

A joint inspection on work
prior to sentence with
offenders with mental
disorders

by HMI Probation, HMI
Court Administration, HMI
Constabulary and HM
Crown Prosecution Service
Inspectorate

Foreword

The whole subject of 'offenders with mental disorders' is a huge one, and therefore this inspection has focused only on some specific aspects. In particular we have examined cases that have been identified prior to sentence as having a mental disorder, and we have examined how these have been handled in practice.

Even defining this subject is complicated, with different assessments of the issues it raises being based on different definitions. Therefore we have recommended adopting the 'Bradley definition' (see page 8) because although it is a broad definition it is workable and does have 'currency'. This should enable better data collection to start that depends on clarity of definitions.

We found, perhaps surprisingly, that there was not a clamour from either criminal justice or health professionals for diverting an increased number of offenders from prosecution. Most felt that the majority of such offenders should be expected to take responsibility for their actions, and that treatment should be alongside rather than instead of court action. However, in the minority of cases, the ones who were suitable for diversion, there did appear to be scope for greater efficiency by diverting these earlier in the process, before they got to the court stage. Most of the areas we visited would also benefit from a better quality and more timely psychiatric report service once at the court stage.

More generally, whilst we would not suggest that mental disorders 'cause' people to start offending, except in a small number of cases, it was clear that treatment did help some current offenders to stop offending, so sustained access to treatment continues to be very important.

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Glossary of abbreviations

ACPO	Association of Chief Police Officers
AMHP	Approved Mental Health Professional: a social worker trained to implement elements of the Mental Health Act 2007 in conjunction with medical practitioners. They have a pivotal role in assessing individuals and in deciding whether they meet the criteria to detain them without their consent. Formerly known as Approved Social Worker
ASBO	Anti-Social Behaviour Order: introduced by the Crime and Disorder Act 1998, a civil order issued by the magistrates' court against a person known to have engaged in antisocial behaviour
CDRP	Crime and Disorder Reduction Partnership: multi-agency partnerships set up in each local authority in England with funding from the Home Office to achieve a community-based approach to crime reduction. The statutory partners are police, the local authority, the police authority, the fire authority and primary care trust
CJCIG	Criminal Justice Chief Inspectors' Group consisting of the five Chief Inspectors of the criminal justice inspectorates
CPA	Care Programme Approach: the system for delivering services in the community to those with mental illnesses. It requires health and social services to work together to assess need, provide a written care plan, which is regularly reviewed, and allocate services
CPS	Crown Prosecution Service
CPN	Community psychiatric nurse: a fully trained psychiatric nurse, with several years experience of working on a ward, based in the community as an integral part of the mental health team
GP	General practitioner
HM	Her Majesty's
HMCPSP	HM Crown Prosecution Service Inspectorate
HMCS	HM Courts Service
HMIC	HM Inspectorate of Constabulary
HMICA	HM Inspectorate of Court Administration
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
LCJB	Local Criminal Justice Board: these boards bring together the chief officers of the local Criminal Justice Service agencies to coordinate activity and share responsibility for delivering criminal justice in their areas. They report to the National Criminal Justice Board

LHB	Local Health Board: these boards fulfil the same function in Wales as primary care trusts in England. They are coterminous with the 22 local authorities in Wales
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together in a given geographical area to manage certain types of offenders. The National Guidance for MAPPA was contained in Probation Circular 54/2004
NHS	National Health Service
NOMS	National Offender Management Service: the evolving single service covering both the probation and prison services
NPIA	National Policing Improvement Agency: a non-departmental public body which became operational in 2007. It supports the police by providing expertise in areas as information technology, information sharing and recruitment
OASys	Offender Assessment System: the prescribed framework for both the probation and prison services to assess offenders
OCJR	Office for Criminal Justice Reform
OMI	Offender Management Inspection: the inspection programme led by HM Inspectorate of Probation examining the delivery of offender management by probation areas and other relevant partner organisations
PACE	Police and Criminal Evidence Act 1984: instituted a legal framework, supported by Codes of Practice, for the exercise of police powers in combating crime across England and Wales
PCT	Primary Care Trust: part of the National Health Service in England and Wales, providing a range of health services, some of which they commission from other providers. They have their own budgets and set their own priorities within the overriding priorities and budgets set by the relevant Strategic Health Authority and Department of Health
PNC	Police National Computer: a computer system, maintained by the National Policing Improvement Agency as from April 2007, giving police access to information about known individuals
PSR	Pre-sentence report: a written document prepared at the request of the court. It usually contains proposals for sentence and comments on the <i>Risk of Harm</i> posed by offenders, their likelihood of reoffending and the factors which need to be addressed to support desistance from future offending
<i>Risk of Harm</i>	As distinct from likelihood of reoffending: if an offender has a medium or higher <i>Risk of Harm</i> it means that there is some probability that they may behave in a manner that causes physical or psychological harm (or real fear of it) to others. The offender's <i>Risk of Harm</i> can be kept to a minimum by means of restrictive interventions

KEY FINDINGS AND RECOMMENDATIONS

1. This inspection was agreed by the Criminal Justice Chief Inspectors' Group (CJCIG), following consultation with key stakeholders, as part of the Joint Inspection Business Plan 2008/2009. Its purpose was to:
to assess the quality and effectiveness of information exchanges between criminal justice agencies in dealing with mentally disordered offenders during the period from arrest/detention to sentence in:
 - ▶ *ensuring appropriate treatment and support both within and outside the criminal justice system*
 - ▶ *facilitating their diversion from prosecution or custody where appropriate.*
2. During the course of the inspection, we considered the case files of 130 individuals where concerns had already been expressed about their mental health. These cases were drawn from the six areas visited during the inspection: Dyfed-Powys (Aberystwyth and Carmarthen), Greater Manchester (Bolton), London (Camberwell), West Mercia (Hereford), Warwickshire (Nuneaton and Leamington Spa) and Wiltshire (Swindon).

DEFINITIONS

3. Although there are a number of definitions of what constitutes an offender with mental disorder, none have been universally accepted. The statutory definition of 'mental disorder' given in the Mental Health Act 1983 as amended by the Mental Health Act 2007, refers to '*any disorder or disability of the mind*' as determined by the court on the evidence of a medical practitioner. Despite the amendments introduced by the 2007 Act, the definition still only applies to the group of offenders who fit the criteria for treatment and admission to hospital under the appropriate legislation and failed to establish a common language between health and criminal justice organisations. It also, as we were to discover, allowed for different interpretation within the medical profession.
4. Some other definitions take a very broad approach and include, for example those with substance misuse problems. These wider definitions of mental health needs can be helpful except where they perpetuate a lack of focus.
5. As a consequence of the lack of a national agreed definition of offenders with mental disorders, there are no consistent estimates as to the number of these offenders in the criminal justice system. It is therefore extremely difficult to project need, define the nature of the services required or evaluate initiatives. It is, however, generally agreed that there are higher levels of mental health need amongst offenders than in the general population, although it is not clear how far their mental health impacts on their offending.

6. Overall, we felt that the definition of an offender with a mental disorder initially put forward by the National Association for the Care and Resettlement of Offenders (NACRO) and later adopted by Lord Bradley in his review of people with mental health problems and learning difficulties within the criminal justice system in 2009 provided us with a workable option:

'Those who come into contact with the criminal justice system because they have committed, or are suspected of committing, a criminal offence, and who may be acutely or chronically ill. It also includes those in whom a degree of disturbance is recognised even though it may not be severe enough to bring it within the criteria laid down by the Mental Health Act 1983 (now 2007).'

We therefore recommend that the Department of Health, Department for Children, Schools and Families, the Ministry of Justice, the Youth Justice Board and the Home Office adopt a common definition that defines the scope of offenders with mental disorders.

THE STRATEGIC FRAMEWORK

7. The most recent guidance to be issued nationally to all criminal justice agencies was in the 1990s. It encouraged them to work together to ensure that, wherever possible, offenders with mental disorders were considered for diversion from prosecution or imprisonment. Although a great deal of effort was initially put into diversion projects, and despite growing awareness and concern about this group of offenders, the momentum was not maintained in the absence of further strategic direction.
8. Some work, however, continued. The needs of offenders with mental disorders, and their disproportionate representation within the prisons, continued to be raised through a number of cross-cutting reports. The Social Exclusion Unit's report *Reducing Reoffending by Ex-Prisoners* in 2002 firmly established mental and physical health as one of the nine factors that contributed to offending and informed the development, in 2007, of the new Public Service Agreements, setting out the Government's priority outcomes for 2008-2011. Responsibility for raising the standard of healthcare for offenders across the criminal justice system was devolved to Offender Health, a team which spans both the Department of Health and the National Offender Management Service (NOMS), who in 2007 produced a consultation document *Improving Health, Supporting Justice* on the proposed direction of the new Offender Health and Social Care Strategy.
9. This work was given further impetus in April 2009 by the publication of Lord Bradley's independent review of offenders with mental disorders in the criminal justice system, undertaken at the request of the Secretary of State. The review recognised that the implementation of the diversion policies put forward in the 1990s had been, at best, inconsistent, and now needed to be re-invigorated. The report contained a number of far-reaching recommendations, many touching on issues also raised in this report, which are currently being taken forward through the Health and Criminal Justice Delivery Plan, scheduled for publication in November 2009.

LEADERSHIP AT LOCAL LEVEL

10. Despite the recent activity at a national level, organisations were still working to the 1990s guidance and strategic planning at a local level was underdeveloped. Some guidance had been issued to individual agencies and we found a number of examples of senior managers working together effectively to develop services in the areas we visited. The involvement of health commissioners with criminal justice agencies in developing services for offenders with mental disorders was showing some signs of progress, but was not yet secure and still subject to funding and access problems.
11. Effective planning was impeded not only by the lack of an agreed definition at a national level of what was meant by the term '*mentally disordered offenders*' but by the paucity of data and the incompatibility of recording and data collection systems amongst the key criminal justice organisations. As a result, any attempts at performance management were likely to fail as it was extremely difficult for any criminal justice organisation to monitor or audit its work.
12. Although we did not identify any key concerns about the management of black or minority ethnic offenders or female offenders in the course of this inspection, in our view the absence of effective data systems would have impacted in particular on these groups, and contributed to difficulties in assessing their disproportionate representation in both the criminal justice and mental health systems.

We therefore recommend that the Office for Criminal Justice Reform (OCJR), in collaboration with the Home Office, Ministry of Justice and Department of Health ensure effective cross-cutting work with offenders with mental disorders by the development and implementation of guidance to local criminal justice organisations through the National Criminal Justice Board on the rigorous and systematic collection of data to promote joint working.

13. Few information exchange protocols existed between the criminal justice agencies that focused explicitly on offenders with mental disorders, but the existing arrangements such as Multi-Agency Public Protection Arrangements (MAPPA) were used to good effect. These arrangements, although they did not specifically address offenders with mental disorders, appeared to operate satisfactorily in many cases.

ASSESSMENT AND CARE FOLLOWING ARREST OR DETENTION

14. The offenders with mental disorders included in the inspection had committed a wide range of different types of offences, many of which were relatively minor. We found that custody sergeants in police custody suites fulfilled a crucial role both in their identification and in ensuring that they had had access to assessment and care. Particular attention was paid to individuals liable to self-harm. We remained concerned, however, that, despite the findings of the review undertaken by the Independent Police Complaints Commission in 2007, police cells were in some instances still being used as designated 'places of safety', rather than only in exceptional circumstances, for people who should have been taken to a hospital or

clinic.

We therefore recommend that police forces, in collaboration with local health and social care agencies, develop joint protocols on the location and operation of places of safety, to include agreement on the 'exceptional circumstances' under which a police station is to be used.

15. Although some police staff expressed concerns about delays in accessing medical care and the adequacy of arrangements for people whom mental health workers did not consider to be treatable (e.g. those suffering from a personality disorder), where an offender was identified as having a potential mental disorder, the standard of care in police custody and the recording and exchange of information was generally good. Nevertheless, all the relevant police staff interviewed indicated that they would welcome the opportunity to improve their knowledge and understanding of the symptoms of potential mental health conditions. Access to specialist advice, such as community psychiatric nurse (CPN) services, where available, was therefore particularly valuable.
16. Relevant information about mental health was passed from the police to the Crown Prosecution Service (CPS) and used to inform decision making about prosecution; in one area this information was collated by an inter-agency group that included police, probation and mental health workers.

DIVERSION FROM PROSECUTION

17. The CPS *Code for Crown Prosecutors* requires the prosecutor to examine the evidence and where the evidential stage of the test is met, to consider the public interest in prosecution. The priority in dealing with individuals with mental disorders is to balance the welfare of the individual against other public interest factors, including the need to protect the public.
18. The majority of alleged offenders with mental disorders whose cases were included in this inspection were prosecuted in accordance with the *Code for Crown Prosecutors* and convicted; their conditions were then taken into account by a court when sentencing. Very few were considered unfit to plead by virtue of their mental illness and/or dealt with after proof of the facts by means of a hospital order or supervision order under the Criminal Procedure (Insanity) Act 1964.
19. Neither the CPS nor the police were able to provide details of the number of cases that were diverted at the pre-charging stage or who were conditionally cautioned, although it is clear that some were. Additionally, a significant proportion (approximately a quarter of the CPS case files examined) were diverted from prosecution by way of discontinuance of the case during the court process. These cases were usually where the offence was considered not so serious and/or unlikely to be repeated and the individual was already receiving treatment. It would therefore appear possible, dependent on the availability of good quality information about the offence, the alleged offender and the provision of available treatment, for the number of cases diverted from prosecution at the earlier, pre-charge stage to be increased. Whilst this would not result in any overall growth in the number of

cases diverted overall, it would mean that a rise in number diverted before the court processes were invoked, thereby benefitting both the individual and saving public time and money.

20. The approach currently adopted was a twin track one whereby offenders were dealt with in accordance with the judicial process whilst, at the same time, encouraged to enter into treatment and we found little appetite for increasing the numbers diverted from prosecution. Many of the mental health professionals we met during the course of the inspection expressed the view that most offenders with mental disorders should be dealt with by the criminal justice system in order to ensure justice should be seen to be done and that the individual was, where possible, held responsible for their actions.
21. Concerns remained, however, about the engagement of the health services and the subsequent availability of treatment for the many offenders who had low-level mental health issues or whose mental illness was associated with substance misuse. Whether the mental disorder had led to the current offence or not, helping offenders to achieve a level of personal stability by sustained access to treatment not only promoted their rehabilitation but was one factor in many in preventing further offending.

We therefore recommend that criminal justice organisations, in liaison with local social care organisations, engage with their local Primary Care Trusts (PCTs) to ensure that assessment and treatment facilities for offenders with mental disorders are available promptly and of good quality.

COURT PROCESSES

22. The availability of mental health professionals to assist the courts in the identification and assessment of offenders with mental disorders varied. There had been a trend, however, for much of this activity to take place at an early stage in the criminal justice process, often at police stations, and the need for input at court was therefore reduced.
23. Court staff did not often, therefore, have to identify offenders with mental disorders, unless, as was possible given the dynamic nature of mental illness, any concerns did not become apparent until the case reached the court. They then welcomed advice from mental health professionals at court where this was available. However many courts did not have regular access to such advice.
24. In some cases, the police had identified mental health issues in relation to the defendant, but nevertheless the crown prosecutor determined that the individual should be charged and taken before the court. In these circumstances, the crown prosecutor should alert the defence representative to the mental health issues so that the defence representative can consider drawing these to the attention of the court. If the defendant is not represented, the crown prosecutor must make a professional judgement how to proceed, taking account of the interests of justice and accepting that the defendant may not wish for such personal information to be

disclosed.

25. Although psychiatric reports were used by the courts to help them decide on issues of fitness to plead and questions of culpability, many of the sentencers, court staff and probation officers interviewed during the course of the inspection expressed significant concerns about their quality, relevance and cost. In only one area, where there were close links with a prison in-reach mental health team, were there few concerns about quality and timeliness. In all others, problems in the production of psychiatric reports, conflicts of opinion, confused funding arrangements and lack of available treatment facilities meant that many cases were significantly delayed; at times these delays could have exacerbated mental health conditions.

We therefore recommend that the Ministry of Justice and the Department of Health review the arrangements for the commissioning and monitoring of psychiatric reports in order to ensure that delays in sentencing are minimised and that the reports are of good quality.

26. Probation staff used the Offender Assessment System (OASys), an assessment tool, to identify offenders with mental disorders. In a number of cases, we found that the assessments tended to over-state the severity and significance of the condition. The reasons for this were beyond the scope of this inspection but included staff training issues and the structure of the assessment tool itself. Again, the quality of the assessments was better where there had been consultation with mental health professionals.
27. Pre-sentence reports (PSRs) on offenders with mental disorders were nevertheless generally of a good quality, especially where probation staff had access to specialist advice, although in some greater analysis was required to establish the link, or otherwise, between offending and mental health. We did not find evidence from the PSRs that offenders with mental disorders were being sent to custody for want of other treatment options in the community. There was, however, a concern amongst sentencers and court staff that the treatment facilities in the community were not always available or suitable for offenders leading chaotic lives who were often difficult to engage.
28. Generally, communication between courts and the other agencies was satisfactory and it was clear that concerns about self-harm on the part of the offender were communicated to the relevant people in prisons and other institutions.

CONCLUSIONS

29. In the cases we examined, offenders with mental disorders had committed a range of different types of offences, although it was difficult, because of the lack of an agreed definition, to identify precisely how many such offenders were in the system. The absence of reliable data impacted on criminal justice organisations' ability both to monitor their performance and to make effective provision for this group of offenders. In most cases, there was no direct association between the offence and the offender's mental health.
30. Concerns about the offender's mental health, even those with the lowest level of

need, were followed up in almost all the cases we saw and taken into account during the pre-court and sentencing stages. Cases were discontinued, where appropriate, and we saw little scope for increasing the total numbers diverted without radically altering the scope and powers under the Mental Health Act 1983 as amended by the Mental Health Act 2007, and the criminal justice policies and powers of sentencing which relate to the protection of the public. Consideration could, however, be given to increasing the number diverted at the earlier pre-charge stage, but such action would be dependent on the availability of good quality information.

31. Overall, we found that the communication process between the criminal justice agencies worked, albeit in a somewhat piecemeal fashion; once identified, cases were assessed and referrals made. It was overreliant on individuals and could undoubtedly be made more systematic and effective. We found a number of isolated examples of good practice which, whilst encouraging, were not currently the norm. We also uncovered concerns about the availability of treatment facilities and their ability to engage effectively with offenders; these issues are beyond the scope of this inspection but nevertheless should be addressed.

1. THE STRUCTURE OF THE INSPECTION

Summary

This chapter outlines the inspection structure and methodology. It also comments on the difficulties encountered in developing the inspection in the absence of reliable data about offenders with mental disorders.

- 1.1 This inspection was agreed by the CJCIG and formed part of the Joint Inspection Business Plan 2008/2009¹ as the first in a number of incremental inspections looking at offenders with mental disorders within the criminal justice system. Its scope was:
- to assess the quality and effectiveness of information exchanges between criminal justice agencies in dealing with mentally disordered offenders during the period from arrest/detention to sentence in:*
- ▶ *ensuring appropriate treatment and support both within and outside the criminal justice system*
 - ▶ *facilitating their diversion from prosecution or custody where appropriate.*
- 1.2 The inspection was led by HM Inspectorate of Probation (HMI Probation), with support from HM Inspectorate of Court Administration (HMICA), HM Crown Prosecution Service Inspectorate (HMCPSP) and HM Inspectorate of Constabulary (HMIC).
- 1.3 A set of criteria, informed by a scoping document prepared in 2007/2008, was devised for the inspection based upon the existing policy and guidance relevant to the inspected organisations.
- 1.4 In order to assess policy and practice against the criteria, we visited six areas: Dyfed-Powys (Aberystwyth and Carmarthen), Greater Manchester (Bolton), London (Camberwell), West Mercia (Hereford), Warwickshire (Nuneaton and Leamington Spa) and Wiltshire (Swindon). These areas were selected to give different socio-economic and demographic profiles. The choice of metropolitan as well as smaller areas gave us access to a mix of rural and urban areas, with their different populations, from which to draw evidence.
- 1.5 We examined work that had taken place with offenders with mental disorders carried out by the police, CPS, magistrates' and the Crown Court and probation staff. In addition, we interviewed a number of providers of health services to offenders.

Identification of case file sample for inspection

- 1.6 For the purposes of the inspection, we examined the case files of 130 individuals from the six areas visited where concerns had already been expressed about their mental health. The original intention was to examine cases where the offender had received a clinical diagnosis of mental illness. However, it proved difficult to isolate such cases because of the different recording systems (see paragraph 1.8) used by the criminal justice agencies concerned. As a result, the scope was broadened to include offenders with a potential mental health illness requiring assessment, but where the outcome of the assessment did not necessarily result in a confirmed clinical diagnosis.
- 1.7 We did not, therefore, examine the initial identification process and this issue remained outside the scope of this particular inspection. Similarly, the inspection did not include mentally disordered offenders who had been remanded into custody prior to sentence.
- 1.8 We nevertheless found the same difficulty as that experienced by agencies in identifying offenders with mental disorders as, although relevant information was recorded on each agency's information systems, or was otherwise documented, it was not held in such a way as to be readily accessible:
- ▶ **the police** – although mental health issues were identified, assessed and recorded on the custody system by the police, and prior history information could be researched when an offender was brought into custody, the fact that there was no detailed 'flagging' mechanism for an offender's mental health status meant that searching for cases fitting the inspection criteria was a complex process. Whilst some cases were flagged on the Police National Computer (PNC), using the PNC warning markers, the system was not sufficiently reliable for the purposes of inspection as the markers simply indicated that there was some mental health risk and only provided limited information on the circumstances and nature of the risk. As a result, an initial search of the custody system was made which allowed a preliminary list to be compiled and each case was then checked manually to ensure that it fitted the inspection criteria
 - ▶ **CPS** – similarly, the CPS did not have a specific 'flag' on its Case Management System for offenders with mental disorders. Discontinued cases were held under the heading 'Elderly and Significantly Ill'. There was no means of identifying cases where offenders with mental disorders had been prosecuted
 - ▶ **the courts** – court records did not identify offenders with mental disorders; the only means of doing so was by analysing the requests for psychiatric reports by tracking the records of payment through the court's billing system and then identifying the relevant cases
 - ▶ **probation** – not all probation areas routinely flagged offenders with mental disorders but where such issues were identified, the OASys assessment provided information about the health needs of offenders, including mental health.

1.9 To produce an inspection sample that included a broad range of different types of cases, we aimed to examine at least 15 cases in each inspection site. In each area:

- ▶ we selected six police cases where a medical examination had been requested by custody staff in relation to an arrested or detained person
- ▶ HMCP SI identified three discontinued cases where the defendant appeared to have had a mental health issue
- ▶ court staff were asked to provide details of three cases where a psychiatric report had been requested either in the magistrates' court or the Crown Court
- ▶ probation was asked to give details (based on OASys assessments) of three PSRs where the offender was currently receiving some form of psychiatric intervention.

File reading tools were then designed to collect the evidence from these cases.

1.10 It was anticipated that we would be able to assess work carried out by all the four relevant organisations in relation to each offender in the sample. In the event, this was only achieved in a small number of cases, due to incompatible recording practices on the part of the agencies involved. For example, the police largely tracked cases by the date of the crime or incident (whether or not it led to a prosecution), whereas the courts tracked cases by reference to the date(s) of court appearance; probation, meanwhile tracked cases by the date of the PSR request in court. CPS files on the other hand were reasonably easy to align with police records. Difficulties in identification of the relevant files across the agencies was compounded by the fact that many of the offenders involved had had more than one court appearance and/or had committed more than one offence within our time period.

1.11 In total we looked at the experience of 130 individuals, as reflected through the case files held by the different criminal justice agencies. The sample inspected comprised:

- ▶ 80 police records
- ▶ 61 CPS files
- ▶ 42 PSRs
- ▶ 58 court files.

1.12 These cases covered a very broad range of offence types. Violence against the person accounted for 29% of cases and 9% were theft and handling stolen goods. However, the largest category of offence was 'other' (30%), which related primarily to public order and offensive weapons offences. The individuals displayed the following characteristics:

- ▶ 84% were male
- ▶ 75% were White British
- ▶ 9% were Black or Black British.

2. DEFINITIONS

Summary

This chapter describes the range of definitions applied to offenders with mental disorders and the consequences of the lack of a nationally agreed definition. It also comments on the estimated number of offenders with mental disorders in the criminal justice system and explains the terminology used in the report.

Definitions of offenders with mental disorders

- 2.1 Mental health is a complex issue and those with mental health conditions can also have complex needs – for example, misuse of alcohol or drugs can be the cause of mental illness in some people or a response to symptom in others.
- 2.2 At the time of the inspection, there was no unanimously accepted definition of the term '*mentally disordered offender*'. The statutory definition of mental disorder put forward under the Mental Health Act 1983 as amended by the Mental Health Act 2007, '*any disorder or disability of the mind*' essentially applies only to the group of offenders who fit the criteria for treatment and admission to hospital under the appropriate legislation. As a consequence, because much of the dialogue about offenders with mental disorders centres on the clinical judgement, the definition had failed to establish a common language between the health service, criminal justice system and other relevant organisations. It also, as we were to discover, allowed for different interpretation within the medical profession.
- 2.3 Other definitions take a very broad approach and include, for example those with substance misuse problems. These wider definitions of mental health needs can be helpful except where they perpetuate a lack of focus.
- 2.4 Overall, we felt that the definition of an offender with a mental disorder initially put forward by NACRO and later adopted by Lord Bradley in his review of people with mental health conditions or learning difficulties within the criminal justice system² provided us with a workable option:

'Those who come into contact with the criminal justice system because they have committed, or are suspected of committing, a criminal offence, and who may be acutely or chronically ill. It also includes those in whom a degree of disturbance is recognised even though it may not be severe enough to bring it within the criteria laid down by the Mental Health Act 1983 (now 2007).'

Prevalence of offenders with mental disorders within the criminal justice system

- 2.5 As a consequence of the lack of a national agreed definition of offenders with mental disorders, there are no consistent estimates as to the number of these offenders in the criminal justice system. It is therefore extremely difficult to project need, define the nature of the services required or evaluate initiatives. There is, however, general consensus that there are higher levels of mental disorder amongst offenders than in the general population. HM Inspectorate of Prisons' (HMI Prisons') report³ on the mental health of prisoners, for example, found that 17% of new prisoners disclosed a psychiatric history on reception. Similarly, data from the HMI Probation's Offender Management Inspection (OMI) findings (comprising 3,511 offenders) identified *emotional well-being* as a criminogenic factor in 39% of the cases considered, but as the priority factor in only 6%.
- 2.6 In considering the needs of these offenders, however, it is important to differentiate between serious mental illness, such as: psychosis and bipolar disorder; the most severe anxiety and depressive states; mild and moderate mental illnesses; learning disabilities and personality disorders. All the disorders in this spectrum have different aetiologies and require different interventions.
- 2.7 Offender populations reflect all these conditions, but generally at higher levels of prevalence of personality disorder. Personality disorders are common conditions, with different levels of severity. Studies into the incidence of personality disorder estimate a prevalence rate of between 5% and 13% of adults in the community, whereas prison populations have an estimated 64% of male and 50% of female sentenced prisoners with a personality disorder.
- 2.8 It is still not clear how far mental health impacts on offending behaviour. A potential relationship between mental disorders and risk behaviour in some individuals, particularly those with personality disorder, is accepted but the degree to which personality disorder can be identified as a directly causal factor in offending remains a matter for research.
- 2.9 We are clear that the psychosocial problems presented by offenders are related to their level of cognitive and social functioning. Regardless of whether mental disorder is directly linked to offending or an underlying but co-occurring condition, it remains a significant factor which has to be taken into account by all agencies in the criminal justice system to promote the rehabilitation of offenders.

Terminology

- 2.10 There is no common agreement about how such offenders with a mental disorder should be described. Terms in common usage currently include: '*mentally disordered offender*', '*offender with mental health issues or needs*', '*offender with mental ill health*', '*offender with mental health problems or conditions*'.

2.11 The statutory definition of *mental disorder* places particular emphasis on a health issue that may or may not contribute to the offending. We therefore prefer, in this inspection report, to refer to this group as *offenders with mental disorders* as a way of emphasising that in the majority of the cases we examined, the significant issue was the fact that they had committed an offence. The term '*offender*' in this context refers to all offenders, regardless of the seriousness of their offence, whilst our use of the term '*mental disorder*' covers the wide range of conditions described, including those that would not meet the statutory definition for mental disorder under the Mental Health Act 1983 as amended by the Mental Health Act 2007.

Key Findings

- ▶▶ As a consequence of the lack of any agreed definition of an offender with mental disorder:
 - there are no accurate figures of the number of offenders who fall within the legal definition of '*mentally disordered offender*' under the Mental Health Act 1983 as amended by the Mental Health Act 2007, and either enter the criminal justice system or are convicted
 - it is therefore extremely difficult to project need, define the nature of the services required or evaluate initiatives.
- ▶▶ Mental disorder, whether as an underlying or co-occurring condition or directly linked to offending, is a significant factor for a high proportion of offenders which has to be taken into account by all organisations within the criminal justice system.

We therefore recommend that the Department for Children, Schools and Families, the Ministry of Justice, the Youth Justice Board and the Home Office adopt a common definition that defines the scope of offenders with mental disorders.

3. THE PROCESS: THE ROLES OF THE KEY CRIMINAL JUSTICE AGENCIES

Summary

This chapter gives a brief summary of the role of the criminal justice agencies when dealing with offenders with mental disorders.

Police

- 3.1 The police are often the first criminal justice agency to come into contact with people with mental health conditions, irrespective of whether or not they have previously been diagnosed. The police role is to focus on the individual's offending, based on the presumption that those with mental health conditions will be dealt with through the criminal justice system in the same way as any other person. This presumption, however, can be overridden if all of the following criteria apply:
- ▶ the offence is not serious and relates to a minor infringement of the law or appears to be an isolated incident and not part of a series of offences
 - ▶ it has been decided in consultation with other agencies and health professionals that prosecution is neither in the public interest nor that of the individual and that the issues will be dealt with through the health/social care system
 - ▶ the individual will be provided with an appropriate health/social care response.
- 3.2 As well as dealing with offenders, the police also come into contact with individuals whose behaviour, although not criminal, gives cause for concern. Sections 135 and 136 of the Mental Health Act 1983 make provision, in appropriate circumstances, for people to be taken to a place of safety so that they can be assessed by a registered medical practitioner and interviewed by an Approved Mental Health Professional (AMHP), if required. Under Section 136, the police have a specific power to remove a person who appears to be suffering from a mental disorder and be in immediate need to a place of safety. Although police stations are included within the definition of a place of safety, they should only be used in exceptional circumstances and are not generally considered suitable for detaining people with mental health conditions for longer than absolutely necessary.
- 3.3 The Police and Criminal Evidence Act 1984 (PACE) and associated Codes of Practice set out the legislative framework for dealing with those who come into contact with the police. In addition, the standards expected of the police in dealing with those in custody are set out in Association of Chief Police Officers (ACPO) *Guidance, The Safer Detention and Handling of Persons in Police Custody*. This

guidance complements PACE and identifies police responsibilities and the action to be taken from the point of first contact to departure and remand, including assessment and care of detainees. Guidance on police responses to people with mental disorders or learning difficulties is also being produced by the National Policing Improvement Agency (NPIA) on behalf of ACPO.

Crown Prosecution Service

- 3.4 The CPS is responsible for the decision to charge individuals brought to its attention by the police in more serious or contested cases. It took over this responsibility from the police on a statutory basis as part of a rolling programme, implemented across the CPS and criminal justice areas from 2004 to April 2006. Whilst it is not required to consider all cases where the alleged offender is believed to have some form of mental disorder, the police will often refer such cases because of the nature of the offence or where the custody sergeant does not consider bail appropriate.
- 3.5 It operates within the principles set out in the Code for Crown Prosecutors, which applies to both decisions to charge and the continuing review of all prosecutions, and the guidance on charging issued under PACE. Crown prosecutors adopt a two-stage process in reaching a decision whether to charge a defendant or whether to continue with a prosecution. The full Code test requires them firstly to consider the available evidence, and if satisfied that there is enough to provide a 'realistic prospect of conviction', the crown prosecutor then determines if it is in the public interest to prosecute. The Code provides that:
- 'a prosecution will usually take place unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour, or it appears more appropriate in all the circumstances of the case to divert from prosecution. The more serious the offence, the more likely it is that the prosecution will be needed in the public interest'.*
- 3.6 Any sound information provided by police at the charging stage about a defendant's mental health condition should be taken into account by the crown prosecutor who may also have to consider the availability of suitable treatment for the alleged offender and their willingness to accept this. The expanding role of the crown prosecutor has provided some more scope in recent times for diversion through the power to offer a caution with conditions to an offender against whom there is sufficient evidence to provide a realistic prospect of conviction. In the future, the developing role of the community prosecutor may also provide scope for taking into account the conditions and concerns within the local community.
- 3.7 The CPS guidance on Mentally Disordered Offenders⁴ is used in conjunction with the *Code for Crown Prosecutors* when dealing with cases involving suspects/defendants with mental health issues. The mental condition of a suspect may be relevant to the decision to prosecute or divert, to fitness to plead, and to sentencing or other disposal. There is no presumption either in favour of or against prosecution of an offender with mental disorders. The crown prosecutor examines the facts in each case and, when considering the public interest, takes

account of all available information about the disorder, including any provided by the police or the offender's legal representative, to see if it led to the offending. The Code advises that:

'Crown Prosecutors must balance the desirability of diverting a defendant who is suffering from significant mental or physical ill health with the need to safeguard the general public'.

- 3.8 If the alleged offender is charged (whether by the police themselves or on the authorisation of the CPS) then the case would be kept under continuing review within the prosecution process and a subsequent decision not to proceed with the prosecution would lead to the case being dropped or discontinued.

Courts

- 3.9 The function of courts is to ensure that cases are objectively and appropriately heard and determined.
- 3.10 The mental health status of a defendant or offender can become relevant at different stages of the hearing of a case to the way it is managed. In a relatively small number of cases, the defendant may be considered unfit to plead on mental health grounds. Prior to sentence (where the defendant has pleaded or been found guilty), the court may wish to be advised about their mental health status and any considerations relevant for sentencing purposes, including possible treatment options.
- 3.11 In some cases a psychiatric report is required. Such a report can be commissioned by the court or by the defence representative. More frequently, the court may request advice about any relevant mental health issues (including drug and alcohol related problems) to be provided by the probation service.
- 3.12 It is important to recognise that mental health conditions of varying kinds affect a significantly higher percentage of offenders than those on which a psychiatric report is obtained.

Probation

- 3.13 The primary role of the probation service prior to sentence is to prepare reports at the request of the courts on offenders and to provide information and advice about their circumstances, including any concerns about their physical or mental health. This information is normally presented to courts as a written document but can, on occasion, be given orally. The PSR should include an assessment of *Risk of Harm* and likelihood of reoffending and, usually, a proposal as to the most suitable sentence.
- 3.14 PSRs are underpinned by an actuarial and clinical assessment system known as OASys that takes account of the factors that contribute to offending (including, where relevant, mental health concerns). It provides probation staff with an

indication of the *Risk of Harm* presented by the offender and an assessment of their likelihood of reoffending.

- 3.15 Probation staff are also sometimes involved in case discussions about offenders with mental disorders at an earlier stage, i.e. inter-agency arrangements set up to review such cases before they get to court.

4. THE STRATEGIC FRAMEWORK

Summary

This chapter gives an outline of the key legislation and guidance currently available. It comments on the lack of recent guidance to criminal justice agencies working with offenders with mental disorders, and the consequent impact on the development of services.

Introduction

- 4.1 In 2007 the Offender Health Team was set up to lead Government work on mental health and criminal justice and to improve standards of health care for offenders. The work of this team spans the Department of Health, Department for Children, Schools and Families, Ministry of Justice, Youth Justice Board and Home Office and they are responsible for the development and implementation of the National Delivery Plan of the Health and Criminal Justice Programme Board.

Legislation

- 4.2 The Mental Health Act 1983 remains the key legislation in respect of offenders with mental disorders. It made provision for the compulsory detention and treatment of those with a mental disorder by way of a hospital order. The 1983 Act subsequently was amended by further legislation, the Mental Health Act 2007 which removed the four categories of mental disorder (mental illness, psychopathic disorder, mental impairment and severe mental impairment) defined in section 1 of the 1983 Act and provided for a single definition: '*any disorder or disability of the mind*'.
- 4.3 If the defendant's fitness to plead is at issue, the court can, under the powers established by the Criminal Procedure (Insanity) Act 1964 as amended, hear evidence about whether the defendant did the act or the omission as charged and, after which, make either a hospital order (with or without a restriction order), a supervision order or an order for the defendant's absolute discharge.

Strategic response 1990-2000

- 4.4 The Home Office issued two circulars, in 1990⁵ and 1995⁶, which gave guidance on the way in which the criminal justice agencies should provide for the needs of offenders with mental disorders and, where appropriate, consider diversion from the formal criminal justice process.

4.5 Despite now being over ten years old, these two circulars have not been superseded (although further guidance was issued to courts on remand and sentencing powers in 2008) and still provide the strategic framework in which with offenders with mental disorders should be taken forward. They created the expectation that criminal justice agencies would work together to address the challenges posed by offenders with mental disorders:

- ▶ **The Home Office Circular 66/1990 Provision for Mentally Disordered Offenders** drew the courts' attention, and those services responsible for dealing with mentally disordered persons who commit, or who are suspected of committing criminal offences, to *'the legal powers which exist; and the desirability of ensuring effective cooperation between agencies to ensure that the best use is made of resources and that mentally disordered persons are not prosecuted where this is not required by the public interest'*
- ▶ **The Home Office Circular 12/1995 Mentally Disordered Offenders: inter-agency working** specifically promoted effective inter-agency working. It described the key elements of effective local cooperation and action in relation to offenders with mental disorders which had emerged from the work done up to that point, and provided details of when to charge and prosecute.

This process was given further impetus by the publication by the Home Office and Department of Health of a joint review of services in the community for offenders with mental disorders, known as the Reed Report⁷, in 1993.

4.6 A range of other guidance was subsequently issued individually to the courts, police and CPS. Although detailed and helpful, it unfortunately did not stress the importance of joint working. The main guidance is summarised below:

- ▶ **Police:** no national guidance exists on the identification, assessment and management of offenders with mental disorders, although comprehensive guidance on police responses to people with mental disorder or learning difficulties is currently being produced by the NPIA on behalf of ACPO. This guidance will include responses to victims and witnesses as well as offenders. The care and custody of prisoners is covered by national guidance and also by/through PACE
- ▶ **CPS:** guidance, *Mentally Disordered Offenders*, provides direction on CPS policy and practice on handling cases where the defendant has a mental disorder
- ▶ **Probation:** guidance has been issued on some aspects of practice, e.g. requirements for psychiatric treatment and provision of information to victims of crime where the offender has been made the subject of a Hospital Order
- ▶ **Courts:** the Crown Court manual covers procedures relating to offenders with mental disorders and, at the time of the inspection, is in the process of being updated to account for the provisions of Mental Health Act 2007. For magistrates' courts, the Legal Advisers' Manual (and magistrates' bench book) serves a similar purpose. In addition, the

Consolidated Criminal Practice Directions describe the way in which vulnerable defendants are to be treated at court. The definition of vulnerable specifically refers to those who suffer from a mental disorder within the meaning given by the Mental Health Act 1983, as amended by the Mental Health Act 2007.

4.7 The health services were also active in developing a strategy for offenders with mental health conditions. The current health strategy is based on the overarching principle that offenders should, wherever possible, have access to the same treatment as the general public. The *National Service Framework for Mental Health*⁸ published in 1999 set out seven overarching standards relating to:

- ▶ mental health promotion
- ▶ primary care and access to services
- ▶ effective services for people with severe mental illness
- ▶ caring about carers
- ▶ preventing suicide.

These standards (which have since been supplemented by additional guidance such as *Best Practice in Managing Risk* published by the Department of Health in 2007) were intended to set the agenda for the provision of services for all individuals with mental illness for a ten year period which is now about to expire. It is anticipated that they will then be subsumed into *New Horizons*, the forthcoming strategic approach to the development of mental health services.

Strategic response 2000 onwards

4.8 In December 2001, the Department of Health, HM Prison Service and the National Assembly for Wales jointly published *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Service in Prisons*⁹. This document established a joint approach to the 'far-reaching development and modernisation of mental health services in prisons over the next 3-5 years' and brought prisoner healthcare into mainstream National Health Service (NHS) provision via the Primary Health Trusts and Care Programme Approach.

4.9 In 2005, the *Offender Mental Health Care Pathway*¹⁰ was introduced which set out the route for all offenders to access assessment and treatment where applicable. Crucially, one of the care pathways covers the pre-court/sentence stage and details the steps that need to be taken by the relevant agencies in working with offenders with mental disorders.

4.10 The needs of offenders with mental disorders, and their disproportionate representation within the prisons, continued to be raised through a number of cross-cutting reports. One, undertaken in 2002, established that diversion from court to hospital could help offenders to access treatment more easily¹¹. The Social Exclusion Unit's report, *Reducing Reoffending by Ex-Prisoners*, also undertaken in 2002¹², firmly established mental and physical health as one of the nine factors that contributed to offending and, in 2005, a Home Office/Department

of Health review¹³ identified a wide variation in funding and organisation of initiatives to help those with mental health conditions access treatment, and suggested that the most effective were those jointly funded by health and social care.

- 4.11 These issues were picked up by the Department of Health in a series of consultation documents and White Papers^{14,15,16} aimed at improving the accessibility of healthcare for socially excluded groups and, following the Comprehensive Spending Review in 2007, through the introduction of 30 new Public Service Agreements which set priority outcomes for Government departments in working with disadvantaged groups, including those in contact with the mental health services.
- 4.12 Concern continued to focus on the needs of offenders with mental health disorders. In 2007, HMI Prisons published its report on a further inspection of the mental health of prisoners which found that: *'Court diversion and liaison schemes, introduced in 1989, have no ring-fenced funding, no service blueprint and no clear accountability The lack of NHS secure beds and insufficient community provision continues to be a barrier to successful diversion. Community services tend to operate in silos and may not be able to pick up the complex needs of offenders'*. The position of women offenders with mental health needs was similarly commented upon by Baroness Corston in her review of women in the criminal justice system¹⁷.
- 4.13 In November 2007 the Offender Health Team published a consultation document entitled *Improving Health, Supporting Justice*¹⁸. This work was given further impetus in April 2009, by the publication of Lord Bradley's independent review of offenders with mental disorders, undertaken at the request of the Secretary of State. The review recognised that the implementation of the diversion policies put forward in the 1990s had been, at best, inconsistent, and needed to be re-invigorated. The report contained a number of far-reaching recommendations which, informed by feedback from the consultation, are currently being taken forward through the Health and Criminal Justice Delivery Plan, scheduled for publication in November 2009.

Impact

- 4.14 As we were to find in our inspection, this increasing level of central activity had still to make its impact on practice. In the absence of an effective national framework and up-to-date guidance, the work with offenders with mental disorders lacked strategic direction. The schemes established in the 1990s had developed in different ways, with the changing role of the CPS and greater awareness of mental disorder amongst practitioners in the criminal justice system. There was consequently less investment at the (later) court stage as the focus had shifted to assessment at police stations or the provision of advice at different points in the criminal justice process.
- 4.15 Whilst it was important to allow enough flexibility to meet local need, many of the schemes had evolved in a piecemeal fashion. The level of resourcing provided to

the different schemes varied considerably and, too often, insufficient collective consideration had been given across the partner agencies to their sustainability.

- 4.16 Even when the arrangements had been formalised they frequently masked significant variations on the ground, with no consistent concept of best practice. Although all courts had access to information and advice on psychiatric issues, in one area, the PCT had withdrawn all services to court, although it was in the process of replacing them, whilst there was a fairly well-resourced court-based scheme in another. In yet another area, attention had been paid to engagement with offenders at the point of detention following arrest through the deployment of CPNs: this reduced the need for a court presence. One area used a case conference approach to consider assessment and treatment, whereas in another a CPN was available to assist with assessment but the service had not been well promoted to the criminal justice agencies.

Key Findings

- ▶▶ The increasing level of central activity had still to make its impact on practice.
- ▶▶ No national guidance to criminal justice agencies on work with offenders with mental disorders had been issued between 1995 and 2008.
- ▶▶ Although other guidance had subsequently been issued to the individual criminal justice agencies, it did not stress the importance of joint working.
- ▶▶ Health services had been developed for offenders with mental disorders but it was difficult to assess their impact.
- ▶▶ The schemes established in the 1990s to work with mentally disordered offenders had evolved in a piecemeal fashion.

5. LEADERSHIP AT LOCAL LEVEL

Summary

This chapter identifies the characteristics of effective local leadership as: planning, information exchange, capacity planning, training, PCT and local health board (LHB) engagement, guidance to staff and attention to diversity.

It uses examples from the six areas visited to illustrate arrangements for working with offenders with mental disorders and describes how the lack of strategic direction at a national level had impacted on local practice, particularly in relation to engagement with the PCT/LHB.

Introduction

- 5.1 In the absence of up-to-date national guidance to criminal justice organisations, work at a local level operated in a policy vacuum. Under these circumstances, strong leadership and clear vision of joint working was vital. A perception existed amongst senior managers in the criminal justice agencies in all six areas visited that the development of collaborative approaches to deal with offenders with mental disorders had lost momentum and become less of a priority in the face of other, competing, demands. As one manager put it, the 1990s guidance had “*been lost in the mists of time*”.

Characteristics of effective local leadership in work with offenders with mental disorders

- 5.2 We identified the following factors as significant in ensuring effective local leadership amongst criminal justice agencies dealing with offenders with mental disorders.

a) An agreed definition for mental disorder

- 5.3 Not surprisingly given the lack of an agreed definition at a national level, there was no common definition at a local level of what was meant by the term: *an offender with mental disorder*. Different interpretations existed within areas between the relevant agencies, together with confusion about which conditions were considered treatable or not. This led to frustration amongst staff in all organisations. For example, during interviews with police officers, cases were cited where the individuals involved clearly presented a risk of significant harm to themselves or who displayed disturbing or alarming behaviour, but who, following assessment, were not regarded as having a treatable mental health condition.

These reports were supported by evidence from the file reading, with the behaviour in such cases being attributed to a 'personality disorder' or identified as being drug or alcohol related. Where this occurred, police officers often found it difficult to reconcile the diagnosis with the behaviour, particularly where the behaviour was felt to be a significant factor in the commission of the offence.

b) Strategic planning

- 5.4 In Warwickshire an inter-agency group had survived and prospered. The Local Criminal Justice Board (LCJB) had also taken an interest in the work, although we found that this was not typical and that in other areas, despite being well-placed to promote joint working, LCJBs had not given the issue of offenders with mental disorders a high priority. There was also some good, inter-agency strategic work in Greater Manchester, including the joint funding of a development post.

Practice example:

In Warwickshire, an inter-agency steering and liaison group had been established to provide strategic oversight of this area of work. In particular, a 'suite' of 11 joint protocols had been developed, taking into account the needs and requirements of a range of partners. At the time of the inspection, police training in relation to the protocols was ongoing and, once completed, the intention was to establish an operational group to test and challenge the policy documents against working.

- 5.5 In Wiltshire, the Department of Health Care Services Improvement Partnership provided a clear lead at regional level; this multi-agency partnership had produced the South West Offender Health and Well-being Programme Delivery Plan for 2008/2009, on which developments within the region were based. It was also leading on pilot diversion projects elsewhere in the region, the learning from which had informed plans for future services in Swindon. The partnership had secured multi-agency agreement to set a broad definition of 'mental disorder' across the region. However, there was no evidence that the definition had been adopted beyond the local mental health team or had, as yet, influenced the provision of services.

c) PCT/LHB engagement

- 5.6 Successful work with offenders with mental disorders was predicated on effective engagement by the criminal justice agencies with health service commissioners and providers.
- 5.7 We found a mixed picture in terms of PCT/LHB engagement with offenders with mental disorders. In Herefordshire, for example, plans were under way to combine the PCT with the local authority to produce a potentially very powerful commissioning body.
- 5.8 In some areas, such as Wiltshire, the PCT/LHB had taken arbitrary decisions about the future provision of services, with no reference to the criminal justice agencies

at local level. As a result, none of the practitioners we met in any of the criminal justice agencies in Swindon knew anything about the new service to be introduced except that it was being done progressively.

- 5.9 In contrast to the other agencies, commissioning and budgetary responsibility for healthcare services in police custody suites currently rests with the police service. This not only reinforced the separateness of the offender with mental disorders from mainstream mental health commissioning, but could also impact on the continuity of healthcare for this group of people. This issue was also raised within the Bradley Report and resulted in a recommendation to the NHS and police to “*explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS at the earliest opportunity*”. The findings of this inspection support this recommendation which is currently being considered under the National Delivery Plan of the Health and Criminal Justice Programme Board.
- 5.10 Despite probation areas generally engaging well with joint commissioning arrangements for services to address substance misuse, their impact on the provision of mental health services was not always so visible. Offender Health Teams, whilst established in the prisons, did not appear to be active at a local level in the community.
- 5.11 Offenders with mental disorders posed challenges to health agencies who sometimes found it hard to provide services for a difficult and often socially excluded group. As a result, they could remain in the criminal justice system longer than was desirable, at times remanded in custody pending assessment/agreement about treatment. Yet, mental health commissioners often saw the criminal justice world as a specialised area and the provision of services for offenders were generally regarded as vulnerable to changes in PCT/LHB finances and commissioning priorities. This was reflected in the fact that, in the localities visited, service level agreements and commissioning arrangements were for most part under developed.
- 5.12 We found a number of examples where provision relied on the enthusiasm and commitment of individual members of staff rather than a strategic decision. Although we did find good practice in some Community Mental Health Teams using a holistic approach, for the most part, existing mental health services were targeted at those with ‘*severe and enduring*’ mental illness and, whilst appropriate for some offenders, did not cater well for the majority with lower level needs or those with personality disorders. The problem of ‘*dual diagnosis*’ i.e. those with mental illness or learning difficulties and substance misuse problems, was also not properly addressed in some areas. A number of staff suggested that there was a possible conflict of approach between the Care Programme Approach and criminal justice offender management model. We took the view that these two approaches were not mutually exclusive. These issues were, however, also highlighted by the Bradley Report and are currently being taken forward as part of the National Delivery Plan for the Health and Criminal Justice Programme Board through the development of a cross-departmental strategy for the management of people with personality disorders. Guidance is also being developed on offenders with a dual diagnosis.

d) Capacity planning and data collection

- 5.13 It was not surprising, given the problems of definition and data collection already discussed, that we found little evidence of agencies collating information about the needs of offenders with mental disorders to inform commissioning decisions. Indeed, with the possible exception of probation, no agency had a system capable of reliably identifying this group of offenders. Even probation's use of OASys was dependent on the quality of practitioners' assessments. Some, limited, use was nevertheless beginning to be made of the information available. London Probation Area had provided health service commissioners with aggregated OASys data about mental health issues; similarly, PCTs had also started to engage with Crime and Disorder Reduction Partnerships (CDRPs) in a number of areas.

e) Information sharing

- 5.14 Although problems remained in some locations about medical confidentiality, on the whole the information sharing arrangements worked well amongst the criminal justice agencies. We found few examples, however, of inter-agency protocols in relation to offenders with mental health needs, apart from Warwickshire where there was a multi-agency agreement on the system for sharing information. Most agencies relied on already established procedures, for example CPS charging policy or the information sharing protocols drawn up for MAPPA or similar fora.

f) Training

- 5.15 Whilst we heard of a number of examples of inter-agency training about offenders with mental health needs, many staff from criminal justice organisations lacked the confidence required to navigate the complex world of the health service or the knowledge to deal effectively with individuals with severe and enduring difficulties. In addition, many newly qualified probation officers had little training in working with this challenging group of offenders. The need for better training for front line staff across all criminal justice organisations was highlighted by a number of recommendations in the Bradley Report and is currently being addressed by the National Delivery Plan for the Health and Criminal Justice Programme Board.

Practice example:

Bolton magistrates had received training in identifying and dealing with mental health issues [three sessions in 2008 plus one in early 2009] led by the CPN team manager supported by probation staff.

g) Guidance

- 5.16 Local guidance developed by agencies varied in its extent and content. In one area visited, there was no documentation that specifically related to offenders with mental health needs, whilst in another (Greater Manchester) there was more available to inform practice. CPS staff in all areas worked to a national framework of guidance.

Diversity

- 5.17 It was perhaps not altogether surprising, in light of the problems already identified about data, to find so little evidence in any of the areas visited of any attempts to collate information by gender or ethnicity. It was nevertheless disappointing, given the research evidence¹⁹ about the over-representation of women and certain black or minority ethnic groups in both the criminal justice and the mental health systems. In our view, the absence of effective data systems would have impacted in particular on these groups, and contribute to difficulties in assessing their disproportionate representation in both the criminal justice and mental health systems. Similarly, we found no examples of policies being subject to equality impact assessments.
- 5.18 Although the inspection sample included a relatively large proportion of black and minority ethnic offenders, we did not identify any significant differences in the management of these cases, nor in the cases of women.
- 5.19 Although some attempt had been made to monitor outcomes – for example in Bolton where steps had been taken to track the progress of individuals referred to the inter-agency panel meetings – such efforts tended to be the exception and overall there was little evidence of structured performance management. In the absence of a national definition, systematic data collection to inform improvement is likely to remain problematic.

Practice example:

The appearance of a defendant with Asperger’s Syndrome brought home to the judge and court staff the difficulties of managing such cases. Training was arranged for all staff, including magistrates and judges, to raise awareness about Asperger’s. Staff were subsequently able to consider what reasonable adjustments should be made in future in these cases.

Key Findings

- ▶▶ The development of collaborative approaches to work with offenders with a mental disorder was no longer seen as a priority by local agencies.
- ▶▶ Different interpretations used to define an offender with mental health conditions caused difficulties across all organisations.
- ▶▶ The provision of services for offenders with mental health conditions were vulnerable to changes in PCT/ LHB priorities and commissioning arrangements with health were, for the most part, underdeveloped in the areas visited.
- ▶▶ There was little evidence of agencies collating information about the needs of offenders with mental disorders to inform policy decisions or commissioning arrangements. This was particularly surprising in respect of women offenders and those from minority ethnic groups who were generally regarded as over-

represented in both the mental health and the criminal justice systems.

- ▶▶ Information sharing arrangements generally worked well amongst criminal justice agencies.

We therefore recommend that OCJR, in collaboration with the Home Office, Ministry of Justice and Department of Health, ensure effective cross-cutting work with offenders with mental disorders by the development and implementation of guidance to local criminal justice organisations through the National Criminal Justice Board on the rigorous and systematic collection of data to promote joint working.

6. ASSESSMENT AND CARE FOLLOWING ARREST OR DETENTION

Summary

This chapter describes the key role played by police custody sergeants in the identification and assessment of offenders with mental disorders.

Assessment by the police at point of arrest/detention

- 6.1 The police custody record provides the focal point for the police for recording information about risk and the custody officer is responsible for completing the custody record, ensuring that any risks are identified, assessed, documented and managed. Although different custody recording systems were used across the six sites visited, all contained a prescribed risk assessment with questions and prompts in relation to both physical and mental health.
- 6.2 The primary source of information on mental health was the offenders themselves. However, a range of other sources of information was also used, including the arresting officers, known history and previous custody records, medical practitioners and mental health services (where the offender was already believed to be receiving treatment), medication found on (or being taken by) the offender at the time of arrest, PNC and local intelligence. In some cases, the behaviour of the offender was sufficient to indicate a potential mental health condition or risk requiring further assessment.
- 6.3 Under PACE, advice must be sought from a healthcare professional if a detainee is believed to have a physical or mental health condition, other than a minor ailment. This is to determine whether the detainee is fit to be detained and interviewed and, in the case of those with a suspected mental health condition, whether a full psychiatric assessment is required.
- 6.4 Although healthcare provision was in place in all of the forces visited, local arrangements varied, from dedicated 'on call' doctors to contracted local GPs. The services provided were generally found to meet the need, although some occasional difficulties existed, for example where police doctors were also general practitioners (GPs) with their own surgery responsibilities, or where there were limited Section 12 (mental health) approved doctors. Two of the sites had introduced a CPN service at custody suites. Although arrangements varied locally according to the location and size of the custody suite and demand, CPNs were found to provide an effective gateway into the mental health services.
- 6.5 Of the 80 offenders within the police file sample, 38 (48%) were confirmed by medical examination as having a clinically diagnosed mental health condition.

Nevertheless, a range of other vulnerabilities was confirmed in the remaining 42 (52%) cases, primarily alcohol and/or drugs misuse, risk of suicide/self-harm, behavioural problems and personality disorders. It was apparent that, in a small number of cases, individual doctors (including psychiatrists) took different positions about whether certain conditions, such as 'personality disorder' or 'depression', constituted a clinical mental health condition. This practice was not only confusing to the other professionals involved in the case, but could, more significantly, make the difference whether the offender was referred for treatment and support to the mental health services or not.

- 6.6 These findings supported those of the joint inspections of police custody suites, undertaken by HMIC and HMI Prisons, which comment further on inconsistencies in the provision of forensic medical examiners.
- 6.7 The police risk assessment process is carried out for all offenders, regardless of whether any risks are apparent when the offender is arrested or detained. Examination of the inspection case file sample showed that the custody risk assessment process was being carried out promptly and was effective in identifying potential risks. It has to be emphasised, however, that no cases where no specific mental health issue had been highlighted at the point of custody were examined during the file reading, and this finding is therefore based only on cases where potential mental ill health had already been identified. We cannot, as a result, comment on the effectiveness of the initial identification process.
- 6.8 In most instances, appropriate action was thereafter taken to safeguard the well-being of the offender until such time as they could be examined by a doctor, including regular observations and, where necessary, constant watches. The file reading highlighted the key role played by custody sergeants and the importance of effective handover and briefing at shift changeover to ensure that risk was regularly reviewed. This was further evidenced by the fact that 22 of the 42 (52%) offenders where no clinical diagnosis of mental illness had been made, nonetheless were considered vulnerable due to risk of suicide or self-harm. Indeed, this proved to be a significant risk factor in over half (55%) of the total file sample.
- 6.9 All the custody sergeants interviewed during the inspection were found to be acutely aware of their responsibilities and had received relevant training about their role. However, the extent to which mental health issues were covered during this training varied according to when it had been undertaken. For front line response officers and other personnel, there was little available by way of awareness raising, and, without exception, all interviewees indicated that they would welcome the opportunity to improve their understanding and knowledge, in particular, in recognising the signs of potential mental health conditions and communication. In those areas where a CPN service had been introduced, the availability of specialist advice in bridging the knowledge gap was highlighted as particularly valuable.

Role of the Appropriate Adult

- 6.10 PACE Codes of Practice specify procedures and safeguards for those with a mental disorder or who are otherwise vulnerable during their detention by the police, and provides for the presence of an Appropriate Adult to safeguard their interests during interview and other stages of the detention process. The doctor's overall assessment also allows for medical opinion as to whether an Appropriate Adult may be required. This assessment is intended to assist the custody sergeant in making this decision and was found to play a significant part in practice.
- 6.11 Overall, with the possible exception of two cases, the decisions made by custody sergeants in employing Appropriate Adults in the cases inspected were considered defensible. Of the 38 cases within the police file sample where a mental health condition had been confirmed by a medical practitioner, 20 (53%) involved an Appropriate Adult. In the remaining 18 cases, there was usually an acceptable reason as to why an Appropriate Adult had not been used – for example medical opinion or where the offender was considered unfit to be interviewed or was transferred to hospital. An Appropriate Adult was also used in nine of the 42 (21%) cases with no clinical diagnosis of mental illness. These decisions were again generally taken following medical advice.
- 6.12 We found few difficulties in this inspection in the availability of Appropriate Adult services, or their timeliness of attendance. The impact of any problems, when they did arise, however, tended to be significant, delaying offender interviews and the completion of investigations, and increasing the length of time offenders spent in custody. These difficulties primarily related to accessing services out of hours and we saw cases where the offender had to be detained overnight until the attendance of an Appropriate Adult could be arranged for the following morning. These issues are currently being addressed by the National Delivery Plan of the Health and Criminal Justice Programme Board.

Duty of care

- 6.13 The duty of care placed on the police towards detainees is explicit during the time that a person is in police custody. Although there is no specific duty of care for a person released from custody or transferred to another agency, there is an ongoing duty to act on foreseeable risks beyond police custody.
- 6.14 Of the 38 cases involving offenders with a confirmed mental health condition, a release or aftercare strategy was not applicable in 15 (as the offender was, for example, detained in custody or transferred to hospital for assessment). In a further four cases, there was insufficient information within the file to determine whether an aftercare strategy had been developed, and in one case the offender refused to engage with services. Of the remaining 18 cases, reasonable steps had been taken to ensure that there was an aftercare strategy on release in 15. In just over half of these cases (eight), the offender was already receiving support or treatment which formed the basis of the strategy.
- 6.15 Of the 42 offenders where no mental health condition had been confirmed, 12 were detained in custody. Of the remaining 30, an aftercare strategy was put in

place in seven cases, primarily through Drug/Alcohol Arrest Referral Schemes or follow-up to initial medical assessments through the CPN or Mental Health Team services. Many practitioners commented, however, about the lack of available services for those whose behaviour remained a cause for concern, but who were not regarded as having a treatable mental health condition – for example those considered to have personality disorders.

Practice example:

A young man walked into hospital to seek voluntary admission. The hospital refused to admit and called the police to remove him from the hospital. Due to his conduct, the individual eventually had to be arrested. He was taken to the police station and, because of his mental health issues, the assessment process was started resulting in health professionals from the hospital having to be called out to do an assessment.

- 6.16 In some areas the prevalence of drug induced mental health conditions created a number of problems in that both the mental health and substance misuse services were not well co-ordinated and assessments suffered as a result. (47% of the probation cases also had a substance misuse problem identified.)
- 6.17 In general, although there were satisfactory arrangements in place for the provision of *places of safety* under Section 136 of the Mental Health Act 1983 in all but one of the inspection sites visited, it was clear that there was considerable pressure on beds in all areas. In addition, the arrangements did not always work effectively in practice, particularly where individuals presented with mental ill health and drug or alcohol problems. There will inevitably always be instances where an individual's behaviour poses an unmanageable risk to others and a police station is the most appropriate option for their immediate detention. However, the 'exceptional circumstances' under which a police station should be used as a *place of safety* were not always defined or agreed by partner agencies. As a result, we found examples of decisions about whether to accept admission to a healthcare facility being based on the presence of alcohol or drugs as opposed to the potential risk to others.
- 6.18 In the remaining inspection site visited, the designated *place of safety* was a police station, and this was a significant issue for the force concerned. Although efforts had been made to address the situation, including the establishment of a joint strategic group to examine provision under Section 136, progress remained dependent on the engagement and commitment of the PCT/LHB.
- 6.19 Over the years, a number of studies and reviews have highlighted the reasons why police custody is not a suitable environment for those with mental ill health. More recently, these concerns have been reiterated in the Bradley Report which indicated that use of police stations as *places of safety* was likely to be more widespread than the findings of our inspection initially suggested. The issue is, as a result, to be taken forward through the National Delivery Plan of the Health and Criminal Justice Programme Board who are to produce a national template and guidance on the implementation of Section 136 by autumn 2010.

Practice example:

In London, as a result of previous concerns, a tiered police response had been introduced for those cases relating to potential Section 136 detentions. For example, if social services wanted to enter an individual's property to do an assessment, they had to obtain a warrant. In the past, any request for a police presence on such occasions was given low priority, with the result that some cases could not be resolved for two or three days. A policy had now been introduced whereby such calls were passed to the Communications Room Supervisor, a police risk assessment completed, overseen by the supervisor, and a tiered police response put in place depending on the circumstances. If an individual was to be detained under Section 136, a room was usually arranged at Lambeth Hospital and individuals were only brought to the police station in exceptional circumstances.

Key Findings

- ▶▶ The custody risk assessment process was carried out promptly and effectively in all cases inspected.
- ▶▶ The provision of healthcare services to custody suites was generally sufficient to meet the need, although some occasional difficulties existed in their availability.
- ▶▶ The provision of CPN services, where available, proved an effective gateway to treatment.
- ▶▶ Individual doctors, including psychiatrists, took different positions about whether certain conditions such as personality disorders could be regarded as a mental health condition.
- ▶▶ Appropriate Adult services were used properly in nearly all the cases seen. Where problems did arise, however, they tended to be significant.
- ▶▶ Although there were satisfactory arrangements in place for the provision of *places of safety* under Section 136 of the Mental Health Act 1983 in all but one of the inspection sites visited, the use of police stations as *places of safety* is likely to be more widespread than the findings of our inspection initially suggest.
- ▶▶ Action was taken to ensure that an aftercare strategy was in place on release in the large majority of cases with a confirmed mental health condition.
- ▶▶ Custody staff would welcome the opportunity to improve their understanding and knowledge of potential mental health conditions and communication.
- ▶▶ Services were not always available for those whose behaviour remained a cause for concern but who did not have a treatable mental health condition.

We therefore recommend that police forces, in collaboration with health and social care agencies, develop joint protocols on the location and operation of places of safety, to include agreement on the 'exceptional circumstances' under which a police station is to be used.

7. DIVERSION FROM PROSECUTION

Summary

This chapter outlines the role of the CPS in determining the prosecution of offenders with mental disorders.

- 7.1 The CPS *Code for Crown Prosecutors* requires the prosecutor to examine the evidence and where the evidential stage of the test was met, to give consideration to the public interest in prosecution. Where the offender has mental health issues, a balance has to be struck between the public interest in diverting a defendant from the criminal justice system and other public interest factors in favour of a prosecution, including the need to safeguard the public.
- 7.2 The relevant main powers and duties of crown prosecutors are set out in paragraphs 4.4 onwards. In the more serious and contested cases, the CPS has taken over the responsibility from the police for determining whether an alleged offender should be charged. At this stage the crown prosecutor should be provided, generally by police, with good quality information about the defendant's mental health condition and the facilities for treatment available to the individual. Careful consideration should be given by the crown prosecutor to the evidence and information in the case in the light of the Code and the public interest factors in determining whether or not to charge the defendant. The decision not to charge, or to offer a conditional caution, would constitute diversion from prosecution. Because of the lack of definition and flagging of cases relating to offenders with mental disorders, we were not able to examine a sample of such files, or to gain any sound information as to the total number of cases involved.
- 7.3 The majority of CPS prosecutors we met considered their role in relation to the identification of offenders with mental disorders as responding to information or evidence supplied by the police. Occasionally, the nature of the evidence led them to asking the police to enquire into a suspect's mental health but, in the main, they relied on the police to pass any relevant information on to them or for issues to be raised by the defence. Police notification could take a number of different forms and any concerns were either passed on orally when the police attend for pre-charging advice, or else noted on the MG5 (the form setting out the case summary) or MG6 (the form which contains the case file information)*.
- 7.4 We found that in all the cases we examined, the crown prosecutors took decisions in accordance with the *Code for Crown Prosecutors*. We examined 61 CPS files identified as involving defendants with mental health issues. We considered that the decisions to prosecute the cases, and the decisions to discontinue or drop the cases, all took appropriate account of the information available about mental

* The MG5 and MG6 form part of the police file presented to the CPS lawyer when pre-charging advice was sought.

disorders and complied with the *Code for Crown Prosecutors*. In 15 of the 61 cases, the CPS discontinued or dropped the case (25%). In five cases, proceedings were dropped on the grounds of public interest because at some point during the proceedings the defendant was made subject to non judicial orders under Section 2 of the Mental Health Act 1983 and there were letters or reports to confirm the illness or the admission to hospital. In a further nine cases, the proceedings were dropped because the defendants were receiving treatment either at the time of the offence or during the course of the proceedings and it was not considered necessary in the public interest to prosecute the case to conviction. In one further case, the prosecution could not proceed because the defendant could not be traced and the offence, criminal damage, was not so serious as to merit protracted attempts to find them. In a further two cases, the court, taking the evidence of medical practitioners into account, found that the defendants were unfit to plead and made hospital orders under the Criminal Procedure (Insanity) Act 1964.

- 7.5 In most cases, it was concluded that the person would have committed the offence irrespective of any mental health condition, and the seriousness of the offence weighed heavily in determining whether it was in the public interest to prosecute.
- 7.6 Although neither the CPS nor the police were able to provide details, it was clear that some were diverted from prosecution without being charged. This might be by the police (where the decision rests with them) or on the advice of a crown prosecutor at the charging stage in those cases covered in the charging scheme. There is no way of knowing how many cases are now diverted by crown prosecutors at the charging stage that would have been previously charged by the police before the responsibility was taken over by the CPS. A significant proportion of defendants within the CPS file sample (25%) were the subject of discontinuance (albeit the proportion within the court file sample was less).
- 7.7 If good quality information about the offence, the alleged offender and potential treatment was available at an early stage, then there is scope for taking some of the decisions to discontinue at the earlier stage pre-charge. This would support the national guidance and the renewed invigoration provided to diversion within Lord Bradley's Report. A substantial proportion of offenders with mental disorders would still be subject to prosecution, with the emphasis being to ensure that good quality assessments were available and that the offenders were referred into treatment at the same time as their offending was dealt with by the court. Although this would not result in an increase in the number of cases diverted overall, it would mean that more cases were diverted earlier before the court processes were invoked.

Practice example:

The public interest sometimes weighs heavily in favour of prosecution despite the significant nature of the defendant's mental illness. A mentally ill woman, who was experiencing significant problems with her partner, set fire to her flat in three places. It was in one of the tallest properties in the area, and there were 13 stories above her. Although the CPS asked for her to be remanded in custody, she was granted bail. The CPS, who would have been criticised for failing to protect the public if they had not taken action, consequently appealed against the decision and the Crown Court remanded her to custody.

- 7.8 In one area, the police file also contained a short report from a diversionary panel which included information about the individual from community mental health staff. Whilst such an approach had much to commend it, the panel's report lacked analysis and gave insufficient rationale for any recommendation. A form had been introduced which all the agencies were meant to complete prior to the panel meeting as backing papers to support the decision-making process. However, the partner agencies did not routinely complete these sheets.
- 7.9 In two areas, a protocol had been agreed between the police, CPS and mental health services which encouraged the prosecution of health service users who had committed an offence against a member of staff or other health service users – even if they were in hospital for treatment. The rationale for this was clinical, i.e. patients had to accept responsibility for their actions and for the potential consequences of not receiving or cooperating with their treatment, and also for future risk assessment in that a formal record of the behaviour was retained. Other areas adopted a more flexible approach, with each case treated on its merits.
- 7.10 Overall, we found little appetite to increase the number of offenders with mental health needs diverted from the justice process at the pre-charge stage. Nor, in our view, was there any reason to do so. The cases we saw were charged appropriately and proceeded correctly through the criminal justice system. Only a small number had a severe and enduring mental illness which had a direct influence on their offending and these offenders were mostly dealt with by way of a hospital or supervision order under the Criminal Procedure (Insanity) Act 1964. For the most part, mental health issues, of varying degrees of severity, ran alongside offending and in many cases, together with substance misuse problems. Concerns remained, however, about the engagement of the health services and the subsequent availability of treatment for the many offenders who had low-level mental health issues or whose mental illness was associated with substance misuse. Whether the mental disorder had led to the current offence or not, helping offenders to achieve a level of personal stability by sustained access to treatment not only promoted their rehabilitation but was one factor in many in preventing further offending.

Key Findings

- ▶▶ In the cases we examined, the decisions taken by the CPS took account of information available about mental disorder and complied with the *Code for Crown Prosecutors*.
- ▶▶ We saw little scope for substantially increasing the numbers diverted from prosecution or discontinuance after charge without radically altering the scope and powers of the Mental Health Act 1983 as amended, and policies behind the use of the criminal justice system and powers of sentencing which relate to the protection of the public.
- ▶▶ We did see scope for the provision of better quality information to enable more decisions to be made at the charging stage for diversion from prosecution before entering the court process.
- ▶▶ The CPS generally relied on either the police or the defence to pass relevant information on to them.
- ▶▶ Concerns remained, however, about the engagement of the health services and the subsequent availability of treatment for the many offenders who had low-level mental health issues or whose mental illness was associated with substance misuse.

We therefore recommend that criminal justice organisations, in liaison with local social care organisations, engage with their local PCTs to ensure that assessment and treatment facilities for offenders with mental disorders are available promptly and of good quality.

8. COURT PROCESSES

Summary

This chapter identifies the limited opportunities for diversion at the court stage and describes the variable arrangements for the provision of information and advice to the court about a defendant's mental health. It also discusses the provision of psychiatric and PSRs.

At court

- 8.1 In most cases, offenders with significant mental disorders had already been identified as requiring assessment or some form of intervention by health professionals before they had reached the courts, or had been drawn to the court's attention by defence representatives, frequently during the completion of applications for legal aid. Opportunities for diversion at court appearance were therefore limited as most cases had been picked up at an earlier stage. Representations were made at court for the case to be discontinued in only 7% of the cases we examined (four out of 54). It was clear that these submissions had only been made after proper consultation with the relevant agencies.
- 8.2 In the majority of occasions where concerns about the individual's mental health were identified at a police station, the person was subsequently charged and bailed. Although the police would generally have passed this information on to the CPS using the relevant forms, there was no systematic process to convey such information to courts unless the defendant was legally represented. If the defendant was not represented, the prosecutor had to make a judgement about how to proceed, taking account of the interests of justice and accepting that the defendant might not wish for such personal information to be disclosed.
- 8.3 If, having previously been bailed, individuals were subsequently remanded in custody by the court, it was possible that potentially important information about their well-being might not be communicated to either the courts or court custody staff, despite being known to others in the system. Although the Prisoner Escort Record, which would be generated at whatever point the individual entered custody, could be used to convey such information, it was not clear whether the record always picked up on information obtained earlier in the process and a number of court and court custody staff suggested that it would have been helpful to have information more systematically from the police about offenders with mental disorders who were remanded in custody.
- 8.4 However, given the dynamic nature of mental illness, concerns about the defendant's state of mind were not always apparent until the case came before the court. We found a number of examples of prompt action by court staff,

particularly custody staff, in alerting others to the deteriorating mental health of prisoners.

- 8.5 The majority of issues of self-harm were clearly recorded on the court files in 73% of relevant cases (11 out of 15). Court custody contractors had well-established procedures for liaising with prisons and prison escort staff in such cases, and for monitoring defendants assessed as at risk of self-harm, while in court custody. In one case in our sample, newly identified issues of self-harm had been clearly communicated to escort and prison staff.

Practice example:

In general there were no flags on court files to indicate any concerns about the defendant's mental health, although in Camberwell Crown Court, case files encouragingly reflected a sense of continuity by collating information, such as any statements about the defendant's mental health, from charge through magistrates' to the Crown Court.

Mental health schemes based in court

- 8.6 Sentencers and court staff generally valued the presence of mental health professionals in court (where this service was available), although we were unable to assess the impact of this activity.
- 8.7 Although all courts had some arrangement for the provision of advice and/or assessment in relation to defendants with possible mental health conditions, the extent of these services varied considerably and could not be described as comprehensive. For example, we found examples of mental health staff only being available to one court a week, with no cover for sickness or leave, or being restricted as to the number of referrals that they could accept.
- 8.8 Whilst the level of resourcing was not always satisfactory, we were, however, impressed with the efforts made by staff in the relevant agencies to work around these logistical problems. The personalities of the staff concerned were important and people worked hard to provide an acceptable level of service.

Case progression

- 8.9 There were wide variations in the time it took for offenders with mental disorders (whether formally diagnosed or not) to progress through the criminal justice system. These appeared to be caused by a variety of reasons, primarily by problems in securing funding from the Legal Services Commission for a psychiatric report, in actually obtaining a psychiatric assessment, accessing funding for treatment and the availability of beds in treatment facilities. The problems of delay were most marked in the Crown Court.

- 8.10 The matter was complicated in Wales by the fact that the Welsh Assembly provided funding for treatment in medium-high secure mental health units. This caused argument and delay around the type of treatment that was necessary for a defendant and responsibility for funding.
- 8.11 London Probation staff reported that hospital beds were normally available for hospital orders, although there were sometimes delays in the placement of homeless offenders because of disputes between PCTs/LHBs about which trust should fund them. This was a problem in other areas but was more marked in London because of its transient population. In other parts of the country, delays existed in obtaining psychiatric assessments. Defendants were often remanded in custody to await a hospital bed so that they could be assessed. This could take months because the Trust often reported that there were no beds available.

Practice example:

Camberwell Magistrates' Court had developed a system of mental health liaison meetings that were considered to be very useful by all participants. They were chaired by an expert District Judge, and included court staff and other District Judges, mental health assessment team and prison clinicians. The meeting considered operational issues and discussed strategic developments.

- 8.12 We were pleased to find examples of systematic communication with prisons, under a national requirement established by HMCS. In the Crown Court sitting in one of the areas visited, the court clerk was particularly proactive in ensuring that psychiatric reports were sent, with the PSR, antecedents, and copy of indictment, to prison with imprisonment order, and also highlighted self-harm issues.

Psychiatric reports

- 8.13 We found no national or local inter-agency protocols that covered the provision or use of psychiatric reports for the courts. There was no consistently applied national system for the commissioning, tracking or monitoring of psychiatric reports by the courts. It was, however, hoped that two pilot exercises, currently being conducted by HMCS in partnership with Offender Health, would result in the development of a national service level agreement for psychiatric reports to be delivered to all courts throughout England and Wales by the end of 2011.
- 8.14 At the time of the inspection, the magistrates' courts had no way of monitoring the number of requests for psychiatric reports apart from interrogating their invoice system to identify how many such reports had been requested. Some Crown Court centres, however, had developed local systems to record and track the commissioning and receipt of psychiatric reports, including reports requested by defence representatives or other agencies.
- 8.15 The effectiveness of administrative case progression in minimising delay varied considerably in the cases examined – in some instances it was highly effective and

in others needed significant improvement. The court logged the receipt of the report and tracked its progress in only 14 cases of the 34 psychiatric reports examined. Local logging systems for reports, where these had been developed, had the potential to support case progression and to help to minimise delays.

Practice example:

In Bolton and London, a flow chart set out the process and rationale for sentencers when requesting such a report, and at Swindon, a service level agreement, which had been developed by courts elsewhere in the HMCS South West Region, was being considered for adaptation and use. The planned agreement would see all reports ordered by the court commissioned through the local mental health team who would engage local psychiatrists for a predetermined fee. This seemed a sensible arrangement.

- 8.16 Psychiatric reports commissioned by the court were invariably to assist in sentencing, usually to determine either fitness to plead, culpability and *Risk of Harm*. On rare occasions the CPS might also order a report where it wished to confirm fitness to plead or culpability. In the majority of cases, psychiatric reports were suggested by defence solicitors or barristers in order to assist with mitigation. Whilst many reports could appropriately be prepared by a general psychiatrist, particularly where they had prior knowledge of the individual, it was important that cases thought to present a high *Risk of Harm* were referred to a forensic psychiatrist for assessment.
- 8.17 Managers in London Probation Area (and health professionals and court staff in some of the other places inspected) took the view that PSR authors suggested psychiatric reports be obtained unnecessarily. It was often thought by probation staff that a psychiatric report was always needed to propose a treatment requirement. This is not always the case as, for example, when the person is already known to the treatment services.
- 8.18 Whilst we found some good examples of reports that were helpful to sentencers, we also heard of significant problems about psychiatric reports, which included: delays in obtaining a report, poor quality of information and concerns about high costs.

a) Delays in obtaining a psychiatric report

- 8.19 Normally, where the court ordered a psychiatric report, a consultant psychiatrist (or in some areas a forensic psychiatrist), often attached to a local clinic, would undertake the assessment, prepare the report and, if appropriate, recommend treatment at the clinic concerned. For reports written at the request of the defence, the position was often more complex. The time taken to obtain these reports was frequently longer than with court-commissioned reports, occasionally because of delays in obtaining funding for the report from the Legal Services Commission. It was not unusual for courts to wait for six to eight weeks for psychiatric reports and some courts reported production times of 12 weeks. We noted particular problems with reports on offenders remanded into custody when

no appropriate local expert or psychiatric unit was available to undertake the assessment. In Camberwell, where the magistrates' court, the local prison in-reach team and the mental health trust worked effectively together, these reports could be prepared in three to four weeks if required.

b) Quality of information

- 8.20 The questionable quality of many psychiatric reports had been recognised prior to the inspection by HMCS who had commissioned a research project to develop national good practice guidance on the content and structure of court psychiatric reports.
- 8.21 The majority of the reports (81% or 17 out of 21) examined during the course of the inspection, contained a clear proposal for sentence, treatment or fitness to plead. However, in more than one case we found difficulties in implementing the treatment recommended because, unknown to the psychiatrist preparing the report who was not from the locality, it was not available in the area where the offender lived. We were told of examples of cases in the Crown Court where psychiatric reports were used by the defence to counter assessments of dangerousness put forward in PSRs. We also heard from sentencers that, in some cases, the defence representative would not present the report to the court or share its contents with the CPS if they felt that it would prejudice the defendant's case by doing so.
- 8.22 Whilst such allegations are difficult to verify, their very existence indicates some lack of confidence in the quality of psychiatric reports and highlights the need to clarify the role of psychiatrists when preparing reports at the behest of the defence.

c) Costs

- 8.23 The funding arrangements for psychiatric reports were not without difficulties. If a report was ordered by the court, payment came from court funds, whereas if it was requested by the defence, payment came from central Legal Aid funds. Although the number of reports commissioned by most courts was small, many were concerned about the high costs sometimes charged by mental health experts. In the case of both court-commissioned and defence-commissioned reports, the work of the mental health experts concerned was likely to be regarded as part of their private practice, with associated cost implications. We were surprised by the wide range in the cost of reports in our case sample. Whilst some reasonable variation was to be expected, the differences in the complexity of the cases or the level of input required in the assessment could not account for the discrepancies found in the inspection.

Action taken

- 8.24 Efforts had been made in a number of areas to improve the position regarding psychiatric reports and assessments. Camberwell Green Magistrates' Court had set up a Court Psychiatric Liaison Scheme. Staff from the scheme attended court one

day a week interviewing up to three people on a triage basis in order to assess the need for a full psychiatric report. As a result, fewer psychiatric reports were requested, thus saving time and money. Similarly in Warwickshire, a CPN was available to provide an assessment of mental health and treatment but not an opinion or prognosis or assessment of dangerousness.

- 8.25 In many instances, a psychologist's report would have appeared more helpful to the court than a psychiatric report. In Hereford, the probation area was able to obtain local forensic psychological assessments post-sentence from a private firm. The service was quick and responsive but, as it was funded by probation, was not generally used to provide the court with reports pre-sentence unless the offender was already on some form of order or licence.
- 8.26 In practical terms, courts were often left 'holding the offender' and seeking to broker appropriate outcomes, including treatment as necessary, for sometimes vulnerable and difficult offenders with whom health services were reluctant to engage.
- 8.27 Many of our concerns about the production of psychiatric reports were also recognised in the Bradley Report and are to be taken forward by the National Delivery Plan of the Health and Criminal Justice Programme Board. The development and implementation of effective national systems for use by all courts to commission, record and monitor the receipt of psychiatric reports would have significant benefits to all stakeholders. Individual courts would be able to monitor more effectively the commissioning, progress and timely receipt of reports, to assist the administrative progression of cases in support of the judiciary, to check and quality assure the coverage of reports, and to monitor and control their costs. At national and, as appropriate, regional and area level, the operation of a consistent national process would enable HMCS and the departments to produce data about the use of psychiatric reports, and potentially about wider mental health issues, for the purposes of analysis, evaluation and report, and as an input to the development of policy and to the consideration of resources.

Practice example:

A defendant from Nottingham believed her mother lived in West Wales and was convicted, in Wales, of stalking a person whom she believed was her mother. She was subsequently remanded in custody and psychiatric reports prepared, recommending in-patient treatment. The local PCT refused to pay for treatment, however, because the woman was from Nottingham and the PCT in Nottingham refused to pay because she was no longer a Nottingham resident. Ultimately, the Judge asked for an explanation in court of the funding issues, subsequent to which agreement was reached for treatment.

Pre-sentence reports

- 8.28 OASys assessments are used by probation staff to identify offenders with mental disorders. OASys also has the capacity to indicate the need for further mental health assessment, but there is an expectation generally placed on staff that they would refer the individual offender on so that such an assessment could be undertaken.
- 8.29 Where probation staff had access to mental health specialists as in Bolton and London, the quality of the OASys assessments was better. In other areas, the assessments tended to overstate the significance of the mental health condition. The reasons for this happening require further investigation but appear to include issues of staff competence and the structure of the assessment tool itself. Its significance is, however, considerable, not only for the individual but also, if the assessments are used to supply aggregated data for planning purposes, for the areas themselves.
- 8.30 All but one of the six probation areas visited had agreed an explicit policy with their local courts that a standard PSR would be produced in all cases where there was a concern about an offender's mental health. This agreement reflected the perceived increased complexity of such cases and need to seek additional information. In the area without an explicit written policy, the practice was nonetheless to produce a standard report.
- 8.31 CPS information about the offence(s), previous convictions and detail of any mental health issues identified at the time of arrest and charging, was available to PSR authors and provided a secure base on which to form judgements about the nature and seriousness of the offending.
- 8.32 We examined 42 PSRs written on offenders with some form of mental health condition. All were of the appropriate type, prepared within the timescale set by the court and completed using the nationally approved format. All took account of the court's view, where indicated, of the seriousness of the case. We noted, however, some problems of double scoring in OASys which could result in an overestimation of the level of risk posed by the offender. This issue requires further investigation by probation areas as part of their quality control processes.
- 8.33 Further findings from our analysis of the PSRs examined during the inspection were as follows:
- ▶ although 84% of relevant reports (32 out of 38) included reference to previous convictions and the impact of the mental health issues when considering the pattern of offending behaviour, offending and mental health tended to be treated as separate issues. We felt that PSR writers needed to undertake a more sophisticated approach and analyse the interplay between the two factors, clearly stating whether the individual's mental health was a contributory factor in their offending
 - ▶ the PSR included a clear *Risk of Harm* assessment that differentiated between the likelihood of harm related behaviour and the impact of that behaviour in 79% of cases (33 out of 42). The assessment took into

account relevant mental health issues in 82% of relevant cases (31 out of 38). We considered the *Risk of Harm* assessment accurate and that the report demonstrated an awareness and understanding of the mental health needs of the offender in 78% of cases

- ▶ only 33% of PSRs (14 out of 42) were suitably concise. However, we noted the over-use of the phrase in one area of: '*In my professional judgement ...*'; sometimes simply unnecessarily, or else to preface a judgement that only a mental health professional would have been qualified to make
- ▶ the PSRs contained appropriate victim information in only 70% of cases (23 out of 33), although in a further three cases, sentence details had been supplied to victim liaison staff as required by national policy. All areas had updated their guidance to staff in relation to supplying sentence details and information to victims of those sentenced to Hospital Orders
- ▶ 71% of relevant reports (29 out of 41) contained an appropriate outline plan and in 86% of cases the plan addressed the mental health issues
- ▶ issues of self-harm were identified in a little under half of the PSRs, which in 17 out of 20 cases were clearly noted within the report. In all three relevant cases the self-harm issue was communicated to prison staff
- ▶ a proposal for a community sentence was made in 78% of reports (32 out of 41) and this was followed by the court in 88% of cases (28 out of 32). This suggested that prison was not the default option for these cases.

8.34 There were relatively few proposals for a community sentence with a requirement for mental health treatment. There appeared to be a number of reasons for this: many offenders had low level or untreatable conditions and therefore were deemed to be unsuitable, whereas others were already in contact with treatment providers. We also found evidence from the assessments of reluctance on the part of offenders to engage with treatment mirrored by the lack of treatment options suitable for the chaotic lifestyles that many offenders led. Some mental health providers clearly preferred the Care Programme Approach (CPA) (voluntary) approach to treatment and, in a number of instances, the culture of enforcement for criminal justice agencies did not sit well with the more permissive mental health services.

Other provisions

8.35 Overall, mainstream mental health services were not always well resourced or accessible to offenders with chaotic and difficult lives. In some situations, the authorities had been forced to utilise civil orders such as antisocial behaviour orders (ASBOs) to manage people who whilst not formally diagnosed with a mental illness were acting in an antisocial manner. One example was given of an individual who continually threatened suicide by drowning and whose behaviour

not only had significant financial implications for the emergency services (estimated at approximately £1million in one year) but also placed others at risk. They were not, however, diagnosed as suffering from any mental illness and ultimately an ASBO with appropriate conditions was successfully used to manage their behaviour.

- 8.36 In West Mercia, the multi-agency Vulnerable Adults Scheme provided for the referral of vulnerable adults to appropriate services. A framework for multi-agency strategy discussions/meetings had been developed so that action could be taken to protect the individual concerned. 'Alerts' were raised through completion of a Safeguarding Referral form. This triggered adult protection procedures, an investigation was initiated (by the police and/or social care services as appropriate), and a strategy discussion, followed by a strategy meeting, took place. Timescales for each stage of the process have been agreed, together with responsibilities in relation to the investigating and managing roles and delivery of comprehensive multi-agency guidance.
- 8.37 Although primarily aimed at victims of crime, such schemes can provide another option for referral into services for individuals who are vulnerable due to behavioural problems. In one case, an elderly woman had been assaulted by her adult son who was subsequently convicted of the crime. The vulnerable adult referral process allowed steps to be taken to protect the victim and for coordinated action to be taken by the agencies involved, including a court disposal which allowed for the relationship to continue, but gave control of when and where contact would take place back to the mother.

Key Findings

- ▶▶ In most cases, offenders with significant mental health conditions had already been identified before they reached the courts, or been drawn to the court's attention by defence representatives. Concerns about mental health issues were therefore usually addressed before the defendant appeared in court and opportunities for increasing the level of diversion at the court appearance were therefore limited.
- ▶▶ However, although the police generally passed information about a defendant's state of mind on to the CPS, there was no systematic process whereby such information would be conveyed to the court.
- ▶▶ All courts had some way of obtaining advice about defendants with possible mental health conditions, the extent of these services varied considerably.
- ▶▶ The time taken for offenders with mental disorders (whether formally diagnosed or not) to progress through the criminal justice system varied considerably.
- ▶▶ We found no national or local inter-agency protocols that covered the provision of psychiatric reports for the courts. Whilst we found many good examples that were helpful to sentencers, we also heard of significant problems about delays in obtaining

psychiatric reports and their quality, as well as concerns about their cost.

- ▶▶ PSR writers needed to undertake a more sophisticated analysis of the offender's behaviour, clearly stating whether the individual's mental health was a contributory factor in their offending.
- ▶▶ Overall, mainstream mental health services were not always well resourced or accessible to offenders with chaotic and difficult lives who were often reluctant to engage with the treatment process.

We therefore recommend that the Ministry of Justice and the Department of Health review the arrangements for the commissioning and monitoring of psychiatric reports in order to ensure that delays in sentencing are minimised and that the reports are of good quality.

Appendix A

Statement of Purpose

HMI Probation is an independent Inspectorate, funded by the Ministry of Justice and reporting directly to the Secretary of State. Our purpose is to:

- ▶ report to the Secretary of State on the effectiveness of work with individual offenders, children and young people aimed at reducing reoffending and protecting the public, whoever undertakes this work under the auspices of the National Offender Management Service or the Youth Justice Board
- ▶ report on the effectiveness of the arrangements for this work, working with other Inspectorates as necessary
- ▶ contribute to improved performance by the organisations whose work we inspect
- ▶ contribute to sound policy and effective service delivery, especially in public protection, by providing advice and disseminating good practice, based on inspection findings, to Ministers, officials, managers and practitioners
- ▶ promote actively race equality and wider diversity issues, especially in the organisations whose work we inspect
- ▶ contribute to the overall effectiveness of the criminal justice system, particularly through joint work with other inspectorates.

Code of Practice

HMI Probation aims to achieve its purpose and to meet the Government's principles for inspection in the public sector by:

- ▶ working in an honest, professional, fair and polite way
- ▶ reporting and publishing inspection findings and recommendations for improvement in good time and to a good standard
- ▶ promoting race equality and wider attention to diversity in all aspects of our work, including within our own employment practices and organisational processes
- ▶ for the organisations whose work we are inspecting, keeping to a minimum the amount of extra work arising as a result of the inspection process.

The Inspectorate is a public body. Anyone who wishes to comment on an inspection, a report or any other matter falling within its remit should write to:

*HM Chief Inspector of Probation
2nd Floor, Ashley House
2 Monck Street
London SW1P 2BQ*

<http://inspectorates.justice.gov.uk/hmiprobation>

Appendix B: References

- 1 Criminal Justice Joint Inspection: *Joint Inspection Business Plan 2008/2009*
- 2 The Department of Health: *The Bradley Report: Review of people with mental health conditions or learning disabilities in the criminal justice system* (April 2009)
- 3 HM Inspectorate of Prisons: *The mental health of prisoners: a thematic review of care and support of prisoners with mental health needs* (October 2007)
- 4 http://www.cps.gov.uk/legal/l_to_o/mentally_disordered_offenders/#guidance
- 5 Home Office Circular 66/1990: *Provision for Mentally Disordered Offenders*
- 6 Home Office Circular 12/1995: *Mentally Disordered Offenders: inter-agency working*
- 7 Department of Health: *Review of mental health and social services for mentally disordered offenders and others requiring similar services* HMSO (1993)
- 8 Department of Health: *National Service Frameworks for Mental Illness* (1999)
- 9 Department of Health, HM Prison Service and the National Assembly for Wales: *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Service in Prisons* (2001)
- 10 Department of Health: *Offender Mental Health Care Pathway* (2005)
- 11 Home Office RDS paper 2002: *Outcomes of psychiatric admission through the courts*
- 12 Social Exclusion Unit's report: *Reducing Reoffending by Ex-Prisoners*
- 13 Home Office/Department of Health: *Review of the current practice of court liaison and diversion schemes*. Update report for health and offender partnerships (2005)
- 14 Department of Health: *Choosing Health – making healthy choices easier* (2004)
- 15 Department of Health: *Our Health, Our Care, Our Say* (2006)
- 16 Department of Health: *Quality Care for All* (2008)
- 17 Baroness Corston's Review of provision for vulnerable women with the CJS
- 18 Department of Health, Ministry of Justice: *Improving Health, Supporting Justice* (2007)
- 19 NACRO: *Black communities, mental health and the criminal justice system* (2007)