random sample of 16 schemes, it is hard not to be struck by the extent of diversity between schemes. This variety is apparent not just in structural characteristics such as size of scheme and organisational form but in outputs as well. For example, two of the court-based schemes we visited were broadly similar in size, each carrying out about a thousand assessments a year with roughly equal numbers being assessed as having severe mental illness, yet in one case 5.6% of clients were diverted to hospital while in the other only 0.5% were diverted, a more than ten-fold difference. Further investigation would be needed to explore the possible reasons for this difference.

## Efficiency benefits in the criminal justice system

Diversion and liaison schemes operate at the interface between two highly complex systems: criminal justice and mental health. The two systems work on the basis of very different aims, imperatives and constraints. It is all too easy for the requirements and processes of one system to create problems for the other when they come into contact. These problems are compounded by widespread lack of knowledge in each system about the workings of the other and by the sheer multiplicity of



organisations involved in the two systems combined. One scheme told us that they are in regular contact with at least 35 separate agencies in their daily work.

Operating at the interface, diversion and liaison schemes can improve the efficiency of processes in both systems. While not their primary objective, this is certainly an important by-product and one which should always be taken into account in any consideration of value for money. It also has implications for the optimal design of schemes and for their funding.

The greatest scope for realising efficiency savings appears to be within the criminal justice system. But there may also be opportunities for benefit in the NHS. The assessments carried out by diversion and liaison schemes may, for example, serve to reduce the number of unnecessary or inappropriate referrals to NHS providers, including for assessments relating to admission to hospital under the Mental Health Act. Schemes may also improve performance in the NHS by providing a means of re-engaging people who have lost contact with services and by helping to get into treatment for the first time those needing care who might otherwise be hard to engage.

## **Police-based diversion schemes**

The managers of diversion and liaison schemes based at police stations identified the main areas of benefit they could bring to the criminal justice system:

### **1 Charging decisions**

The assessments carried out by schemes may influence the decisions taken by the police and Crown Prosecution Service on whether or not to charge people. Where it is decided not to charge, this will clearly reduce the number of people proceeding through the criminal justice system, with associated savings in the courts and elsewhere.

### **2 Mental health reports**

Where people are charged, the mental health reports written by schemes can provide information which is relevant to decisions taken later on in the criminal justice process. Information can be provided on the availability of local mental health and other services which may influence decisions on the granting of bail by the courts, in turn leading to possible reductions in the use of remand.

### **3 Mental Health Act assessments**

For people who are seriously ill and require a Mental Health Act assessment, schemes can significantly speed up the process of admission to hospital and so reduce the amount of time spent in custody awaiting transfer. One scheme told us that they are able to get people sectioned on the same day.

### **4 Formal psychiatric reports**

Schemes can initiate the process of commissioning formal psychiatric reports, where it is clear that these will be required in due course by the courts. This again will speed up procedures within the criminal justice system, as the provision of psychiatric reports is a common cause of delay.

### **5 Information and advice**

The information and advice provided by schemes can lead to improvements in the management of offenders in custody suites. Schemes also provide a means of rapid access to information from other agencies, which can save the police time and help them in a variety of tasks including risk assessment.

### **6 Reduced arrest rates**

Schemes can help to reduce the number of arrests made by the police, for example by providing an early link to treatment for minor offenders. This can result in reduced re-offending. Training for police

officers in mental health issues also tends, as US evidence has shown, to result in lower arrest rates (Steadman *et al.*, 2000). Training may also help police officers in approaching people at risk of suicide.

## **7 Reduced use of police custody**

Linking clients to mental health services early on may serve to reduce repeat use of Section 136 of the Mental Health Act, which covers police powers and responsibilities to provide a place of safety in crisis or emergency situations for people with severe mental illness.

## **Court-based schemes**

The managers of court-based schemes identified the main areas of efficiency improvement they could provide within the criminal justice system:

### **1 Prosecution decisions**

The mental health reports prepared by schemes can influence the decisions taken by the Crown Prosecution Service on whether or not to continue with a prosecution.

### **2 Bail**

Schemes can influence the decisions taken by courts on the granting of bail. This may be achieved by providing risk assessments, by initiating contact with bail hostels and arranging placements, by advising the courts on the availability of support services in the community and by arranging links to the relevant agencies. Where bail is granted, the amount of time that defendants spend in custody on remand will be reduced.

### **3 Mental Health Act assessments**

Schemes can promote greater use of Section 35 of the Mental Health Act. This allows a court to send someone to hospital for a report to be prepared on their mental health condition instead of remanding them to prison.

### **4 Speeding up court proceedings**

Schemes provide rapid advice to the courts on mental health issues. This can significantly speed up proceedings. The timetabling of hearings can mean that the courts find it hard to accommodate even short delays in obtaining relevant information and are thus required to adjourn hearings, sometimes for several weeks until a new slot in the programme can be found. Such delays necessarily impose costs on the system, particularly when offenders are being held on remand.

Some schemes also provide advice and support to the probation service in the preparation of pre-sentence reports. This can prevent lengthy delays which might otherwise arise while probation officers collect information on mental health cases.

In Crown Courts, the provision of timely advice by schemes can also help to prevent adjournments relating to a defendant's fitness to plead.

### **5 Formal psychiatric reports**

A widely recognised cause of problems arising at the interface between the criminal justice and mental health systems is the commissioning of formal psychiatric reports. These problems can include:

- Reports are not commissioned at the appropriate time;
- They are commissioned unnecessarily;
- They take a long time to prepare, sometimes because their authors are not always provided with all the relevant information by solicitors or the Crown Prosecution Service;

- Their content is not always helpful to the courts, for example, through failing to provide a risk assessment or because the psychiatrist preparing a report comes from outside the area and is not therefore responsible for ensuring the availability of local services.

All of these problems result in delays, adjournments and unnecessary or ineffective court hearings, with associated costs in court, remand and prison escort services. Schemes can help to address all these problems, including by:

- Advising the courts if and when a formal report is required;
- Taking a pro-active role in facilitating the commissioning of reports and chasing them up;
- Advising on their coverage.

Two pilot projects are currently putting these arrangements on a more formal footing via service-level agreements (see Chapter 2). But even in advance of this initiative, it seems clear that the present, less formal methods are having beneficial effects. For example, one manager told us that before his scheme was set up the courts would remand 20-30 people a month for psychiatric reports. This has subsequently been reduced to just 2-3 a month.

## 6 Sentencing decisions

Schemes can influence the decisions taken by courts on sentencing and disposal, either by making direct recommendations to the courts or by influencing the recommendations made by probation officers in their pre-sentence reports. Managers were clear that in some cases this can result in genuine diversion, usually from custody to a community order (including on occasion the Mental Health Treatment Requirement).

## 7 Risk management

Schemes provide advice on risk management, in some cases throughout the criminal justice system including community risk management via participation in the MAPPA process (Multi Agency Public Protection Arrangements).

## 8 Training and advice

Schemes provide informal advice (and sometimes formal training) on mental health issues to a wide range of workers in the criminal justice system. It is clearly difficult to identify, let alone quantify, the specific benefits of such support, but it was seen by many managers as an important part of their work. As an example, schemes can increase the confidence of sentencers in using community options by increasing their awareness of available local services. Such support can help to oil the wheels of the criminal justice system and to minimise the amount of friction at points of contact with the world of mental health.

## Impact and influence

The extent to which potential savings are realised in practice depends among other things on the *impact* of diversion and liaison schemes in influencing the decisions made by relevant criminal justice agencies, particularly in such areas as charging, bail and disposal.

This issue was specifically raised during our interviews with scheme managers. We sought their views on the extent to which the recommendations they made were accepted or rejected by key decision makers in the criminal justice system. There are inherent difficulties in this line of enquiry. Would the decisions taken by the courts etc. have been any different if the schemes had not existed? Do the schemes simply make recommendations which they know will be accepted? But the general response

was positive. Managers were confident that their schemes had a definite impact on decisions and that the great majority (90% or more) of their recommendations were accepted.

## Mental health benefits

All schemes seek to improve the mental wellbeing of their clients by arranging access to appropriate mental health care and other services. It is far from straightforward to assess the impact or effectiveness of schemes in this aspect of their work. In particular, the schemes themselves are not direct providers of mental health care, except sometimes of brief interventions as clients pass through the criminal justice process. Rather, they play an intermediary role. So any improvements in mental health resulting from diversion and liaison, particularly over the longer term, will depend on the services provided by other agencies or by professional colleagues working in different sections of the same agency.

Schemes collect virtually no follow-up information on their clients after onward referral to local services. A number of scheme managers in our sample commented that such information should ideally be collected and one said that plans were in hand to pursue this by contacting a sample of clients six and twelve months post-referral.

In the absence of any systematic follow-up data on mental health outcomes, our assessment of effectiveness in this area takes an indirect approach. We looked at the key activities undertaken by schemes which, if successfully implemented, should maximise the scope for mental health gains. These activities include:

- 1 Ensuring that all offenders with mental health needs are correctly identified and assessed;
- 2 Arranging links with local agencies providing services to address these needs;
- 3 Seeking to ensure that clients properly engage with the services in question.

### Identifying offenders with mental health needs

The schemes in our sample used a variety of methods to identify clients with mental health needs. All relied to a large degree on referrals from other, usually non-health agencies (police officers, court staff etc.) and many said they allowed referrals from any source including self-referral. A number supplemented this by regularly cross-checking the names of all people in custody cells or suites against local mental health information systems to identify those currently in contact with mental health services. Some also said that they arranged to see and assess *all* female offenders in places of custody, because of the particular vulnerabilities of women after arrest.

In the light of the research evidence on the potential shortcomings of referral-based systems, it is clear that the more pro-active approaches followed by some schemes will improve effectiveness in the identification of individuals with mental health needs. But a number of concerns remain. Checking names against local mental health information systems may still mean missing many people even with serious mental health needs, for example because they have lost contact with local services or because they come from outside the area. It also necessarily means missing those who have never engaged with statutory services, for example people with a first episode of illness or from hard-to-reach groups. Assessing all female offenders is a step in the right direction, but women account for a small proportion of the offending population (for example, only about 5% of all those in prison).

None of the schemes in our sample operated a 24/7 service. Most were available on a 9am to 5pm, Monday to Friday basis, and some for less than this. Particularly for police-based schemes, this inevitably means that some potential clients will be missed.

Statistical information on the characteristics of clients showed that there were very wide variations between schemes, for example in the relative and absolute numbers of clients with different mental health conditions (severe as compared to mild / moderate mental illness, personality disorder, substance misuse etc.). To some degree these will reflect genuine local differences in underlying prevalence. But their scale is such that other factors must also be at work, including major differences in selection and referral processes. It is hard to avoid the conclusion that, in some areas at least, significant numbers of people with serious mental health needs are not being picked up.

### **Linking clients to services**

The success of schemes in linking clients to local mental health and other services is conditional on factors including their knowledge of local services and associated care pathways, their relationships with a range of service providers and the availability and accessibility of local provision. All the schemes we visited appeared to be well-informed about mainstream local services, community-based or otherwise (e.g. prison inreach teams). They have well-developed arrangements for liaising with these services, for exchanging information about clients and for arranging appointments and referrals where appropriate.

In addition to linking clients with services, schemes may also pass on information and advice to local mental health teams to improve the management of clients after they have passed through the criminal justice system. This might include suggested amendments to a care plan, such as temporarily increasing the number of home visits. One scheme said that they regularly attended CPA meetings if required, particularly to help with risk management. All work of this nature should contribute to better care and improved mental health outcomes.

Against this general background, we identified some areas of concern. Effectiveness in linking clients to services depends to some degree on the size and composition of schemes. A large, multi-disciplinary team is likely to be more effective than a single-worker scheme: its combined knowledge of local services is likely to be greater and individual members of a multi-disciplinary team may have stronger relationships with specific groups of service providers (e.g. nurses with NHS mental health services, social workers with social care services and so on).

A number of schemes identified difficulties in arranging access to hospital beds for clients with severe mental illness, resulting in inappropriate and unnecessary remands to prison. Access to beds is generally easier where a consultant psychiatrist is attached to the scheme.

Several schemes commented on the unwillingness of community-based general (i.e. non-forensic) mental health services to take on clients with an offending history, for example because of concerns about risk management or because of a belief that good mental health care is now available in all prisons. Particular concern was expressed about the difficulty of arranging services for people diagnosed with personality disorder.

The access criteria employed by community mental health teams (and, in some cases, crisis resolution teams) mean that many offenders with mental health problems are excluded from specialist mental health care because their needs are judged to be 'sub-threshold'. For these clients, access to services provided by the voluntary sector is likely to play an important role in providing community support.

Most diversion schemes, especially those in the NHS, have less knowledge of voluntary sector services than they do of statutory services.

In some cases the reluctance of general mental health services to take on offenders arises from misunderstandings or disagreements about the boundary between general and forensic services. For example, a psychiatric intensive care unit (PICU) may refuse to accept responsibility for an offender needing crisis care, on the grounds that – irrespective of risk – this should always be the responsibility of a medium secure unit. In consequence, some clients can end up, as one manager put it, being “batted around” between the two services.

A number of schemes referred to particular difficulties in arranging services for out of area cases: people not normally resident in the area where they were arrested. Local service providers may be unwilling to take on such cases without assurances about funding from the appropriate PCT.

Finally, many offenders have multiple needs, including substance misuse problems, insecure housing and lack of employment. Some of the schemes we visited seemed to have good links with local alcohol and drug services, including for example working jointly with local Drug Interventions Programme (DIP) teams to carry out assessments and identify agreed care pathways. But this was not always the case. Most schemes included housing agencies in the list of organisations covered by their liaison work, and one scheme mentioned that they were specifically taking on a housing link worker as a member of the team, but others said that this was outside their remit. Little work appears to be done by schemes in the employment field, despite the evidence that having a job is good for mental health and is an important determinant of reduced re-offending.

## **Engagement with services**

Schemes were able to provide relatively little hard information on the extent to which their clients engaged with local services after referral. Schemes do not see it as their role to manage the relationship between their clients and local services following referral, except in some cases to ensure that a first appointment is taken up. And schemes do not generally collect any systematic follow-up data on their clients, including on the take-up of services.

Among scheme managers who were willing to express a view, most – but by no means all – thought that the initial take-up of mental health services was reasonably good. One scheme was able to produce an estimate of around 75%. A number of managers also commented that, on the basis of their experience, the take-up of mental health services was better than the corresponding rate for some other services, including those relating to drug misuse.

But there was general agreement that subsequent drop-out was an important concern, not least because many of the clients coming through their schemes were people who were previously known to services but had become disengaged. Several managers said the transient and sometimes chaotic lifestyle of offenders was a major barrier to continuing engagement.

## **Impact on re-offending**

All of the schemes we visited said that one of their aims was to help to reduce recidivism, by linking their clients to services which act on a range of risk factors that may be associated with possible re-offending. These include not only mental ill health but also alcohol and drug misuse and insecure

housing. There was some variation between schemes in the weight they attached to this objective and also in their perceptions of likely success.

The scope for reducing subsequent offending is not easy to assess. The majority of the clients seen by schemes already have a previous criminal record and significant numbers can be described as multiple offenders. One scheme provided evidence showing that, after excluding 'not knowns', only 19% of their clients had no previous criminal history, 49% had 1-4 previous convictions, 26% had 5-9 convictions and 6% had 10 or more. A number of schemes referred to the importance of trying to tackle the 'revolving doors' syndrome in which offenders move repeatedly in and out of prison without anything being done to address their underlying problems and needs.

Most scheme managers thought that their schemes were having some effect on recidivism. But the absence of follow-up data means that they were not able to substantiate this assertion.

One possible indicator is the number of clients coming back through a scheme after having been seen previously. Several managers were able to provide some approximate information on this. This indicator is, however, incomplete as a measure of re-offending and the figures suggested by managers varied widely, with the proportion of clients identified as having been previously seen varying between 10% and 50%.

Several schemes commented that high rates of re-offending are particularly associated with dual diagnosis, in which mental health problems are accompanied by substance misuse, rather than mental health problems on their own. Conversely, severe or acute mental illness was thought to be generally associated with low rates of re-offending; in cases where a further offence was committed, this was often associated with a patient not taking medication.

Success in reducing recidivism clearly depends on engaging clients with appropriate services on a continuing basis. A lack of engagement and drop-out rates are as relevant to re-offending as they are to improving clients' mental health. A number of schemes commented on this issue and emphasised the need for some form of assertive follow-up to promote engagement and compliance. One scheme also commented that reducing recidivism would be better achieved if more interventions specifically targeted at this objective were available in the community.

Several of the schemes in our sample work closely with probation services. These were generally the most positive about the scope for reducing re-offending. One scheme provides a combined court liaison and probation service and this allows considerable continuity of support through the criminal justice process. It maintains regular contact with clients on community sentences for several months after they have gone through the courts. Such continuity may reasonably be expected to result in better outcomes in terms of reduced recidivism.



## **Conclusions**

We collected evidence from 16 diversion and liaison schemes around the country to identify and assess the main ways in which the work of schemes can result in improved outcomes.

There is little doubt that well-designed schemes can generate a number of improvements in the performance of the criminal justice system.

There is significant scope for financial savings and other benefits such as the quicker administration of justice.

The potential of diversion schemes to improve their clients' mental health or to reduce re-offending is less clearly established.

Shortfalls in identifying people with mental health needs and in ensuring their subsequent engagement with services are major barriers to improving outcomes.

Detailed quantitative information on the scale of benefits remains elusive.





## Value for money

This chapter assesses the potential value for money of diversion schemes. It assess whether the overall benefits of diversion outweigh its costs.

The shortage of reliable quantitative data on outcomes and effectiveness which has been emphasised throughout this report necessarily imposes a number of limitations on such an analysis and also implies that any findings should be regarded as indicative rather than conclusive. These constraints mean that the assessment of value for money has to be approached indirectly rather than directly, asking:

- What scale of benefits must be achieved by a diversion scheme to justify investment on value for money grounds?
- In the light of the limited available evidence on outcomes and effectiveness, how likely is it that benefits on this scale can be secured?

Cost-benefit analysis can be defined as a systematic attempt to identify, value and compare all the costs and all the benefits of alternative policies or interventions. The value-for-money case for diversion is not just or even mainly about achieving narrowly defined financial benefits such as cost savings in the criminal justice system or elsewhere in the public sector. The Exchequer or taxpayer perspective is certainly important but is only part of the story. Diversion schemes can help to achieve a range of potential benefits, including cost and efficiency savings in the criminal justice system, better mental health outcomes and reductions in re-offending. It is important that all these effects are taken into account.

As diversion has multiple outputs, good value for money can be achieved overall even if, for example, its impact on future offending is relatively limited. Put another way, seen purely as a method of crime reduction, diversion does not need to be as effective as other interventions in this area, because of its potential for simultaneously achieving benefits in other areas, notably better mental health.

Most of the available evidence on the outcomes and effectiveness of diversion is based on surveys which follow up clients for a relatively short period of time, usually one or two years. Reliance on such data in cost-benefit analysis is likely to mean that total benefits will be understated, to the extent that diversion and any associated interventions have enduring effects on mental health and offending behaviour.

Finally, it is important to emphasise that, while cost-benefit analysis can helpfully contribute to decision making in the public sector, it does not provide all the answers. For example, in sentencing policy, legal and moral considerations also come into play and these cannot sensibly or realistically be analysed in economic terms.

This chapter looks in turn at the potential value for money of diversion in the areas of:

- Cost savings in the criminal justice system;
- Reductions in re-offending;
- Better mental health.

It should be noted that the analysis of cost savings in the criminal justice system focuses exclusively on savings in the short term, i.e. as an offender passes through the system because of the offence he or she has just committed. It is possible that there may also be savings in the longer term, most obviously because diversion may help to reduce the number of offences committed in the future and hence the numbers going through the criminal justice system at a later stage. These longer-term savings are covered in the second part of the analysis, dealing with reductions in re-offending.

### Cost savings in the criminal justice system

The main areas of potential savings in the criminal justice system which may be promoted by diversion schemes are reductions in:

- The number of arrests;
- The number of prosecutions;
- The use of remand;
- The number of formal psychiatric reports;
- The number of ineffective court hearings and other causes of delay in the administration of justice;
- The number of prison sentences, because of diversion to appropriate community alternatives.

This list is by no means comprehensive. It excludes activities, such as improved risk management, where there is little realistic scope for quantification or valuation. This inevitably means that the overall benefits of diversion are likely to be understated.

There are also a number of ways in which diversion schemes can help to speed up the administration of justice. This is desirable both as an end in itself and because it can contribute to cost savings, such as reducing the amount of time defendants spend on remand. But there is no obvious way of attaching a monetary value to the first of these sources of improvement, which again implies that the total benefits of diversion will be understated.

However, there is a degree of overlap between some of the areas for potential saving. For example, the main financial benefit from commissioning fewer formal psychiatric reports is likely to be the reduced use of remand during the average eight-week period it takes to prepare a report rather than from direct savings in psychiatrists' fees (the average payment for a formal psychiatric report is around £600, which is only about a tenth of the cost of eight weeks in custody). Reducing the number of formal reports can therefore be seen mainly as one of several ways in which diversion schemes reduce the use of remand.

Building on this last point and also taking account of limitations in data availability, we have restricted our analysis to a shortened list of potential savings, comprising reductions in:

- The number of arrests;
- The number of prosecutions;
- The use of remand;
- The number of prison sentences.

We have assessed the possible scale of such savings, measured in monetary terms, through information on:

- The unit costs of the relevant processes in the criminal justice system, for example the cost of an average arrest or spell on remand;
- The amount by which the use of these procedures might be reduced through the work of diversion schemes.

## Unit costs

Information on unit costs in the criminal justice system is limited. We have used a number of sources (including Harries, 1999; Brand and Price, 2000; Godfrey *et al.*, 2002; and Matrix Knowledge Group, 2008) and all figures from these studies have been updated to 2007/08 values in line with average earnings, to reflect the fact that costs in the criminal justice system are very largely pay-related. On this basis, broad estimates of costs incurred by criminal justice agencies (police, Crown Prosecution Service, courts, legal aid, probation, prison service) are shown in Box 1.

### Box 1: Unit costs in the criminal justice system

#### Arrest

- £1,780: average police costs per arrest

#### Prosecution

- £880: average cost of a magistrates' court proceeding
- £13,760: average cost of a Crown Court proceeding

#### Remand

- £5,250: cost of average spell for a defendant awaiting trial

#### Sentences

- £7,920: average cost of a prison sentence imposed by a magistrates' court
- £2,960: average cost of a community sentence imposed by a magistrates' court
- £48,800: average cost of a prison sentence imposed by a Crown Court
- £4,000: average cost of a community sentence imposed by a Crown Court.

It should be noted that the figures in Box 1 are broad averages across all offences and all offender groups (i.e. not just offenders with mental health problems). In practice there is likely to be a substantial degree of variation around the central figures, particularly by type of offence.

In estimating the total cost of an offender pathway, from arrest through sentencing, it is not always correct simply to add together the costs of the individual elements identified in Box 1. In particular, if an individual is held on remand and subsequently given a prison sentence, the amount of time spent in custody on remand counts towards the prison sentence and so reduces the time to be served. The combined cost of remand and a prison sentence is therefore less than indicated in Box 1. About half of all those held on remand go on to receive a prison sentence, implying that if the sentenced time to be spent in custody is longer than the time spent on remand, the true cost of remand should on average be only half the estimate of £5,250 given in Box 1. In practice some offenders spend *more* time on remand than subsequently required by their sentence, which means that the cost offset will be less

than half. In the absence of more detailed information, it is assumed that on average the cost of a spell on remand, allowing for the adjustment just described, is around £3,000.

Our calculations of the average criminal justice costs of some illustrative offender pathways are shown in Box 2.

### **Box 2: Costs of illustrative criminal justice pathways**

- Arrested only: £1,780
- Arrested and charged in court: £2,660
- Arrested, charged and given a community sentence: £5,620
- Arrested, charged and given a prison sentence: £10,580
- Arrested, charged, held on remand and given a community sentence: £10,870
- Arrested, charged, held on remand and given a prison sentence: £10,580.

All of the costs set out in Box 2 relate to magistrates' courts, as this is where the great majority of cases are heard. Corresponding costs for Crown Court cases are much higher. For example, the cost of the pathway 'arrested, charged, held on remand and given a prison sentence' for an average Crown Court case comes out at £64,340.

### **The scope for financial savings**

These figures illustrate the potential financial benefits of diversion. For example, reducing the number of arrests saves between £1,780 and £10,870 per case, depending on the pathway that the offender would otherwise have followed. In practice the saving is likely to be toward the bottom end of this range, as only a minority of those arrested by the police are subsequently charged to appear in court, with most being subject to various pre-charge disposals, including no further action, cautions and fixed penalty notices. For other forms of diversion:

- Reducing the number of prosecutions after arrest might save between £880 and £9,090 per case, again depending on the pathway which the offender would otherwise have followed;
- Reducing the use of remand saves up to £5,250 per case, depending on whether the offender subsequently receives a custodial sentence;
- Diverting an offender from a prison sentence to a community sentence saves up to £4,960 per case, depending on whether the offender had previously been held on remand.

To set these figures against the cost of diversion services, evidence given to us by Nacro suggests that there are currently around 125 diversion and liaison schemes in this country with a combined caseload in the order of 30,000 to 40,000 clients a year. Most schemes are based in the courts rather than police stations, with services being provided to about 190 courts, nearly all which are magistrates' courts.

Drawing also on the findings of our site visits, we estimate that the total number of staff employed by these schemes is of the order of 200-250 full-time equivalent workers, and the aggregate combined cost of the schemes is around £10 million a year.

These figures imply that an average or representative scheme:

- Employs roughly two full-time workers;

- Deals with around 270 cases annually;
- Costs £80,000 a year.

For an average or representative diversion scheme to cover its own costs in full, the required level of savings within the criminal justice system is thus £80,000 a year.

### How savings might be achieved

There are various ways of illustrating how this saving might be achieved. For example, £80,000 is equivalent to the cost of just over 100 weeks of imprisonment. Given an estimated average scheme caseload of 270 a year, a saving of £80,000 a year corresponds to an average reduction in the amount of time that would otherwise be spent in custody, whether on remand or after sentencing, of 2.7 days per client.

Under present arrangements, diversion schemes in this country provide little scope for reducing the number of people with mental health problems in the criminal justice system at the pre-arrest stage. This is partly because most schemes are court-based and partly because those operating in police stations generally focus on supporting clients after arrest. While there may be one or two indirect ways in which police-based schemes can help to reduce the number of arrests, these are likely to be modest in scale and the main opportunities for cost saving currently arise very largely at later stages in the offender pathway.

Since April 2006, the Crown Prosecution Service has taken over responsibility for authorising all but some minor charges against a suspect. Prosecutors make their decisions on charging and prosecutions in accordance with the Code for Crown Prosecutors. As the Code includes guidance to the effect that a prosecution is less likely to be needed if a defendant suffers from significant mental ill health, it might be expected that people with mental health problems would be charged at a lower rate for particular offences than the general offender population. However, the limited available evidence suggests that mental ill health does not lead to any such reduced probability of charging (Home Office, 2006).

Both police- and court-based diversion schemes see it as part of their role to provide information and advice relating to prosecution decisions. Intervention at this early stage in the offender pathway offers scope for significant savings, of up to £9,090 per case for those charged in magistrates' courts. We estimate that a decision to discontinue prosecution for just one per cent of an average court diversion scheme's caseload (i.e. three cases a year) would result in savings in criminal justice costs of around £15,000 a year, taking into account the likely balance of outcomes that would otherwise have occurred.

There is good evidence that offenders with mental health problems are more likely to be held on remand than other offenders, particularly when a formal psychiatric report has been requested (Home Office, 2006). Information from two localities cited in this Home Office study indicated that nearly 60% of people requiring a formal report were remanded in custody, compared with average rates of remand for all cases of 40% in the areas concerned. As each additional case held on remand imposes, on average, additional costs of £3,000 on the criminal justice system, diversion schemes can significantly reduce costs, both by shortening delays in the provision of formal reports and by reducing the number of reports which need to be commissioned.

One of the schemes we visited reduced the number of people being remanded by the courts for psychiatric reports from 20-30 a month to 2-3 a month. Assuming on a conservative basis that this amounts to 200 cases a year, the implied savings are extremely large, at around £600,000 a year in the

costs of remand and a further £120,000 a year in psychiatrists' fees. The scheme in question is a large one (more than double the national average number of staff employed), but the estimated savings from this source alone are sufficient to cover its costs several times over.

It is estimated that twice as many offenders with mental health problems who are charged at court receive a community sentence as receive a prison sentence (Home Office, 2006). This is broadly in line with the average for other offenders, i.e. those with mental health problems do not generally receive a higher or lower rate of custodial sentencing than other offenders. Diverting an offender from a prison sentence to a community sentence saves up to £4,960 per case, though the savings are lower (and may even be slightly negative) if the offender had been previously been held on remand. Allowing for the fact that only a minority of offenders are remanded, the average saving is estimated at around £3,650 a case. The diversion of, say, 10 offenders a year (out of an average caseload of 270) from a custodial sentence to a community sentence would therefore save nearly half the overall costs of a diversion scheme.

These findings relate largely to the cost implications of procedures and decisions taken in magistrates' courts rather than Crown Courts. The scope for savings in Crown Courts should not, however, be ignored, though the focus may need to be different. In particular, because of the greater seriousness of offences being considered, there are likely to be fewer opportunities for diversion in the narrow sense (i.e. from custody to the community). But the much higher cost of Crown Court proceedings greatly increases the potential financial benefits of improving administrative processes, for example by reducing the numbers of adjournments, ineffective hearings and other causes of delay.

One of the schemes we visited operates at a Crown Court in London and was able to cite numerous examples of how costs could be saved, particularly in cases characterised by a high degree of legal and medical complexity. A planned evaluation of this scheme should in time allow the scale of these potential benefits to be quantified. In the meantime, the head of the scheme was confident that the savings being realised more than covered the scheme's costs. Given that costs in the court concerned are reckoned to be up to £6,000 an hour, this looks a plausible claim.

Diversion schemes can promote cost savings in the criminal justice system in a variety of ways. Insufficient evidence is available to estimate the size of these savings with any precision, but it is clear that in specific cases they can be substantial. Given the extent to which schemes do generate such financial benefits, it is arguable that criminal justice agencies should make a greater contribution to the funding of schemes than is presently the case.

## Reductions in re-offending

In analysing the costs and benefits of potential reductions in re-offending, this section focuses on the diversion of offenders with mental health problems from custodial sentences to community-based alternatives. Much of the analysis is also relevant to the more general work of diversion and liaison schemes in linking offenders to appropriate mental health and other support services, but there are good reasons for highlighting diversion from prison.

First, there are known to be very large numbers of people with mental health problems in custody and it is widely accepted that in many cases this is neither necessary nor appropriate. A report on reducing re-offending by the Government's Social Exclusion Unit noted that:

“ Too many of the people being sent to prison should not be there and would be better punished in the community or diverted ... to mental health care. ”

(Social Exclusion Unit, 2002, p.120)

Second, a focus on diversion from prison is particularly relevant in the value for money context, as the evidence suggests that prison is a high-cost intervention which is ineffective in reducing subsequent offending. The average cost of keeping someone in prison is £750 a week, or £39,000 a year (House of Lords, 2008). This excludes expenditure on health services, which is met by the Department of Health. Spending on mental health care in prisons is estimated at around £20 million a year, which is likely to mean that up to £2,000 a year should be added to the average cost of prison for someone with a severe mental illness (Sainsbury Centre, 2008b).

There is evidence from the US that, even after allowing for extra health care costs, it is much more expensive to imprison people with severe mental illnesses than other inmates, for example because of the need for more frequent observations. Thus one study found that prisoners with severe mental illness cost \$160 a day to keep in prison, twice as much as the average cost of \$78 a day for those without mental illness (Boothroyd *et al.*, 2003). Unfortunately no comparable information is available for this country.

Allowance should also be made for various indirect costs, whether falling on the families of prisoners (e.g. loss of earnings) or on wider society (e.g. increased spending by local authorities on foster care). A small-scale study in this country has estimated that the direct costs of prison need to be increased by nearly a third (31%) to allow for these secondary or indirect effects (Smith *et al.*, 2007).

Although there has been some improvement in recent years, rates of re-offending among those leaving prison remain very high. Some 65% of prisoners are re-convicted within two years of release (Cunliffe and Shepherd, 2007). While this figure refers to the prison population generally, the limited available evidence does not suggest that rates of re-offending among those with mental health problems are significantly different from the average (Harper and Chitty, 2005).

### **Diversion of prisoners on short sentences**

There are also good reasons for focusing on the potential for diverting prisoners with mental health problems who have received short sentences, i.e. less than one year. This is because:

- 1 Prisoners in this category are the obvious target group for diversion, having committed relatively minor offences and so posing little or no risk to public safety if diverted into the community.
- 2 The numbers involved are large, certainly in terms of the flow of offenders through the system. More than 70,000 of the 96,000 custodial sentences given out by the courts in 2006 were for 12 months or less (Ministry of Justice, 2007).
- 3 Prison costs per day are likely to be higher for short stays than long stays, for example because of the more limited period over which to spread fixed or one-off costs such as initial assessments.
- 4 Prisoners on short sentences are in most cases unlikely to be in custody long enough to benefit from prison-based programmes aimed at reducing re-offending. Nor are they subject to statutory probation supervision after release, which reduces the scope for subsequent intervention.
- 5 Prisoners on short sentences have a two-year re-conviction rate of 75%. The corresponding re-conviction rate among offenders who have served community sentences is only 50% (Cunliffe and Shepherd, 2007).



## Measuring the benefits of reduced re-offending

Comprehensive estimates of the costs of crime, both in total and by type of offence, were first published by the Home Office in 2000 (Brand and Price, 2000) and partially updated five years later (Dubourg and Hamed, 2005). These show, for example, that the total cost of crime in England and Wales in 1999/2000 was around £60 billion. This covers not just costs falling on the criminal justice system (police, prisons etc.) but also – and much more importantly in quantitative terms – costs falling on the victims of crime, including the value of stolen or damaged property, losses in earnings resulting from crime-related injuries etc., and an imputed monetary value of the emotional and physical impact of crime on victims. These estimates provide a natural starting point for measuring the benefits of reduced re-offending in monetary terms.

The Home Office figures are based wherever possible on the numbers of offences recorded in the British Crime Survey. These are significantly higher than the corresponding numbers of offences which are reported to the police, which in turn are significantly higher than the numbers of offences which result in a conviction. This means that the available statistics on re-offending, which are generally based on rates of re-conviction, would lead to an under-estimate of the total volume of crime associated with re-offending without appropriate adjustment. On average, five recorded offences are committed for each re-conviction (Social Exclusion Unit, 2002). The costs of re-offending also need to take into account the fact that a significant number of offenders are re-convicted more than once. For example, about a third of the people seen by one of the diversion schemes in our sample had five or more previous convictions.

Various studies in this country and elsewhere have sought to estimate the lifetime costs of crime as committed by various types of offender, or the costs of a ‘criminal career’ as it is sometimes called. We have used the estimates published in a recent report on the economic case for and against prison (Matrix Knowledge Group, 2007), which suggest that the total cost of crime committed by an average offender following release from prison is of the order of £220,000 (in 2007/08 prices). Its calculations combine various sources of data, including Home Office figures on the costs of crime and published statistics on re-conviction rates, in order to estimate the level and cost of re-offending over the first two years after release from custody and then to extrapolate these forward to the age of 50 according to data on the statistical relationship between age and offending.

The figure of £220,000 is a broad average and clearly there will be a great deal of variation around it, depending on such factors as age of offender, type of offence and number of previous convictions. For example, the costs of future offending are likely to be relatively low on average for first-time offenders, as only a minority in this group go on to become repeat offenders. The relationship between long-term cost and type of offence is less clear-cut, because although the unit cost of a serious offence is much higher than for minor crimes, the relevant re-offending rate is much lower. For offenders serving short prison sentences in particular, the most reliable indicator of future costs is likely to be the number of previous convictions.

## What works in reducing re-offending?

There is now a substantial body of research evidence on what works in reducing re-offending, although relatively little of this focuses on interventions aimed specifically at offenders with mental health problems.

There is strong evidence that some interventions, including cognitive behavioural therapy programmes, some forms of treatment for drug misuse and other treatment-oriented programmes



combined with intensive supervision, are very effective in reducing re-offending. A recent review, or meta-analysis, of studies of cognitive behavioural programmes, for example, indicated that recidivism among participants was 27% lower than among control groups (Landenberger and Lipsey, 2005). Another review suggests that non-violent offenders receiving residential drug treatment are 43% less likely to re-offend than comparable offenders receiving prison sentences (Matrix Knowledge Group, 2007).

Some of these effective interventions cost relatively little to implement and so score very highly on value for money grounds. For example, a systematic review of nearly 600 control group evaluations recently published by the Washington State Institute for Public Policy found that benefits exceed costs by a factor of 10 to 1 or more for several broad programme types (Aos, Miller and Drake, 2006). It measured benefits in terms of reductions in the total costs of crime, including costs to victims and to taxpayers.

There is some evidence that community-based programmes yield better results in reducing re-offending than prison-based interventions and that well-designed services are of maximum benefit when provided in a non-custodial setting (McGuire, 2000). This supports the case for diversion.

The success of any intervention aimed at reducing re-offending depends critically on whether or not participants complete the programme. A recent review of accredited programmes by the National Offender Management Service (NOMS) found that re-offending fell by 25.8% on average among offenders completing those programmes, compared with only 4.3% among those who started but did not complete them (Hollis, 2007). This underlines the point that, to work effectively, the diversion of offenders with mental health problems must ensure their continuing engagement with services and interventions.

Finally, there is evidence that many offenders have multiple needs, all of which may in varying degree influence their offending behaviour. In view of this, it is increasingly recognised that a multi-modal approach to interventions, of offering support for a range of a person's needs, is likely to be the most effective way of reducing the likelihood of re-offending (Harper and Chitty, 2005).

## **Do mental health interventions reduce re-offending?**

This section considers two sorts of evidence in assessing the possible impact on re-offending of improvements in mental health:

### **1 The importance or otherwise of mental ill health as a causal influence on criminal activity**

The nature of the relationship between mental illness and offending defies generalisation. For some types of personality disorder a direct link is well documented. And it has also been noted that “recent good evidence supports a small but independent association” between schizophrenia and violence (Walsh, Buchanan and Fahy, 2002).

Beyond that, and particularly for common mental health problems such as depression and anxiety, the relationship is much less clear cut. In some cases, mental ill health may be the direct cause of offending, or it may contribute to a chaotic lifestyle which results in criminal activity. It may cause individuals to be stigmatised and excluded from society, with the same outcome. In other cases mental ill health may be present but have no impact at all on criminal activity.

What does seem clear is that subjective distress is often an important antecedent of offending behaviour and that such distress can also contribute to other influences on offending behaviour such as alcohol or drug abuse. In the light of such evidence, a recent review has concluded that:

“While the general relationship of mental disorders to crime .... remains an empirical question, the argument that they are not appropriate targets in reducing risk is unconvincing.”  
(Blackburn, 2004)

In other words, improvements in mental health must be expected to have some impact on re-offending, even if the scale of the effect is uncertain.

## 2 The effects on re-offending of specific interventions aimed at improving mental health

Our review of the international evidence has shown that studies relating specifically to the diversion of offenders with mental health problems towards community-based mental health services generally show some reduction in re-offending. However:

- The quality of the evidence is mixed;
- There is a good deal of variation between studies in terms of the measured change in re-offending;
- The larger effects typically shown in ‘before and after’ studies should be treated with caution, because of inherent limitations in this form of analysis compared with control group designs.

A similarly positive but qualified conclusion is reached in a recent review of evidence on the effectiveness of community orders carried out by the RAND Corporation for the National Audit Office (Davis *et al.*, 2008). This assesses effectiveness in ten areas of community-based intervention, including mental health, about which it concludes:

“Mental health treatment in the community has not been subject to strong evaluations. While there is a lack of meta-analysis or systematic reviews, a small number of studies from the United States suggest that diversion and treatment reduce recidivism amongst offenders with mental illness compared to traditional prosecution.”  
(Davis *et al.*, 2008)

The RAND review also includes comparisons between the ten areas of intervention using two criteria: quality of studies and evidence for impact on re-offending. As might be expected, mental health rates ‘low’ on the first of these criteria. However, it is rated ‘strong’ on the second, where evidence for the impact on re-offending is given this rating if there is consensus among the best-designed studies that the intervention is effective. Only two other areas of intervention – cognitive behavioural therapy programmes and drug treatment – are given this rating for their effectiveness.

## Quantifying the contribution of mental health care

Overall, the balance of evidence suggests that mental health-related interventions have some positive impact on re-offending. However, because of limitations in the quantity and quality of the available evidence, any attempt at quantifying the scale of this effect must be subject to considerable uncertainty.

Our approach to quantifying the contribution of mental health interventions takes as its starting point the average impact on re-offending of other interventions, i.e. those not specifically relating to mental health. A review of 19 accredited programmes (Hollis, 2007), including substance misuse, anger management and behavioural therapy, estimated that, for all participants including non-completers, the average reduction in re-offending against a predicted rate was 10.3%. Taking a conservative view to reflect the limited evidence, it can be hypothesised that mental health-related interventions could achieve a reduction in re-offending in the range 5-10%, taking 5% as a plausible lower limit and the figure of 10% achieved on average by non-mental health interventions as a realistic upper limit. This is only a fraction of the reductions of 25% or more which meta-analysis suggests can be achieved by the

most effective interventions such as cognitive behavioural programmes and some forms of drug treatment, emphasising the conservative nature of the suggested range.

As many offenders have multiple needs, such as lack of work, insecure housing and alcohol or drug dependency as well as mental health problems, it is increasingly agreed that a multi-modal approach to interventions is likely to be the most effective way of reducing re-offending. It is less widely recognised that interventions to improve mental health may have a double effect in this context. Mental ill health is itself a risk factor for offending; in addition, better mental health is likely to improve the effectiveness of interventions directed at other risk factors.

An analogy can be drawn here with the relationship between mental illness and physical illness. There is strong evidence that mental health problems increase the prevalence of a range of physical health conditions, including heart disease, stroke, cancer, diabetes and asthma, and also worsen their prognosis. Compared with physical illness on its own, co-morbidity (i.e. physical illness accompanied by mental illness) results in poorer outcomes. For example, stroke patients who are depressed are four times as likely to die within six months as those who are not depressed (Sederer *et al.*, 2006). Mental illness can cause delays in seeking help for physical illness, reduce the likelihood of accurate diagnosis and adversely affect compliance with treatment regimes including medication and recommended changes in health-related behaviours such as exercise and diet.

It is plausible to argue that these same effects will carry through into the relationship between mental illness and offending. In particular, mental health problems co-existing with other risk factors for offending are likely to limit the effectiveness of interventions aimed at the latter, for example by reducing the willingness or ability of offenders to participate in approved programmes such as drug and alcohol treatment or to comply with their requirements.

Interventions to improve mental health are thus likely to yield both direct *and* indirect benefits in terms of their impact on re-offending. Failure to allow for the indirect effects implies that the full benefits of better mental health are likely to be systematically under-recorded.

## Overall savings in crime-related costs

The diversion of an offender with mental health problems from a prison sentence towards effective treatment in the community yields two forms of saving in crime-related costs:

### 1 Short-term savings to the criminal justice system because of the reduced use of prison

The average cost of a prison sentence imposed by a magistrates' court is £7,920. If an offender who would otherwise have received a prison sentence is diverted out of the criminal justice system altogether, all of this cost would be saved. If on the other hand the offender is diverted from prison to a community order, the saving in criminal justice costs falls to £4,960, representing the difference in average cost between a prison sentence and a community sentence. In practice the savings may be considerably higher, allowing for such factors as the indirect costs of prison and the above-average costs of imprisoning people with mental health problems.

### 2 Longer-term savings associated with reductions in future offending

We estimate the longer-term savings at £16,500 per average offender, based on the figures of £220,000 for the average cost of a criminal career and a mid-point of 7.5% for the average reduction in offending associated with mental health treatment.

These estimates suggest that effective diversion leads to overall savings in crime-related costs of between £21,500 and £24,500 per case. The costs of treatment in the community, to be set against these savings, are considered in the following section.

## Improvements in mental health

Diversion and liaison schemes can promote improvements in mental health in a number of ways:

- They provide an opportunity for the early identification of mental health problems, which generally leads to better outcomes.
- In their liaison work they can engage or re-engage clients with mental health services in the community.
- In their diversion work they can help to re-direct offenders to settings where they are most likely to obtain effective treatment.
- For offenders who receive custodial sentences, they can provide information and support to prison inreach teams.

### Prevalence of mental health problems among offenders

People with mental health problems are over-represented in the criminal justice system. The most reliable evidence for this relates to people in prison. Table 1 is based on large-scale surveys carried out by the Office for National Statistics. It shows that for a wide range of mental health problems, including substance dependency, the prevalence of mental ill health among prisoners is far higher than in the population as a whole.

**Table 1: Prevalence of mental health problems in prisons in England and Wales**

Type of problem	Prevalence among prisoners	Prevalence in general population (adults of working age)
Psychosis	8%	0.5%
Personality disorder	66%	5.3%
Depression, anxiety etc.	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

Source: Singleton *et al.*, 1998

Singleton *et al.*, 2001

Note: men account for about 95% of people in prison. The prevalence rates shown in Table 1 are therefore weighted averages (with weights of 0.95 for men and 0.05 for women) both for people in prison and for people of working age in the general population, to ensure that the comparisons are on a like-for-like basis.

The figures also show that:

- Over 90% of prisoners have at least one kind of mental health problem, which is four times the corresponding rate of prevalence in the wider community.
- More than seven out of ten prisoners have two or more problems, against one in 25 in the general population.

- The prevalence of most problems is higher among people who are in prison on remand than among sentenced prisoners.
- Female prisoners have higher rates of severe mental illness (psychosis) and of common mental health problems such as depression and anxiety than male prisoners.
- Male prisoners are more likely to have personality disorder and substance dependency than females.

The Office for National Statistics survey of mental ill health among prisoners, cited in Table 1, is now 10 years old. Some more recent evidence is available in a longitudinal study of newly sentenced prisoners commissioned by the Ministry of Justice, the baseline results of which were published in October 2008 (Stewart, 2008). This suggests that the prevalence of severe mental illness in prisons has increased over the last decade.

There are, however, differences in the samples of prisoners interviewed and the ways in which mental illness was identified. The 1998 ONS survey used two methods for estimating the prevalence of severe mental illness, one based on lay interviews (i.e. asking a series of screening questions such as “have you taken any antipsychotic medication in the last 12 months?”) and the other on a more detailed clinical assessment. Among sentenced male prisoners, the lay interviews suggested a prevalence of severe mental illness of 4%, but the clinical interviews increased this to 7%.

The new survey uses only lay interviews. Among sentenced male prisoners, the estimated prevalence of severe mental illness has increased from 4% to 9%, while among sentenced female prisoners the rate has gone up from 10% to 18%. Taken at face value, these figures suggest that prevalence has roughly doubled. Allowing also for the fact that the overall size of the prison population has increased by about a third since the 1998 survey, this implies that the aggregate number of people in prison with severe mental illness has gone up from about 5,000 ten years ago to over 13,000 today.

Detailed survey information is not available on the prevalence of mental health problems among offenders at other points in the criminal justice system. Such estimates as are available must be treated with caution. For example, a Home Office report on ‘mentally disordered offenders’ notes that between 7% and 15% of people arrested by the police are identified by custody officers as having a mental health condition (Home Office, 2006). However, there is good evidence to suggest that the assessments made by police and court staff are subject to wide margins of error, even in the identification of severe mental illness.

A figure of 7% to 15% of people arrested looks implausibly low when set against the rate among prisoners. (It also implies that the prevalence of mental health problems among people arrested by the police is lower than the prevalence of these problems in the general population.)

While there is some evidence to suggest that people with mental health problems are more likely to be arrested and charged (but not to be given prison sentences) than other offenders, the differences do not appear to be very large. Any estimates which show grossly disproportionate differences between rates of prevalence among offenders at different points in the criminal justice system should thus be regarded with suspicion.

### **Costs and effectiveness of mental health interventions**

Effective evidence-based interventions are available for most mental health conditions, as described in guidelines produced by the Government’s National Institute for Health and Clinical Excellence (NICE). Guidelines have already been published for treating schizophrenia, bipolar disorder, depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder and eating

disorders. Others are in preparation for severe mental illness combined with problematic substance misuse and for antisocial and borderline personality disorders among others.

For some conditions there is strong evidence that intervention not only yields significant health benefits but also scores highly on value for money grounds. This may be illustrated by a recent study of depression which looks at the economic consequences of using the evidence-based treatments recommended by NICE (Knapp, McCrone and Capdevielle, 2008).

At present only about half of all people with moderate or severe depression receive any kind of treatment. About 30% of people will improve without medical intervention. The improvement rate increases to around 80% if treatment is provided in line with NICE guidelines.

Measured over a one-year period, the net cost to the NHS of providing evidence-based treatment to those not currently receiving it is estimated at around £170 per case. The subsequent economic benefits measured in terms of increased employment and earnings amount to some £3,870 per person, of which nearly 40% flows back to the Exchequer via increased tax receipts and reduced spending on incapacity benefits. In addition, improvements in mental health are valued at £2,760 per case. The combined benefits of treatment thus outweigh the costs many times over (Knapp, McCrone and Capdevielle, 2008).

Although directly comparable figures are not available, it is likely that much the same result would be found for anxiety and other common mental health problems, as the interventions concerned (medication and talking therapy) and their effectiveness are broadly similar. And it is also known that large numbers of people with these conditions are not currently in receipt of any kind of treatment.

About 45% of all people in prison suffer from depression, anxiety and related conditions (Singleton *et al.*, 1998). In the absence of more detailed information, this may be taken as a rough upper estimate of the prevalence of common mental health problems in the offending population as a whole. The lowest likely prevalence among offenders is the weighted average rate of 14% which applies in the population generally. Non-receipt of treatment is likely to be particularly high among offenders, as confirmed by evidence that only about half of those entering prison are registered with a GP (Social Exclusion Unit, 2002).

There is thus substantial scope for improving the mental health of many offenders at low cost. However, there is a high rate of prevalence of personality disorder among offenders (Singleton *et al.*, 1998) and there is evidence that where depression co-exists with personality disorder the individuals concerned respond less well to treatment for depression (Newton-Howes, Tyrer and Johnson, 2006). In such cases the risk of a poor outcome for depression is doubled compared with no personality disorder.

Nonetheless, the overall balance of benefits over costs for intervention is so large that any success by diversion and liaison schemes in engaging offenders with treatment for depression and related problems is likely to prove strongly justified on value for money grounds, even leaving aside any benefits in terms of reduced re-offending.

### **The benefits of early intervention**

Diversion and liaison schemes also provide an opportunity for the early identification of mental health problems and, as emphasised in the recent Foresight report on mental capital and wellbeing, there is good evidence to show that early intervention leads to better long-term outcomes for all types of mental ill health (Government Office for Science, 2008).



The benefits of early intervention are particularly important in the case of severe mental illness. Each year about 7,500 people in the UK develop a first episode of psychosis. About 80% of those people are aged 18-30, the age group in which offending rates are at their highest. Psychosis can lead to long-term, even lifetime, problems. It imposes extremely high costs on the NHS and other agencies, amounting to around £14,000 a year per case aged 15-44 (McCrone *et al.*, 2008).

There is clear evidence that late treatment results in poor long-term outcomes. The cognitive and psycho-social damage caused by psychosis occurs mainly during the early stages of the illness (up to five years after onset), after which a plateau of disability is reached which then predicts the level of disability at 15 years (Harrison *et al.*, 2001). The greater the delay in providing treatment, the greater the risk that individuals will experience more long-term problems, including decreased probability of complete remission and increased resistance to treatment (Marshall *et al.*, 2005). Suicide is also a significant risk in the early phase of illness: one person in ten with psychosis commits suicide and two-thirds of these deaths occur within the first five years (Department of Health, 2001).

Research studies from a number of countries now provide evidence that early intervention after first onset, based on quicker detection and treatment by specialist teams, is feasible and effective. Compared with standard care, early intervention services report shorter durations of untreated psychosis, lower relapse rates, lower use of compulsory detention, reduced hospital admissions, better service engagement and lower suicide rates (Addington, 2007). Early intervention is also cost-effective. One study shows that over an eight-year period a sample of patients receiving early intervention services incurred only about half the costs of standard care, with most of the savings resulting from reduced use of inpatient services (McGorry, 2007).

Such evidence provides a strong case for strengthening the work of diversion and liaison schemes in identifying severe mental illness among offenders as early as possible, in liaising with specialist early intervention in psychosis (EIP) teams and in engaging potential clients with these services. Again, this is likely to be justified on value for money grounds purely as a health intervention. Yet the apparent rise in the prevalence of severe mental illness among prisoners does not suggest that schemes have so far been very successful in diverting offenders with psychosis towards settings where they are most likely to receive effective treatment.

### **The benefits of assertive outreach**

An important development in mainstream mental health service delivery since 1999 has been the introduction and spread of assertive outreach teams, which provide intensive support for people with severe mental illnesses who are difficult to engage in traditional services. Staff working in these teams expect to see their clients frequently, with an average of four or five contacts per week with each client, and to stay in contact with them over time, however difficult that may be. Studies show that at least 95% of clients are still in contact with services even after 18 months (Curtis, 2007).

The overall effectiveness of diversion for offenders with mental health problems depends in large measure on the extent to which they can be successfully engaged with services on a continuing basis. Assertive outreach teams clearly provide a relevant model, given their success in maintaining contact with clients who are difficult to engage.

The costs of assertive outreach are estimated at around £8,000 a year per client (Curtis, 2007). This looks broadly consistent with a figure of around £8,600 a year per client for offenders with drug problems who are put on an intensive supervision programme with drug treatment (Matrix Knowledge Group, 2007).

Assuming that this unit cost is broadly applicable to offenders with severe mental illness, the total cost of providing intensive support will clearly depend on how long the support is needed. The duration of a community order including a mental health treatment requirement can be up to three years. In practice the average duration is around 18 months. The cost of intensive support for such a period would therefore be about £12,000. Equivalent costs of support for offenders with less serious mental health problems would be considerably lower, as less intensive support is likely to be needed over a shorter period.

The cost of assertive outreach for offenders with severe mental illness is therefore significant. However, £12,000 for 18 months of intensive supervision in the community is equivalent to keeping someone in prison for just 16 weeks. And assertive outreach has been introduced for groups of non-offenders because there is good evidence that it is an effective intervention which is justifiable in terms of resource use. It would seem odd not to apply the same model to offenders as to non-offenders when the same mental health benefits are likely to arise in each case and, for offenders, there are additional potential benefits in terms of reduced re-offending.

Finally, it is important to recognise that interventions to improve mental health can have indirect as well as direct benefits, because mental ill health contributes to a wide range of adverse outcomes. This is particularly the case in relation to substance misuse, where it is well established that people with a mental illness often make heavy use of alcohol or drugs as a form of self-medication. Mental ill health is also an important risk factor for poor physical health, unemployment, homelessness, poverty and other aspects of social exclusion. The benefits of intervening to reduce the incidence or severity of psychiatric illness go much wider than better mental health.



## Conclusions

Diversion has multiple outcomes, including cost savings in the criminal justice system, reductions in re-offending and improvements in mental health.

Well-designed arrangements for diversion (and supporting treatment) can achieve significant benefits in all these areas.

The magnitude of these gains cannot be estimated with any precision, but because mental illness and crime impose such large costs on individuals and society, the scale of improvement does not need to be very large to justify substantial investment in diversion on value for money grounds. Nor do schemes necessarily have to show benefits in all three areas to be good value for money.

The case for diversion is particularly strong when it means diverting offenders away from short sentences in prison. Prison is a high-cost intervention which is ineffective in reducing subsequent offending and inappropriate as a setting for effective mental health care.

Diverting offenders towards effective community-based services will improve their mental health.

Better mental health will reduce the level of crime, both because mental ill health is itself a risk factor for offending and because better mental health will reduce other risk factors such as substance misuse and improve the effectiveness of interventions directed at these other influences on offending.



# Conclusions

Hard quantitative information on the effectiveness of diversion and liaison services for offenders with mental health problems is in short supply. Faced with this problem, our approach has been to address the case for diversion from a number of different angles. This multi-method approach has included:

- A review of published evidence, drawing on the international literature as well as studies relating specifically to this country;
- The collection of information on the current workings of diversion and liaison schemes, based on site visits to a sample of 16 established schemes around the country;
- An investigation of the economics of diversion, based on modelling and related analytical techniques.

Our aim in utilising a variety of methods and sources of evidence in this way has been to assemble sufficient material to support a broadly based, informed judgement on the general merits of diversion.

**Our overall assessment is that well-designed arrangements for diversion and liaison can be strongly justified on value for money grounds.**

Central to this assessment is the fact that diversion has the potential for generating multiple benefits, including cost and efficiency savings in the criminal justice system, reductions in re-offending and improvements in mental health. In combination these benefits constitute a powerful case for active intervention aimed at directing offenders with mental health problems towards community-based services and support.

The extent to which these potential benefits are currently being realised in practice is very much open to question.

Seen from a national perspective, the coverage of existing diversion and liaison services is very limited. It is broadly estimated that the combined caseload of current schemes is 30-40,000 clients a year. Set against this, nearly 100,000 people are given prison sentences each year. Even on the most conservative assumptions more than half of these have some kind of mental health problem. In addition, twice as many offenders with mental health problems who are charged at court receive a community sentence as receive a prison sentence. Also taking into account other disposals, a reasonable assessment might be that the combined coverage of existing schemes is at best about 20% of the potential national caseload.

**The nationwide coverage of diversion services recommended by the official Reed report of 1992 has emphatically not been achieved.**

One reason for this shortfall is that there remain parts of the country where diversion and liaison schemes are simply non-existent. But even where services are available, there are legitimate concerns in many cases about the capacity of these schemes and the largely reactive methods they use for identifying potential clients. Significant numbers of people, even with severe mental illness, are not being picked up. It is certainly a cause for concern that, according to recent evidence, the country's

prisons now appear to contain more than twice as many people with severe mental illness as 10 years ago. If an important aim of diversion is to keep such people out of prison, it is not working.

**Many schemes seem to take a modest view of their role, focusing largely if not exclusively on the assessment of offenders with mental health problems and signposting them towards appropriate services.**

Beyond providing information to criminal justice agencies, they do not see it as part of their job to seek to influence decisions taken within the criminal justice system with regard to arrest, charging, remand or sentencing. Given the potential value for money of such activity, this looks like a missed opportunity.

**The effectiveness of diversion and liaison services depends in large measure on the extent to which offenders with mental health problems can be engaged with appropriate community-based services on a continuing basis.**

Signposting on its own is unlikely to be sufficient. Offenders represent a hard-to-reach group, often with multiple needs, who for a variety of reasons may be unwilling or unable to maintain contact with services without active support. In addition, mental health services are themselves often reluctant to take on clients with an offending history. In the absence of assertive interventions to promote long-term engagement, drop-out rates are always likely to be high. Assertive outreach has been shown to be effective in mainstream mental health services and its benefits should not be denied to offenders.

**In the absence of a clear national framework, services have developed in a piecemeal and haphazard way, often insecurely funded and dependent on the commitment and enthusiasm of particular individuals.**

Without seeking to decry the benefits of localism, this has arguably been taken to extremes in the case of diversion and liaison services and there is simply too much diversity in the way that schemes operate around the country. The quality of support provided to clients depends to an uncomfortably large degree on the accident of geography.

These are broad generalisations and, as we discovered during our site visits, individual examples of outstandingly effective practice can readily be found around the country. Nonetheless, our overall judgement is that substantial reform is needed in existing provision in order to reap the undoubted benefits of effective diversion to a much greater extent than is presently the case.



# Recommendations

Our recommendations are intended to address the shortcomings we have identified in the provision of diversion in England. They are:

## National coverage

The publication of the National Service Framework (NSF) for mental health among working-age adults in England in 1999 (Department of Health, 1999) prompted the introduction of a national network of specialist functional teams operating alongside pre-existing community mental health teams. They provide services for crisis resolution, assertive outreach and early intervention. Detailed policy implementation guidance was published shortly after the NSF, setting out prescriptive guidance on the activities these specialist teams should undertake and on such matters as the size and staff mix of teams (Department of Health, 2001).

There is a strong case for adopting a similar approach in relation to diversion and liaison services to ensure national coverage combined with greater uniformity in standards of provision. This would entail setting up a network of specialist teams to provide these services in every locality, in line with a national statement of policy on standards and associated implementation guidance on service specification and related matters. The offender health and social care strategy currently being prepared by the Government for publication later this year provides an opportunity for the announcement of such a policy framework.

**Recommendation 1: A Diversion and Liaison Team for people with mental health problems who come into contact with the criminal justice system should be established in every primary care trust (PCT) area in England. These teams should be supported by a national statement of policy and associated implementation guidance.**

We would envisage that, at a minimum, a team of 4-5 staff should be set up in every PCT area. This implies a cost of around £200,000 a year per PCT or around £30 million a year nationally, compared with total current spending on diversion and liaison services of about £10 million a year. Because of the scope for efficiency savings within the criminal justice system, the actual cost to the economy would be much lower (and indeed negative, if allowance is also made for longer-term savings resulting from reduced re-offending and better mental health).

## Team structure and composition

The make-up of teams will depend to an extent on local need. But there is a strong case for greater uniformity in the nature of provision. Teams should be multi-disciplinary, including some expertise in dual diagnosis, in outreach work and in housing and employment issues. They should also have a

psychiatrist's input, perhaps on a part-time or sessional basis. Psychiatrist involvement has several advantages, including facilitating access to hospital beds.

Most teams are likely to be based in the NHS. Where this is the case, our preference is that they should be linked to general mental health services in the locality rather than to forensic services. This is because the latter are generally very specialised, focusing on the small minority of offenders who both have a severe mental illness and are considered at high risk of causing serious harm to themselves or others. Either way, it is essential that diversion teams establish close working relationships with both of these services.

Given the importance of engagement, we feel strongly that consideration should be given to the possibility of service provision by the voluntary sector, for example because offenders in general and those from minority groups in particular may be more willing to engage with voluntary sector agencies than with statutory services.

**Recommendation 2: Commissioners of diversion and liaison services should wherever possible consider the scope for using voluntary sector agencies, but should specify a requirement for these teams to link to mainstream general and forensic mental health services, including early intervention services.**

### Written agreements

The most effective schemes seen during our site visits had written agreements with criminal justice agencies on the services to be provided, for example in the courts. There are many advantages to be gained by formalising relationships in this way, including greater clarity of aims and objectives, improved accountability and an associated requirement for better data, particularly for monitoring purposes.

**Recommendation 3: The services to be provided by diversion and liaison teams to criminal justice agencies should always be specified in contracts or service-level agreements.**

### Multi-agency working

The effectiveness of diversion and liaison teams depends to a large degree on establishing and maintaining good relationships with a wide range of other organisations and agencies in the locality. There is therefore a strong case for setting up a multi-agency steering or management group to oversee the work of teams which brings together these stakeholders.

**Recommendation 4: Every diversion and liaison team should be overseen by a cross-agency management group.**

### Funding

Diversion and liaison services are very largely funded from mental health budgets (NHS and, to a lesser extent, social services). We think there are very strong arguments for joint funding from mental health *and* criminal justice budgets. The work of diversion and liaison schemes can yield substantial

financial benefits for the criminal justice system, both in the short term, by improving efficiency in the administration of justice, and in the longer term, by reducing re-offending.

On the principle that ‘the beneficiary should pay’, it is entirely reasonable that criminal justice agencies should contribute to the cost of the services which generate these savings. In addition, where payment is involved, both commissioners and providers will be required to specify more clearly than at present the services to be provided by teams. Joint funding is likely to increase the stability and security of resourcing for diversion and liaison services by reducing their dependence on just one funding stream.

**Recommendation 5: Diversion and liaison services should always be commissioned on the basis of joint funding from mental health and criminal justice budgets, underpinned by inter-agency agreements.**

### All-stages diversion

Diversion and liaison teams should play a broader, more active role than they do presently. They should operate at all stages of the criminal justice pathway, from arrest through to sentencing and beyond, rather than concentrating their activities at a single location in the criminal justice system, such as police stations or the courts.

Teams should thus provide an integrated service which will allow them to support individuals from the time of arrest, as they pass through the courts and after they have been sentenced. In the case of offenders who receive a prison sentence, the role of teams will be to liaise with prison inreach services in the same way as they do with community-based mental health services for offenders who do not receive a custodial sentence. For those on community orders, teams will need to work closely with probation staff. The provision of through-care in this way has a number of advantages, including greater continuity of support and the establishment of closer relationships with individual offenders. This in turn is likely to lead to better engagement with services.

**Recommendation 6: Diversion and liaison teams should be organised to provide integrated through-care, supporting offenders with mental health problems at all stages of the criminal justice pathway.**

A possible extension of this role relates to diversion at the pre-arrest stage. Police-based schemes in this country currently focus exclusively on supporting clients after arrest. But there is some evidence from the US that pre-arrest schemes can be effective, based either on the use of specially trained police officers or on mental health workers accompanying police officers to crisis situations. In the light of such evidence, there is a case for exploring the potential applicability of these models to the British context.

**Recommendation 7: The Department of Health, the Home Office and the Ministry of Justice should jointly consider setting up a small number of pilot projects to explore the feasibility, effectiveness and costs of different models of pre-arrest diversion.**

## Identification and assessment

We are concerned that many diversion and liaison schemes use largely reactive methods of identifying offenders with mental health problems. There is evidence that reliance on referrals from police officers and court officials, who generally have limited knowledge of mental health issues, runs a serious risk of under-diagnosis. Even cases of serious mental illness are often missed.

**Recommendation 8: Diversion and liaison teams should extend the use of pro-active methods of identifying potential clients, including 100% screening of selected groups of offenders.**

The selected groups in question might include women and young people, because of particular vulnerabilities such as an elevated risk of self-harm following involvement in the criminal justice system. They should also include repeat offenders, because the potential benefits of intervention in relation to reduced re-offending are likely to be particularly high.

Dual diagnosis, i.e. mental ill health co-existing with substance misuse, is extremely common among offenders. Drug interventions programme (DIP) workers already have an extensive presence in police stations. Both of these factors support a case for close joint working between DIP teams and diversion teams. Possibilities include the use of jointly conducted assessments or the up-skilling of workers in both teams so that either is capable of carrying out assessments that cover both mental illness and substance misuse.

**Recommendation 9: Diversion and liaison teams should work more closely with drug interventions programme (DIP) teams in identifying potential clients.**

Action is also needed to improve the identification of mental illness by police officers, court officials and other criminal justice staff. More training in mental health awareness is one obvious possibility (see Recommendation 11). Another is to strengthen or extend the questions relating to mental health that are routinely asked within the criminal justice system, for example by custody sergeants after an offender is brought into police custody.

**Recommendation 10: The Home Office, the Ministry of Justice and Department of Health should jointly consider the scope for improving the identification of mental illness by police officers, court officials and other criminal justice staff.**

## Training for criminal justice staff

During our site visits a number of scheme managers commented that they were often asked to provide both formal and informal training, particularly on mental health awareness, to people working in criminal justice agencies including police officers, court officials and magistrates. The provision of such training is clearly good practice and can only help to improve the identification of offenders with mental health problems and their management as they go through the criminal justice system.

Training should be seen by all diversion and liaison teams as part of their core business, with explicit provision for this being included in the contracts or service-level agreements with criminal justice agencies (see Recommendation 3).

**Recommendation 11: All diversion and liaison teams should develop and agree plans for the provision of training in mental health issues for criminal justice staff.**



## Influencing decisions in the criminal justice system

During our site visits we found a great deal of variation between schemes in the extent to which they explicitly seek to influence key decisions taken within the criminal justice system such as those relating to charging and sentencing. Some were active in making recommendations, while others said that this went beyond their remit. Because of the many potential benefits of diversion, our view is that schemes should be as assertive as possible in making recommendations, particularly where this may lead to reduced use of custody. (See also recommendation 18.)

**Recommendation 12: All diversion and liaison teams should provide recommendations as well as information to criminal justice agencies, in relation to decisions on charging, remand, sentencing and disposal.**

## Engagement with services

The effectiveness of diversion depends critically on successfully engaging offenders with local services on a continuing basis. There is, however, good evidence to show that, under present arrangements, rates of disengagement are very high. This problem may be addressed in two main ways: first, measures taken by mental health and other service providers to strengthen voluntary engagement; and second, measures which promote engagement via compulsion or threat of sanctions for non-compliance.

While both sets of options may always need to be considered, there is a strong case for using them sequentially. The first priority should be to improve voluntary engagement, for example through the provision of services which are more responsive to a person's needs and wishes. If, however, an offender persistently fails to engage, then – proportionate to the seriousness of the offence, the risks imposed and the costs of further offending – conditionality and compulsion may need to come into play. Any extension of such criminal justice-based options should be accompanied by a reciprocal guarantee of an appropriate, personalised service.

Diversion and liaison teams should play a much more active and assertive role in securing voluntary engagement with services. Teams should operate at all stages in the criminal justice pathway (see Recommendation 6), including working closely with probation staff and others in the post-sentencing phase. For example, many offenders are given supervision orders by the courts which require them to meet regularly with probation officers. A mental health worker from a diversion and liaison team could also attend these meetings, as a means of encouraging and monitoring an offender's engagement with services.

All diversion and liaison teams should also have some expertise in outreach work. This could be achieved by including a dedicated outreach worker in each team, but in general it is preferable to regard outreach as a team function in which all members should develop relevant skills. All teams should respond to the needs of minority groups within the local community, for example by working to meet the needs of particular black and minority ethnic groups.

**Recommendation 13: All diversion and liaison teams should undertake outreach work as a core part of their business to ensure that their clients engage satisfactorily with local services.**

Diversion and liaison teams may also want to consider the scope for employing ex-offenders, particularly for outreach work. They may be better placed than others to develop the relationship of trust with clients that is essential for successful outreach work.

Offenders with severe mental illness are likely to fall into the ‘hard-to-reach’ category of mental health service users. Those living in the community should therefore be eligible for the services provided by mainstream assertive outreach teams. A number of scheme managers commented during our site visits that this was not always easy to arrange and that there was some resistance among assertive outreach teams to taking on clients with an offending history. This is clearly unsatisfactory, given the proven success of these teams in maintaining contact with users.

**Recommendation 14: Commissioners and managers of assertive outreach services, and indeed all community-based mental health services, should ensure that a potential client’s offending history does not act as a barrier to receipt of these services.**

Many offenders have multiple needs but their mental health condition is often not sufficiently severe to meet the acceptance criteria of secondary or specialist mental health services. In other words, their mental health need is ‘sub-threshold’.

This does not necessarily reduce the requirement for support, but it can create particular problems. The mental health services needed by this group are not always readily available in the community. Help with multiple needs also requires engagement with a potentially wide range of services (e.g. drugs, housing and employment as well as mental health). Particularly in the absence of appropriate statutory services, voluntary sector agencies may be well placed to play an important role in supporting offenders with multiple ‘sub-threshold’ needs and some indeed already have considerable experience in this area, using models of support such as the Link Worker scheme previously developed by the Revolving Doors Agency.

**Recommendation 15: PCTs and other commissioners should actively explore the scope for using voluntary sector agencies to provide support for offenders with multiple ‘sub-threshold’ needs.**

An important role in the provision of mental health care for those with ‘sub-threshold’ needs falls to GP-led primary health care teams. Traditional models of primary care based on the general practice surgery are not always well placed to take on this role. Sainsbury Centre for Mental Health has already put forward a proposal for changing the GP contract to support a new service: a Directed Enhanced Service for Social Exclusion, aimed at meeting the needs of various excluded groups including offenders (Sainsbury Centre, 2007). Such a service would be an extension of the current obligation on PCTs to deliver a primary care service for violent patients and would provide the opportunity for primary care teams to work closely with social services, drug and alcohol services and other providers to offer a tailored service to groups of people with complex needs.

**Recommendation 16: The Department of Health and PCTs should develop new methods of primary care support for offenders with complex needs and other similar groups. This could be achieved through a Directed Enhanced Service for Social Exclusion.**

For offenders who persistently fail to engage voluntarily, we support the greater use of conditionality within the criminal justice system as a means of promoting service use. This includes conditional cautions by the police, conditional discharges by the courts and also the use of conditions relating to bail as an alternative to remanding an offender in custody. In all these cases, an offender can be required to engage with services under threat of legal sanctions for failing to comply.

**Recommendation 17: In appropriate circumstances, criminal justice agencies should make greater use of conditionality in decisions relating to charging, remand and sentencing as a means of promoting engagement with mental health services by offenders.**

For offenders receiving a community sentence, one option open to sentencers is a community order with a Mental Health Treatment Requirement (MHTR), under which an offender with mental health problems is required to comply with an agreed care plan under supervision for a specified period of time (up to three years), again with possible sanctions in the event of breach.

Sainsbury Centre is currently preparing a separate report on the MHTR. It will examine the reasons why it has so far been used very little by the courts and will suggest possible reforms. Subject to improvements in its design and operation, we see potential benefit in greater use of the MHTR, particularly for offenders who have a previous history of disengaging from services. An important reason for this is that the MHTR not only requires offenders to engage with services but also requires services to engage with them, as the courts will only give this order when a specified local provider has signed up to deliver an agreed care plan. This may help to overcome any unwillingness in local services to take on clients with an offending history.

One objection to the MHTR is that compulsory treatment for mental health problems is inherently unsatisfactory. It should be noted, however, that an offender always has the initial choice of whether or not to accept this sentence.

**Recommendation 18: More use should be made of the Mental Health Treatment Requirement as a sentencing option.**

One other possible criminal justice-based option is to set up dedicated mental health courts along the lines followed in the US and elsewhere. Two pilot projects funded by the Ministry of Justice are in fact currently in development and these will include arrangements for detailed evaluation.

Pending the results of these pilot studies, our provisional view is that, while mental health courts have some potential attractions, there are also a number of downsides. These include the risk that they will increase the stigmatisation of offenders with mental health problems.

It is not entirely clear what mental health courts offer that cannot already be achieved by existing arrangements, and in any event it is not obviously sensible to introduce a wholly new system in order to compensate for the shortcomings of the current system.

## Improving the evidence base

Shortages of reliable information and evidence on diversion have been highlighted throughout this report. We have identified three priority areas for gathering further evidence about diversion in England.

**Recommendation 19: The Department of Health, the Home Office and the Ministry of Justice should jointly commission a programme of studies on diversion and liaison, based on high-quality research methods including the use of control groups and quantitative measures of outcome, with a particular aim of improving our knowledge of effectiveness and cost-effectiveness.**

**Recommendation 20: The Home Office and the Ministry of Justice should collect and publish much more information on unit costs in the criminal justice system.**

**Recommendation 21: The Office for National Statistics should undertake one or more surveys of psychiatric morbidity among all offenders (and not just prisoners), based on samples of people arrested by the police and / or those appearing in court.**



# References

- Addington, J. (2007) The promise of early intervention. *Early Intervention in Psychiatry*, **1**, 294-307.
- Aizenman, N. (2008) New high in US prison numbers. *Washington Post*, February 29 2008, p. AO1.
- Aos, S., Miller, M. and Drake, E. (2006) *Evidence-based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs and Crime Rates*. Olympia: Washington State Institute for Public Policy.
- Birmingham, L. (2001) Diversion from custody. *Advances in Psychiatric Treatment*, **7**, 198-207.
- Blackburn, R. (2004) 'What works' with mentally disordered offenders. *Psychology, Crime and Law*, **10** (3) 297-308.
- Boothroyd, R., Poythress, N., McGaha, A. and Petrila, J. (2003) The Broward Mental Health Court: process, outcomes and service utilization. *International Journal of Law and Psychiatry*, **26**, 55-71.
- Borum, R., Williams, M., Deane, M. *et al.* (1998) Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness. *Behavioral Sciences and the Law*, **16**, 393-405.
- Brand, S. and Price, R. (2000) *The Economic and Social Costs of Crime*. Home Office Research Study 217. London: Home Office.
- Butterfield, F. (1998) Prisons replace hospitals for the nation's mentally ill. *New York Times*, vol. CXL VII, March 1998.
- Centre for Public Innovation (2005) *Review into the Current Practice of Court Liaison and Diversion Schemes*. London: CPI.
- Chung, M., Cumella, S., Wensley, J. and Easthope, Y. (1998) Quality of life and psychological wellbeing of mentally disordered offenders after court diversion: a 6-month follow-up. *International Journal of Offender Therapy and Comparative Criminology*, **42** (2) 164-173.
- Chung, M., Cumella, S., Wensley, J. and Easthope, Y. (1999) Follow-up study of mentally disordered offenders after a court diversion scheme: six month and one year comparison. *Medicine, Science and the Law*, **39**, 30-37.
- Cosden, M., Ellens, J., Schnell, J. and Yamini-Diouf, Y. (2005) Efficacy of a mental health court with assertive community treatment. *Behavioral Sciences and the Law*, **23**, 199-214.
- Cowell, A., Broner, N. and Dupont, R. (2004) The cost-effectiveness of criminal justice programs for people with serious mental illness co-occurring with substance abuse. *Journal of Contemporary Criminal Justice*, **20** (3) 292-315.
- Cunliffe, J. and Shepherd, A. (2007) *Re-offending of Adults: Results from the 2004 cohort*. London: Home Office.

- Curtis, L. (2007) *Unit Costs of Health and Social Care 2007*. Canterbury: Personal Social Services Research Unit.
- Davis, R., Rubin, J., Rabinovich, L., Kilmer, B. and Heaton, P. (2008) *A Synthesis of Literature on the Effectiveness of Community Orders*. Cambridge: RAND Europe.
- Deane, M., Steadman, H., Borum, R. *et al.* (1999) Emerging partnerships between mental health and law enforcement. *Psychiatric Services*, **50** (1) 99-101.
- Department of Health (1999) *National Service Framework for Mental Health: Modern standards and service models*. London: Department of Health.
- Department of Health (2001) *The Mental Health Policy Implementation Guide*. London: Department of Health.
- Department of Health and Home Office (1992) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services*. London: HMSO.
- Ditton, P. (1999) *Mental Health and Treatment of Inmates and Probationers*. Bureau of Justice Statistics, NCJ-174463. Washington DC: US Department of Justice.
- Dubourg, R., Hamed, J. and Thorns, J. (2005) *The Economic and Social Costs of Crime against Individuals and Households 2003/04*. Home Office Online Report 30/05 (<http://www.homeoffice.gov.uk/rds/pdfs05/rdsolr3005.pdf>) [Accessed October 2008]
- Exworthy, T. and Parrott, J. (1993) Evaluation of a diversion scheme at magistrates' courts. *Journal of Forensic Psychiatry*, **8**, 406-416.
- Godfrey, C., Eaton, G., McDougall, C. and Culyer, A. (2002) *The Economic and Social Costs of Class A Drug Use in England and Wales, 2000*. Home Office Research Study 249. London: Home Office.
- Government Office for Science (2008) *Mental Capital and Wellbeing: Making the most of ourselves in the 21<sup>st</sup> century*. London: Government Office for Science.
- Green, G., Smith, R. and South, N. (2005) Court-based psychiatric assessment: case for an integrated diversionary and public health role. *Journal of Forensic Psychiatry and Psychology*, **16** (3) 577-591.
- Harper, G. and Chitty, C. (eds) (2005) *The Impact of Corrections on Re-offending: A review of 'what works'*. Home Office Research Study 296. London: Home Office.
- Harries, R. (1999) *The Cost of Criminal Justice*. Home Office Research, Development and Statistics Directorate, Research Findings 103. London: Home Office.
- Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J. *et al.* (2001) Recovery from psychotic illness: a 15- and 25-year international follow-up study. *British Journal of Psychiatry*, **178**, 506-517.
- Hartford, K., Davies, S., Dobson, C. *et al.* (2004) *Evidence-Based Practices in Diversion Programs for Persons with Serious Mental Illness who are in Conflict with the Law: Literature review and synthesis*. London, Ontario: Lawson Health Research Institute.
- Hean, S., Warr, J. and Staddon, S. (2008) *Report on Phase 1 Baseline of the Evaluation of the South West Mental Health Assessment and Advice Pilot*. Bournemouth: School of Health and Social Care, Bournemouth University.

Herinckx, H., Swart, M., Ama, S., Dolezal, C. and King, S. (2005) Rearrest and linkage to mental health services among clients of the Clark County mental health court program. *Psychiatric Services*, **56** (7) 853-857.

HM Inspectorate of Prisons (2007) *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*. London: HM Inspectorate of Prisons.

Hollis, V. (2007) *Re-conviction Analysis of Programme Data using Interim Accredited Programmes Software (IAPS)*. London: National Offender Management Service.

Home Office (1990) *Provision for Mentally Disordered Offenders: Circular 66/90*. London: Home Office.

Home Office (1995) *Mentally Disordered Offenders: Inter-Agency Working: Circular 12/95*. London: Home Office.

Home Office (2006) *Final report of the Strategic Policy Team Project on Mentally Disordered Offenders*. Internal report.

House of Lords (2008) *Hansard Written Answers*, 15 October 2008, Column WA55 (<http://www.publications.parliament.uk/pa/ld200708/ldhansrd/text/81015w0001.htm>) [Accessed October 2008]

Hudson, D., James, D. and Harlow, P. (1995) *Psychiatric Court Liaison to Central London*. London: Riverside Mental Health.

James, D. (2000) Police station diversion schemes: role and efficacy in central London. *Journal of Forensic Psychiatry*, **11** (3) 532-555.

James, D., Farnham, F., Moorey, H., Lloyd, H., Hill, K., Blizard, R. and Barnes, T. (2002) *Outcome of Psychiatric Admission through the Courts*. London: Home Office.

James, D. and Hamilton, L. (1991) The Clerkenwell scheme: assessing efficacy and cost of a psychiatric liaison service to a magistrates' court. *British Medical Journal*, **303**, 282-285.

Joseph, P. and Potter, M. (1993) Diversion from custody. I: psychiatric assessment at the magistrates' court. II: effect on hospital and prison resources. *British Journal of Psychiatry*, **162**, 325-334.

Kingham, M. and Corfe, M. (2005) Experiences of a mixed court liaison and diversion scheme. *Psychiatric Bulletin*, **29**, 137-140.

Knapp, M., McCrone, P. and Capdevielle, D. (2008) *Better Treatment Responses to Depression: Economic consequences*. Foresight Mental Capital and Wellbeing discussion paper 25. Available on request from [Foresightweb@dius.gsi.gov.uk](mailto:Foresightweb@dius.gsi.gov.uk)

Lamb, R. and Weinberger, L. (1998) Persons with severe mental illness in jails and prisons: a review. *Psychiatric Services*, **49** (4) 483-492.

Lamberti, S., Weisman, R., Schwarzkopf, S., Price, N., Ashton, R. and Trompeter, J. (2001) The mentally ill in jails and prisons: towards an integrated model of prevention. *Psychiatric Quarterly*, **72** (1) 63-77.

Landenberger, N. and Lipsey, M. (2005) The positive effects of cognitive-behavioral programmes for offenders: a meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology*, **1** (4) 451-476.



Marshall, M., Lewis, S., Lockwood, A., Drake, R., Jones, P. and Croudace, T. (2005) Association between duration of untreated psychosis and outcome: a systematic review. *Archives of General Psychiatry*, **62**, 975-983.

Matrix Knowledge Group (2007) *The Economic Case for and against Prison*. London: Matrix Knowledge Group.

Matrix Knowledge Group (2008) *Dedicated Drug Court Pilots: A process report*. Ministry of Justice Research Series 7/08. (<http://www.justice.gov.uk/docs/dedicated-drug-courts.pdf>) [Accessed October 2008]

McCrone, P., Dhanasini, S., Patel, A., Knapp, M. and Lawton-Smith, S. (2008) *Paying the Price: The cost of mental health care in England, projections to 2026*. London: King's Fund.

McGorry, P. (2007) *Investing in Youth Mental Health*. Melbourne: University of Melbourne, ORYGEN Research Centre.

McGuire, J. (2000) *What works in reducing criminality*. Conference paper. (<http://www.aic.gov.au/conferences/criminality/mcguire.html>) [Accessed October 2008]

Ministry of Justice (2007) *Sentencing Statistics*. London: Ministry of Justice.

Nacro (2005) *Findings of the 2004 Survey of Court Diversion /Criminal Justice Liaison Schemes for Mentally Disordered Offenders in England and Wales*. London: Nacro.

Newton-Howes, G., Tyrer, P. and Johnson, T. (2006) Personality disorder and the outcome of depression: meta-analysis of published studies. *British Journal of Psychiatry*, **188**, 13-20.

O'Keefe, K. (2006) *The Brooklyn Mental Health Court Evaluation: Planning, Implementation, Courtroom Dynamics and Participant Outcomes*. New York: Center for Court Innovation.

Pakes, F. and Winstone, J. (2006) *Mentally Disordered Offenders: Effective practice*. London: Home Office, Office of Criminal Justice Reform.

Pierzchniak, P., Purchase, N. and Kennedy, H. (1997) Liaison between prison, court and psychiatric services. *Health Trends*, **29**, 26-29.

Regan, C. (2001) Mental illness and the criminal justice system. *Mental Health World*, **9** (2) 22.

Ridgely, S., Engberg, J., Greenberg, M. et al. (2007) *Justice, Treatment and Cost: An Evaluation of the Allegheny County Mental Health Court*. Santa Monica, California: RAND Corporation.

Riordan, S., Wix, S., Kenney-Herbert, J. and Humphreys, M. (2000) Diversion at the point of arrest: mentally disordered people and contact with the police. *Journal of Forensic Psychiatry*, **11** (3) 683-690.

Robertson, G., Pearson, R. and Gibb, R. (1996) The entry of mentally disordered people to the criminal justice system. *British Journal of Psychiatry*, **169**, 172-180.

Rowlands, R., Inch, H., Rodger, W. and Soliman, A. (1996) Diverted to where? What happens to the diverted mentally disordered offender. *Journal of Forensic Psychiatry*, **7**, 284-296.

Sainsbury Centre (2007) *Policy Paper: Getting the Basics Right: Developing a primary care mental health service in prisons*. London: Sainsbury Centre for Mental Health.

Sainsbury Centre (2008a) *All-stages Diversion: A model for the future* (web paper) [http://www.scmh.org.uk/pdfs/all\\_stages\\_diversion\\_model.pdf](http://www.scmh.org.uk/pdfs/all_stages_diversion_model.pdf) [Accessed 9 January 2009]

Sainsbury Centre (2008b) *Short-changed: Spending on prison mental health care*. London: Sainsbury Centre for Mental Health.

Sederer, L., Silver, L., McVeigh, K. and Levy, J. (2006) Integrating care for medical and mental illness. *Preventing Chronic Disease*, **3** (2) 1-3.

Shaw, J., Creed, F., Huxley, P. and Tomenson, B. (1999) Prevalence and detection of serious psychiatric disorder in defendants attending court. *The Lancet*, **353**, 1053-1056.

Shaw, J., Tomenson, B., Creed, F. and Perry, A. (2001) Loss of contact with psychiatric services in people diverted from the criminal justice system. *Journal of Forensic Psychiatry*, **12** (1) 203-210.

Sheridan, E. and Teplin, L. (1981) Police-referred psychiatric emergencies: advantages of community treatment. *Journal of Community Psychology*, **9**, 140-147.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. and Meltzer, H. (2001) *Psychiatric Morbidity among Adults Living in Private Households, 2000*. London: Office for National Statistics.

Singleton, N., Meltzer, H. and Gatward, R. (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: Office for National Statistics.

Skrzypiec, G., Wundersitz, J. and McRostie, H. (2004) *Magistrates Court Diversion Program: An Analysis of Post-Program Offending*. Adelaide: Office of Crime Statistics and Research, Government of South Australia.

Smith, R., Grimshaw, R., Romeo, R. and Knapp, M. (2007) *Poverty and Disadvantage among Prisoners' Families*. York: Joseph Rowntree Foundation.

Social Exclusion Unit (2002) *Reducing Re-offending by Ex-prisoners*. London: Office of the Deputy Prime Minister.

Steadman, H., Deane, M., Borum, R. and Morrissey, J. (2000) Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services*, **51** (5) 645-649.

Steadman, H. and Naples, M. (2005) Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behavioral Sciences and the Law*, **23**, 163-170.

Stewart, D. (2008) *The Problems and Needs of Newly Sentenced Prisoners: Results from a National Survey*. Ministry of Justice Research Series 16/08. (<http://www.justice.gov.uk/docs/research-problems-needs-prisoners.pdf>) [Accessed October 2008]

Trupin, E. and Richards, H. (2003) Seattle's mental health courts: early indicators of effectiveness. *International Journal of Law and Psychiatry*, **26**, 33-53.

Walsh, E., Buchanan, A. and Fahy, T. (2002) Violence and schizophrenia: examining the evidence. *British Journal of Psychiatry*, **180**, 490-495.