Liaison and diversion for mentally disordered offenders

A mental health good practice guide
Liaison and diversion for mentally disordered offenders

Nacro
169 Clapham Road, London SW9 0PU
Telephone 020 7582 6500
Fax 020 7735 4666
www.nacro.org.uk
www.nacromentalhealth.org.uk

ISBN 0 85069 214 8
Nacro is a registered charity no. 226171
© Nacro 2006

Nacro welcomes a wide circulation of its ideas and information. However, all reproduction, storage and transmission must comply with that allowed under the Copyright, Designs and Patents Act 1988, namely for purposes of criticism or review, research or private study, or have the prior permission in writing of the publishers.

Front cover photos: manningphotographers@btclick.com and mark@id8photography.co.uk
Contents

A note on terminology page 2
Introduction page 3
1 The role of diversion schemes page 5
2 Establishing the need page 8
   • Needs analysis 8
   • Mapping existing services and resources 9
3 Establishing a scheme page 11
   Identifying the type of scheme 11
   • Court diversion schemes 12
   • Court assessment schemes 12
   • MDO panel schemes 12
   • Criminal justice mental health liaison schemes 13
   • Specialist v non-specialist provision 13
   Funding and commissioning a service 14
   Management of the scheme 14
4 Operating a scheme page 16
   Where a scheme operates 16
   Scheme models 17
   • Police station model 17
   • Court stage model 18
   How a scheme operates 19
   • Screening and/or referrals? 20
   • The ideal scheme 21
   Referrals 22
   • Range of referrers 22
   Operating protocols and practice 23
   • Operational protocol 23
   Publicity 23
   Days of operation 24
   Assessments 24
   Advice and recommendations 24
5 Staffing a scheme page 26
   Staff roles 26
   Case-loads 27
   Skills 27
   Scheme support 28
6 Links and resources page 29
   • Important links and resources 30
   Supporting arrangements 31
   • Premises and equipment 31
   • Protocols 31
   • Complaints and disputes 32
7 Ensuring the scheme meets the needs of all page 34
   Women 34
   • Criteria for women 35
   Black and minority ethnic groups 35
   • Criteria for people from BME communities 35
   Children and young people 36
   People with learning disabilities 36
   Personality disorder 37
8 Recording and monitoring page 39
   Monitoring activity 39
   • What to monitor 40
   Analysing results and taking action 41
9 Evaluating practice page 42
   High priority 43
   Lower priority 47
   What happens next? 50
10 Case study page 51
11 Conclusion page 53
   • Scheme protocol 53
Appendix Diversion diagrams page 54
   Diversion at the police station 54
   Diversion at the court 55
Other Nacro mental health publications page 56
A note on terminology

This good practice guide uses the term ‘mentally disordered offender’ except where direct reference is made to a report or other publication which has expressly used another term. For the purpose of this guide the term ‘mentally disordered offender’ is defined as:

*Those who come into contact with the criminal justice system (CJS) because they have committed, or are suspected of committing, a criminal offence, and: who may be acutely or chronically mentally ill; those with neuroses, behavioural and/or personality disorders; those with learning difficulties; some who as a function of alcohol and/or substance misuse have a mental health problem; and any who are suspected of falling into one or other of these groups. It also includes those in whom a degree of mental disturbance is recognised, even though that may not be severe enough to bring it within the criteria laid down by the Mental Health Act 1983, and those offenders who, even though they do not fall easily within this definition – for example, some sex offenders and some abnormally aggressive offenders – may benefit from psychological treatments.*

This broad definition reflects Nacro’s concerns that we address the wider problems associated with people who come into contact with the criminal justice system with a range of mental health problems and that we avoid concentrating only on a narrow group of mentally disordered offenders whose mental disorder falls within the criteria laid down by the *Mental Health Act 1983.*
The criminal justice system (CJS) is not always well placed to deal with people with mental health problems. Nonetheless, many service users only access mental health services via the CJS. Other mentally disordered people may only be in the CJS in the first place because of the way society reacts to those with mental disorder. However, the criminal justice process, which is itself complex, becomes even more complicated when forced to deal with people with complex needs and to work alongside other agencies with different cultures and perspectives.

For mental health service users, and other mentally disordered offenders in contact with the CJS, there needs to be a matrix of practical solutions to facilitate the transition across the interface between the CJS and the health and social care sectors. Criminal justice mental health liaison schemes, court diversion schemes, and other similar arrangements are a vital part of that process.

Anecdotal accounts from clinicians and other mental health professionals suggest that diversion and liaison schemes can have a negative impact on mental health services, especially on in-patient services, because people admitted from the CJS may be disruptive and prone to violence and bring drug-taking, non-compliance and criminality into these settings. However, a number of studies have demonstrated that such schemes offer significant benefits because: they reduce the need for remands in custody; reduce reoffending; re-engage people with services; reduce, or even abolish, delays; and meet the needs of victims.

Despite promptings from the Home Office and Department of Health and from a number of reports, the development of schemes has been patchy and piecemeal. Reasons for this include: the absence of a centralised strategy including the setting of targets; the large number of police stations, courts, and prisons which exist and require some sort of provision; the lack of enthusiasm among some clinicians to engage with such initiatives; and the lack of resources, including dedicated funding. Where schemes do exist
Introduction

they work to different models and configurations from a range of providers including the voluntary sector. The one thing they may have in common is the commitment and enthusiasm of their practitioners.

If diversion and liaison schemes are to help bring about a meaningful reduction in the numbers of mentally disordered prisoners and to ensure that people with mental health problems in contact with the CJS are identified and appropriately dealt with, they should operate as effectively as possible. This includes being integrated with mainstream services, being adequately funded, having access to a range of resources, and being part of robust management and planning structures.

This good practice guide results from Nacro’s understanding of the issues and the experience gained from its local development work and annual survey.\(^6\)\(^7\) It is aimed at commissioners, managers and practitioners, and sets out how a scheme should be established, funded, and organised. It also identifies the elements that make up a ‘good scheme’, able to meet the needs of different groups and individuals. And it provides a checklist to ensure that the scheme operates as effectively as possible and for the benefit of mentally disordered offenders and those agencies working with them.

Notes

7 For background information about diversion and liaison, see www.nacromentalhealth.org.uk
Court diversion schemes and criminal justice mental health liaison schemes are principally concerned with the assessment and identification of people with mental health problems within the criminal justice system (CJS) and assisting criminal justice agencies to ensure that effective and appropriate outcomes occur. As such, they manage the interface between criminal justice and health and social care to the benefit of all agencies and, importantly, the service user.

There are a number of different models, with the main types being:

- **Diversion schemes** – aim to increase the identification of mental illness and to facilitate and accelerate transfer to hospital where appropriate. Some schemes which started out with this aim would now see that role as being too narrow.

- **Assessment schemes** – are concerned with identifying and assessing people appearing before the courts with a view to assisting magistrates with disposal options. They can significantly reduce the time taken to obtain that advice by assessing the defendant at the court rather than through a remand in prison.

- **Liaison schemes** – reflect the wider role that many schemes now have. Rather than diverting people out of the criminal justice system and into a health setting, they offer support and liaison both to the mentally disordered offender (MDO) and the agencies involved with them to ensure that they are treated appropriately and effectively. This may include processing the person through the CJS as well as dealing with their mental health problem.

- **Panel schemes** – or MDO panels, bring together formally a range of agencies – most notably police, health, social care, and probation – to put forward a co-ordinated package of care for the courts or the Crown Prosecution Service (CPS) to consider. They will also co-opt other agencies and organisations, including from the voluntary sector, where relevant to the case, for example, housing, drug services, etc.
Part 1  The role of diversion schemes

Where there are differences between schemes these are likely to result from what they do, how they operate, staffing, and their operational and strategic links rather than any fundamental philosophical distinction. Unless there is a specific reference to one model, this guide will use the term ‘scheme’ to apply to all models.

A possible outcome when mentally disordered people are in contact with the CJS might be diversion. This can occur with or without the criminal justice process being discontinued. Diversion for mentally disordered offenders usually involves moving the person out of the CJS and into the health and social care system including, but by no means exclusively, admission to hospital. Diversion may occur at any stage of the criminal justice process, before arrest, before charge, after proceedings have been initiated, in place of prosecution, or when a case is being considered by the courts. The diagrams in the appendix show how this process might occur.

Alternatively, the most appropriate and relevant path might be to process the person through the CJS while also dealing with their mental health needs. Schemes will play a large part in ensuring these needs are met.

Many schemes operate what is essentially a triage service at police stations and courts and, occasionally, at other sites in the criminal justice process, such as probation and bail hostels. As such, schemes will screen individuals whom the criminal justice agencies have concerns about. For those with a serious mental illness they will help facilitate a full assessment under the Mental Health Act 1983. Those with less serious mental health problems may be signposted to a more appropriate option including community facilities and GP services.

Schemes will offer advice to criminal justice agencies on the degree of mental health problem, the capacity of the individual, possible disposal, and will help access a range of disposals. There are a few police forces who use the diversion or liaison scheme as the ‘appropriate health care professional’ under PACE (the Police and Criminal Evidence Act 1984) to rule on an arrested person’s ‘fitness to be detained’ and ‘fitness to be questioned’ (Code C: 9.5-9.9).

Schemes can provide a speedy report for the court on a person’s capacity to stand trial, thus reducing delays and the need for unnecessary remands in custody to obtain a psychiatric report. When disposal under Part III of the Mental Health Act 1983 is
considered, the scheme can help with the full psychiatric report required.

Schemes also see their role as assisting with information sharing and being the conduit for the exchange of information between different agencies within the criminal justice process, for example, between the police station and the court and between the court and the prison or between the CJS and health and social care agencies.

A number of schemes also assist in the training of criminal justice practitioners on mental health awareness, risk assessment and risk management, and the function and process of diversion.
Prior to any scheme being developed a needs analysis should be carried out to ascertain the level of provision required.

Where a service for mentally disordered offenders currently exists – this may be a dedicated scheme or a set of separate arrangements – information will be measured to see whether it meets the identified need. The evaluation checklist in this guide can also be used for this purpose (pages 42-52).

The focus of the needs analysis should be all the points of possible intervention in the criminal justice process including: the police station; the magistrates’ court, youth court, and crown court; probation centres including probation and bail hostels; and prison.

The needs analysis might be initiated by the local mentally disordered offenders (MDO) group (where one exists) or by local commissioners. (The MDO group is a multi-agency forum of relevant agencies and stakeholders working with mentally disordered offenders, which takes an overview of arrangements and initiatives for developing a strategy for this client group.)

- **Needs analysis**

  Information which should be collected includes the number of:
  - detentions under Section 136 of the *Mental Health Act 1983*
  - requests for mental health assessment by an appropriate health care professional
  - requests for an appropriate adult for mentally vulnerable individuals
  - assessments carried out under the *Mental Health Act 1983* at the police station
  - pre-sentence reports (PSRs) where a psychiatric assessment was carried out
  - community orders with mental health treatment requirements
• mental health cases identified by OASys or other similar information systems
• admissions to hospital under Part III of the *Mental Health Act 1983*
• admissions to hospital under other sections of the *Mental Health Act 1983* from the criminal justice system
• requests for mental health assessments from prisons

Information can be obtained from a snapshot of different agencies’ involvement with mentally disordered offenders, a retrospective study, or an ongoing observational study. Such information gathering should then become an integral part of the establishment of a new service or the ongoing development of an existing one.

Alongside the gathering of statistical information, there needs to be a mapping of existing services and resources to provide an overview of how a new service might fit with existing ones.

**Mapping existing services and resources**

The mapping of existing services would include information on:

• criminal justice provision including number and locations of police stations, police stations with designated custody suites, courts, probation centres and hostels, and prisons
• any diversion or liaison arrangements including the geographical area and the points in the criminal justice system covered
• mental health services including in-patient units – where they are, how many beds, criteria for admission, etc
• community services including community mental health teams (CMHTs), assertive outreach teams, crisis and home treatment teams
• day services
• social services including the number of approved social workers (ASWs), emergency duty team (EDT)
• accommodation providers including Supporting People-funded provision, and specialist provision

*continued over page*
• homelessness services
• drug and alcohol services
• voluntary sector provision
• service user groups
• provision for young people including youth offending teams (Yots) and child and adolescent mental health services (CAMHS)
• specialist provision for women
• provision for black and minority ethnic (BME) communities and service users

Once all the information has been obtained it needs to be evaluated against the local population profile including psychiatric morbidity, offending rates and offending patterns, and ethnic make-up of the area to identify gaps in service provision. The picture may be compared with another locality that has a similar make-up, especially if that area already has a scheme in place.

The needs analysis and gap analysis will be the basis for decision-making about the need for a diversion or liaison scheme and how that should be configured.

Notes
1 For more information about MDO groups, see Nacro (2005) *Multi-agency Partnership Working and the Delivery of Services to Mentally Disordered Offenders* London: Nacro
2 In addition to other services mentioned here, the voluntary sector may also run helplines, other advice services and day centres and – for some service users – may be seen as more open and accessible than statutory services
The service should have clear aims and an agreed operational protocol, including referral criteria. Its aims might include, to:

- facilitate the early detection of people with mental health problems in the criminal justice system and ensure appropriate and effective outcomes
- ensure that all people with mental health problems who come into contact with the criminal justice system receive speedy and appropriate assessments
- reduce the use of custody for people with mental health problems
- facilitate a multi-agency approach from all relevant agencies working with mentally disordered offenders

**Identifying the type of scheme**

Clearly, the type of scheme developed should reflect what need has been identified by the needs analysis and mapping exercise. However, there can be fundamental differences in the function, staffing and sites of operation of different types of schemes, although there will also be elements common to all.

The role of the scheme would be to: identify people with mental health needs in contact with the criminal justice system (CJS); provide an assessment including a risk assessment; facilitate further assessments if necessary; help access resources; signpost services; and give advice and make recommendations.

Some schemes will offer a very wide service across all points of intervention in the criminal justice process. Others will take a narrower and more focused approach. This could be a diversion scheme which solely facilitates the admission of someone to hospital from the CJS or an assessment scheme which aims to significantly reduce the time taken to obtain an assessment by
assessing the defendant at the court rather than through a remand in prison.

**Court diversion schemes:**
- offer a focused, court-based approach
- are able to access resources – in particular, beds
- are likely to have their recommendations accepted by the court
- however, they are unlikely to meet the needs of mentally disordered offenders at police stations or meet the needs of those mentally disordered offenders who do not meet the criteria for admission under the *Mental Health Act 1983*

**Court assessment schemes:**
- offer a focused, court-based approach which can reduce the time taken to produce reports for the court and reduce the use of inappropriate custodial remands
- however, they do not operate at police stations and are unlikely to facilitate a range of disposal options

Alternative arrangements might include an MDO panel which formally brings together a range of agencies – most notably police, health, social care, and probation – to put forward a co-ordinated package of care for the Crown Prosecution Service (CPS) to consider post-charge or when deciding upon whether or not to discontinue a prosecution, or for the courts to consider post-conviction.

**MDO panel schemes:**
- take a multi-agency approach to MDOs
- can take referrals from all points of intervention in the criminal justice process
- offer packages of care
- however, they are unlikely to provide an immediate response to emergency cases and are unlikely to provide a screening service

Many schemes operate as criminal justice mental health liaison teams or services, reflecting a wider role than either solely
diverting people with mental illness from prison or providing assessments for the courts. Such a service will offer support to and liaise with a range of criminal justice agencies so that mentally disordered offenders are treated appropriately and effectively whatever their needs and wherever they appear within the system.

**Criminal justice mental health liaison schemes:**
- offer a service at all points of the criminal justice process
- deal with all people with a mental health problem irrespective of whether they meet the criteria for admission under the *Mental Health Act 1983*
- facilitate further assessments and liaise with a range of providers to produce an effective outcome and disposal
- however, unless they have input from a psychiatrist, they may have difficulties in accessing beds

As well as the different types of scheme, there are a variety of different arrangements and providers. While most schemes offer a specialist and/or separate service, others are operated by criminal justice practitioners attached to community forensic teams or a community mental health team (CMHT). Although these models have the advantage of being fully integrated with existing services, there is the added pressure of balancing the workload of two different roles. This could include balancing both the quantity of work involved and also the different orientation of two different roles.

**Specialist v non-specialist provision**

**Specialist diversion or liaison teams** offer a dedicated service from practitioners who have knowledge of the CJS and the issues relevant to diversion and liaison. However, they may not be integrated with, and therefore may have difficulties in accessing mainstream services.

**Non-specialist teams**, for example those that might sit within an existing community mental health team, will be integrated with other services but are unlikely to be a dedicated resource for the CJS, and practitioners may lack the experience and knowledge to deal with the full range of issues and cases.
Most providers are from statutory services, usually either a mental health trust or social services, but there are examples of services being provided by the voluntary sector.

The task for commissioners and providers will be to balance what is wanted and needed with what is practical, effective and possible given such restraints as funding and staffing.

**Funding and commissioning a service**

For any service to be sustainable and to be able to develop to meet increased demand, it requires secure, long-term and protected funding. Ideally, schemes should be jointly funded from health, social services, police, probation, and the courts – including in-kind funding (eg, providing an office rather than making a direct grant) – to generate a sense of shared ownership and accountability.

There should also be a clearly identified and agreed commissioner for the scheme and a clearly identified and agreed provider. If the scheme is to be fully integrated with other mental health provision then, ideally, it should be commissioned by the local primary care trust (PCT) – although funding could still come from a variety of sources – and be provided by local mental health services. However, the role that social services has to play should not be forgotten and they should be a key partner in all aspects of the service.

**Management of the scheme**

It is vital that robust and co-ordinated arrangements are in place that link schemes with commissioners and managers of services.

The diversion or liaison scheme should exist as a distinct entity and have a single manager to manage the day-to-day operation of

---

**Services run by the voluntary sector**

The voluntary sector agency Together works in conjunction with the probation service to operate a number of schemes in London and, in Barnsley, with the Metropolitan Borough Council Social Services Department. These services support people who appear at court and make sure that they receive the mental health services they need.

www.together-uk.org
the scheme. Practitioners should be recruited to the scheme although they could also be seconded from other agencies. In these cases they would be managed by the scheme’s manager but would receive individual professional supervision through their own relevant agency structure. For example, the manager of the scheme may be from the probation service with practitioners from health and social services. Both the scheme and each practitioner would be managed by the person from probation but would receive their own professional supervision from a designated individual within health or social services as appropriate.

Schemes require a steering group, which can steer their day-to-day operation and future development. It must meet regularly (at least quarterly), have representatives from all relevant stakeholders (principally from the police, health, social services, probation, CPS, and the courts), and have aims, terms of reference, and a work programme. It must also be able to report directly to relevant agencies and other bodies.

Schemes should not remain static but should seek to develop to meet any unmet need or fill gaps in existing service provision. To achieve this, schemes should have a development plan drawn up and reviewed by its steering group. The scheme should engage with service users to ensure that their views are considered. This might be by direct consultation, through existing channels, or facilitated by a service user organisation.

The steering group is unlikely to co-ordinate strategy or to be responsible for developing additional services. Ideally, this function will be the responsibility of a separate local or countywide MDO group linked to commissioning and planning structures, which the steering group can feed into. However, in many areas the reality is that there is not this hierarchal approach but that both functions are combined, with one group taking responsibility for both steering the scheme and developing and co-ordinating strategy.¹

Note

Where a scheme operates

For intervention and diversion to be effective and to prevent people falling through the net, the scheme needs to operate at a variety of points of intervention in the criminal justice system (CJS). The more sites it covers, the more effective it is likely to be as well as providing a conduit for the exchange of, and passing of, information between these different sites. However, if the scheme is not adequately resourced and staffed to allow this to happen effectively then it might be better to operate at just one point in the CJS.

Wherever possible the service should not operate just at the magistrates’ court, but needs to be available to the crown court and to be linked to the youth court. Consideration should also be given to providing a service or clinics at probation centres and probation and bail hostels. Although the service will be a separate provision, it should complement – and could even be attached to – the assertive outreach team or crisis team. This latter option may be appropriate where there is not a great level of demand from the police station or court and a dedicated service is not required.

Where there is a prison in-reach or prison mental health team, then there should be formal links between it and the scheme. There should be agreement on joint working, communication and information sharing, and referrals, to provide a seamless service of care. The role of the diversion or liaison scheme will be different to that of the prison team. The latter are usually concerned with people who are assessed as having a ‘severe and enduring’ mental illness or who meet the criteria for level 2 or 3 care programme approach (CPA). Diversion and liaison schemes, on the other hand, are likely to work with people with a range of mental health needs including people who are covered by primary mental health care or who require access to community-based options. Therefore, where both services operate in tandem, the differing needs are more likely to be met.
Scheme models
Each model has different strengths and weaknesses which should be taken into account during the planning stage.

- **Police station model**

  Strengths of the police station model:
  - increases the awareness of mental health issues by the police and forensic physicians (FP)
  - increases the sensitivity of the police’s approach
  - re-engages the person with services
  - is more likely to be linked to community-based services
  - reduces the time the person spends in custody
  - provides a better initial assessment – doesn’t just rely on the FP
  - can pass information on to later stages of the criminal justice process to allow for a more appropriate disposal
  - ‘offers intervention at the earliest possible opportunity, either to extricate the mentally disordered individual from the criminal justice process, or to flag up their presence at that stage and identify the need for further intervention at some later point, either following an initial appearance in court, or whilst on bail or remand’. This is likely to mean less involvement with the criminal justice system and, therefore, the avoidance of any stigma in being labelled as an offender

  Weaknesses would include:
  - if the person is not charged it may not be possible to build a full picture of their offending
  - initial assessments may not be joint or multi-agency
  - if there are delays in identifying a suitable resource, for example, a hospital bed, the person may be held in an inappropriate setting – the police station – while that happens
  - unless the person is charged or a care package arranged, the person may be released into the community and not followed up

continued over page
And, as with all diversionary practice:

- early diversion does not necessarily reduce stigmatisation as involvement with mental health services can be at least as stigmatising for service users as being involved in the criminal justice process\(^2\)
- health disposal may be more restrictive than the criminal justice option, leading to disillusionment from service users
- diverting someone may not allow them the option to have the allegation challenged and rejected in court; a solicitor may not be involved if the intention was always to divert them from the CJS and, therefore, the person’s rights may not have been fully explained to them. This might lead the person to accept a disposal that could have subsequent implications for them which might not have happened if, for example, they had not accepted this option and had the allegation tried and rejected by a court

Because there may be too many police stations to cover effectively, a number of schemes choose to operate at the magistrates’ court only. This is a natural filter in the criminal justice process and the scheme will concentrate on those individuals most at risk of being inappropriately sent to prison under sentence or remand.

**Court stage model**

Strengths at the court stage would include:

- a more focused single filter point rather than trying to cover all police stations
- the person’s behaviour is registered and recorded so that future risk might be better assessed and managed
- more options may be available through Part III of the *Mental Health Act 1983*
- may prevent custodial remands and sentences
- greater multi-agency involvement – Crown Prosecution Service, courts, solicitors, probation, etc
- a solicitor can represent the defendant’s interests
Weaknesses would include:

- the person is already involved in the criminal justice process
- the person is more likely to receive a custodial remand
- the stigma of a charge may mean that the person is less likely to be accepted for a community disposal
- magistrates are often not aware of mental health issues nor their powers under the *Mental Health Act 1983*
- time to achieve an appropriate disposal may be restricted
- if the scheme does not operate every day the person may still be remanded in custody to be seen later, so causing the very outcome the scheme was designed to prevent
- legal processes can delay disposal
- the scheme may not be linked into community-based services and therefore it may be difficult to follow-up community recommendations

And, as with all diversionary practice:

- health disposal may be more restrictive than criminal justice disposal leading to service users’ disillusionment with health services
- the health outcome may prevent the arrested person from challenging the legitimacy of the charge

**How a scheme operates**

While schemes may have a variety of different functions performed at different points within the CJS, a major difference between schemes will be how people with mental health needs are identified in the CJS. This might be proactively, where scheme staff attend police stations or courts and screen people there. Alternatively, schemes may operate reactively, and wait until they receive a request or referral to attend. However the person is brought to their attention, the first thing a scheme will do is an initial screening, or triage, to assess the person’s mental health needs – which may require a subsequent fuller assessment – and identify a list of possible options and recommendations.

Staff need to be clear that their role is neither aligned with the police or other CJS agencies nor are they an advocate for the
 Screening and/or referrals?

Those schemes which are able to screen at many points in the criminal justice system are always going to be more effective than schemes that rely solely on referrals from other agencies. Referrals are often dependant upon non-mental health professionals identifying a problem. While many staff are able to do this, it is likely that they will only pick up the most obvious cases and there will always be people who are missed.

Given the size of some courts and the number of police stations, some schemes offer a mix of proactive screening and responding to referrals. However the scheme operates, it should measure its effectiveness against whether:

---

**Keeping neutral**

The staff role is neutral, neither aligned with criminal justice agencies nor an advocate.

---

**Birmingham Court Liaison and Assessment Scheme**

The Birmingham Court Liaison and Assessment Scheme is operated by four community psychiatric nurses from Reaside Clinic who visit the magistrates’ court from 7.30 each morning to screen all those held on ‘overnight arrest’ and filter those cases: where defendants have been charged with a violent offence; where the offence is less serious but there are concerns about the person’s behaviour; and those with a known history of mental disorder. There is then an initial assessment in the form of an unstructured interview where the worker looks for the presence of serious disorders, psychosis and depression, and the potential for self-harm and suicide. The scheme is supported by two CPNs from the women’s forensic service based at Arden Leigh, Erdington.

Birmingham Court Liaison and Assessment Service, c/o Forensic Community Mental Health Nursing Department, Birmingham Great Park, Bristol Road South, Rubery, Birmingham B45 9BE. Tel: 0121 453 6161

---

**Screening and/or referrals?**

Those schemes which are able to screen at many points in the criminal justice system are always going to be more effective than schemes that rely solely on referrals from other agencies. Referrals are often dependant upon non-mental health professionals identifying a problem. While many staff are able to do this, it is likely that they will only pick up the most obvious cases and there will always be people who are missed.

Given the size of some courts and the number of police stations, some schemes offer a mix of proactive screening and responding to referrals. However the scheme operates, it should measure its effectiveness against whether:
it identifies most of the people with mental health needs in contact with the criminal justice system. There can be no certain way of knowing whether this is the case but one way would be to compare the scheme’s activity against the level of psychiatric morbidity locally or with similar schemes operating in similar geographical or criminal justice locations.

- those persons are assessed speedily;
- and, those who require care and treatment from health, social services, housing, etc are able to access it.

The more regularly a scheme operates in a particular location within the CJS, and the more it makes links with criminal justice staff, the more it raises awareness both of the issues and what to look for, resulting in more sophisticated and appropriate referrals. Feedback on those referrals made also helps to increase the awareness and understanding of mental disorder by criminal justice staff as well as increase their own motivation to refer to the scheme.

The ideal scheme

While each scheme will develop according to local need and local resources, the ideal model will have the following elements:

- proactive screening at the police station and courts
- the ability to take referrals from a wide range of professionals within the criminal justice system, health and social care, the voluntary sector, and from service users and carers
- the capacity to act as a conduit for the formal exchange of information between different stages of the criminal justice system and with health and social care
- the capacity to assist with risk assessments
- the provision of advice to the courts either orally or written
- the ability to provide full mental health assessments
- the capacity to run clinics at probation centres and probation and bail hostels
- the provision of advice and information to colleagues in the CJS
Referrals

The greater the range of referrers, the more likely an effective intervention will be made. For instance, some schemes refuse to take referrals from defence solicitors or private security firms because solicitors and security firms have their own procedures for obtaining that advice. However, this reluctance to accept such referrals may result in people being remanded in custody or some other inappropriate disposal.

**Range of referrers**

The scheme should accept referrals from:

- court staff
- magistrates
- probation staff
- crown prosecutors
- solicitors
- gaolers/custody services
- self-referral
- family and friends
- accommodation providers
- prisons
- police
- forensic physicians
- arrest-referral workers
- appropriate adults
- in-patient units
- community mental health teams
- alcohol and drug services
- Yots

It is not enough for a scheme to say that it takes referrals from a particular agency or a range of agencies. The scheme should proactively work with those agencies to ensure that practitioners understand who should be referred and how this should occur. Ideally, practitioners should have received mental health awareness training to assist them in identifying people with mental health problems.
Operating protocols and practice

For the day-to-day operation of the scheme to be effective it is necessary for it to be supported by an operational protocol. The protocol should be jointly agreed by all key stakeholders to encourage ownership and accountability.

Without such a protocol, the scheme has nothing to measure itself against. It also helps guarantee continuation of the scheme if key individuals leave, while allowing newly recruited staff to gain an understanding of the scheme’s aims and its overall operation.

- **Operational protocol**
  
  An operational protocol should include:
  - the aims of the service
  - what the service offers
  - who staffs the scheme, their roles and responsibilities
  - the geographical area the scheme covers
  - a definition of a mentally disordered offender
  - criteria for referral to the scheme
  - how to make a referral
  - where the scheme is located
  - the sites it operates at
  - hours of operation
  - contact details
  - its management and reporting structures

Publicity

In order to advertise the service and encourage referrals, the scheme should publicise itself in a variety of ways. This might include producing posters, flyers and leaflets, and arranging postings on agency websites and in handbooks and other material.

The nature of the publicity will vary depending upon the medium used, but it should include details of: where and when the scheme operates; how to contact the scheme; and how to make a referral. Publicity material should be available at all sites where the scheme operates at as well as at other points in the criminal justice process.
Days of operation

Clearly, the more days the scheme is operational, the greater the opportunities there are to identify people with mental health needs. Those schemes that only operate on one or two days a week may, in effect, force the court to remand someone in custody in order to reappear when the scheme is next able to make an assessment. Ironically, this could mean that the person’s mental health deteriorates further, which is what the scheme is trying to prevent.

Ideally, the scheme should provide a service each day the magistrates’ court sits. If it also operates at police stations, then it should operate on as many days as possible and, at least, from Monday to Friday and 9am to 5pm. The scheme should try and provide an out of hours service either by operating an ‘on-call’ system or by linking with other existing out of hours services, for example, the emergency duty team (EDT) or crisis service.

Assessments

Mental health assessments should be provided by the scheme as speedily as possible. There should be agreement between the scheme, criminal justice agencies, and health and social care about the purpose of the assessment, how it will be carried out, and what outcomes might occur. For example, the purpose might be to provide advice about whether a detainee is ‘fit to be detained’ and ‘fit to be questioned’, whether it is appropriate to process the person through the criminal justice system, or to identify and facilitate a range of appropriate outcomes.

Where the initial assessment identifies concerns which cannot be met by the scheme, there should also be an agreed protocol for obtaining further assessments under the Mental Health Act 1983. Ideally, this should be a joint assessment by a doctor approved under section 12 (2) of the Act and an approved social worker (ASW). In these cases it is important that schemes are able to access psychiatrists and ASWs easily and speedily, especially where an assessment is needed prior to possible admission to hospital.

Advice and recommendations

The scheme should be clear about what advice – and what form that advice takes – can and should be made available to the police, the courts, prisons, defence solicitors, probation staff, and service users and carers. It is likely that advice will be given orally but
supported by a written record. The advice should include: the person’s mental state; any risk of suicide or self-harm; risk of violence to others; drug and alcohol use; and disposal options. Finally, a recommendation about a particular disposal may be offered.

The consent of the mentally disordered offender should always be sought before any advice is given and confidential information shared. For those cases where consent is not given or where it is not possible or practical to obtain consent, there should be clear guidelines contained in jointly agreed information sharing protocols about when and how information might still be shared.4

The advice the scheme is able to offer is likely to reduce the need for courts to request a psychiatric report – unless disposal under Part III of the *Mental Health Act 1983* was being considered – which should reduce the need for unnecessary remands in custody.

**Notes**

1 Riordan S (1999) *Diversion at the Point of Arrest: A description of mentally disordered individuals (sic) early contact with the police in Birmingham for the period 1.11.93–31.10.97* Reaside Clinic
2 See www.openuptoolkit.net/disciminationmatters/work.php
Staff roles

The staff make-up of the scheme is likely to be a balance between what is wanted and what can be afforded. Many of the early schemes were set up and run by psychiatrists. The majority of schemes are now staffed and led by community psychiatric nurses (CPNs) with psychiatrists either providing sessional input or responding to specific requests for assessments. A few schemes are staffed by approved social workers (ASWs), and a few have practitioners from different agencies and operate as, or like, a community mental health team. There are a few schemes that are probation-led. Where the scheme is concerned purely with diverting someone from the criminal justice system (CJS) into a health setting, it will need to be psychiatrist-led and psychiatrist-staffed.

Schemes which have just one worker may lead to quicker processing of the person with mental health needs involved in the CJS and a more immediate response. However, they suffer from an absence of multi-agency assessments and input and may rely more on the individual contacts the scheme has cultivated rather than the full working arrangements that should be in place.

Ideally, schemes should be both multi-agency and multi-disciplinary to allow for a more rounded assessment, and to ensure access to a variety of disposal options. This should, wherever possible, mirror a community mental health team and include or have input from a consultant psychiatrist, psychologist, CPN, ASW, community support workers, with administration or secretarial support. The role of the administrator is vital but one that is often overlooked. Not only does the administrator provide support for the scheme and its workers (eg, collating information, taking messages, etc) but also acts as a contact point for other agencies and referrers.

In order to meet the needs of people with a learning disability who come into contact with the criminal justice system, the scheme might also second a practitioner from learning disability services.
Where such a staff make-up is not possible or practical, schemes should ensure that they develop close working relationships with a range of different practitioners to ensure input into cases as outlined in the Offender Mental Health Care Pathway.¹

Case-loads

It is very unlikely that schemes will carry case-loads, though they may have temporary case-loads of people as they are in contact with and progress through the CJS up to and until, for example, their reception into custody. In order to manage these temporary case-loads, the scheme needs to agree a process for referring individuals quickly to a range of services once their involvement in the CJS is complete, so the case does not get held inappropriately in the diversion scheme.

Skills

The skills needed by scheme staff include:

- mental health assessment skills
- risk assessment skills
- working knowledge of the CJS
- working knowledge of the Police and Criminal Evidence Act (PACE) 1984 including the role of the ‘approved medical practitioner’ and other Codes of Practice
- knowledge of the Mental Health Act 1983 and its Codes of Practice
- knowledge of local mental health services and how to access them
understanding of the issues surrounding mentally disordered offenders including the appropriateness of charging and diversion

**Scheme support**

It is important that schemes are able to access psychiatrists and ASWs easily and speedily, especially where an assessment is needed prior to possible admission to hospital. If funding does not allow for a consultant psychiatrist to be attached to the team, then there should be agreed arrangements for obtaining psychiatric advice or opinion or for there to be regular – at least weekly - sessional input into the service. This might also apply to input from psychological services and occupational therapy (OT) services.

Each scheme worker must have regular support and supervision sessions and regular professional supervision. This is especially crucial where schemes are operated by a lone worker and/or where schemes are not integrated with other services. In these scenarios, workers can feel (and indeed may be) isolated. Training and personal development are vital tools to ensure that staff are skilled to meet the difficult demands often placed on them. Supervision is the key mechanism that allows staff to identify training needs and how these might be met.

**The importance of supervision**

Regular and consistent supervision – including professional and clinical supervision – is vital to both review and improve practice and to develop skills. This is particularly needed in the case of lone workers who may not get peer or agency support.

**Nacro survey findings – sessional input**

Fifty per cent of schemes reported that they had no sessional input from either a psychiatrist or a psychologist and, unsurprisingly, 41% reported difficulties in obtaining psychiatric reports.  

Notes

1 Department of Health (2005) *Offender Mental Health Care Pathway* London: Department of Health

For diversion and liaison to be effective, schemes must be integrated and have a close working relationship with all mainstream services including community services. There should be formal links with a range of community providers to allow for a variety of disposals to take place. A formal link will be one where there are agreed criteria and a protocol for referral and information sharing, and where there is a process to allow for an audit of referrals.

Schemes should also work closely with service users to receive feedback about their operation and to assist with the evaluation process.

In order to react positively and effectively when a serious risk to the public is identified, schemes should ensure that they are aware of local Multi-Agency Public Protection Arrangements (MAPPA) and how to activate these. Schemes should also develop close working arrangements with arrest-referral workers in criminal justice intervention teams set up by the Drugs Intervention Programme (DIP).

Schemes should also be able to access beds either directly or indirectly through an easily contactable and readily available consultant psychiatrist.¹

The scheme should have access to a range of appropriate resources including specialist services for women and black and minority ethnic (BME) service users.

---

**Nacro survey findings – lack of beds**

Seventy-two per cent of schemes cited lack of beds as a barrier to their scheme operating successfully.²
Important links and resources

Schemes should develop formal links with the following agencies and individuals within those agencies (in no particular order):

- **police** – including custody and detention staff, community safety officers, community beat officers, and operational staff
- **forensic physicians** – also known as forensic medical examiners or, formerly, police surgeons
- **CPS** – including those crown prosecutors attached to police stations and those with responsibility for cases where mental health may be a component
- **courts** – including magistrates, court clerks, ushers, defence solicitors, gaolers, and services for witnesses
- **probation** – including bail information officers, pre-sentence reports (PSRs) writers, public protection teams, and case managers
- **prisons** – including in-reach or mental health teams, healthcare, and resettlement units
- **young people’s services** – including youth offending services and child and adolescent mental health services (CAMHS)
- **health** – including in-patient services, forensic services (both in-patient and community), community mental health teams (CMHTs), assertive outreach teams, crisis and home treatment teams
- **social services** – including ASW desk, mental health services, community care workers, day centres, and residential services
- **learning disability services**
- **housing** – social housing and voluntary sector providers, including homelessness services and direct access hostels
- **drug and alcohol services**
- **voluntary sector**
- **service users and carers groups**
- **specialist services** – for women and for people from BME communities
- **translation services** – including services for deaf people and for people where English is not their first language
- **appropriate adult schemes**
Supporting arrangements

Premises and equipment

The scheme’s team base will need computer facilities with a suitable database, preferably compatible with other agency databases, for the recording and sharing of information. The team’s base should also have a fax machine, photocopier, email and Internet access, and secure storage systems. They should have a single telephone number, with mobile phones for on-call and to contact scheme workers at different sites.

If the team is not based permanently at the court or police station, there must be appropriate facilities provided at these locations. These should include suitable space for the scheme’s workers to be able to interview and assess individuals – this should not take place in a police cell except in exceptional circumstances – as well as somewhere to write up notes, make phone calls, etc.

Protocols

For the day-to-day operation of the scheme to be effective it is necessary that it is supported by formal protocols and policies agreed with all relevant agencies. Without these, scheme staff may be vulnerable and/or reliant upon the goodwill and discretion of other practitioners.

As well as the scheme’s own operational protocol there should be jointly agreed protocols on, among other topics:

- **Sharing of confidential information** – This should include what information can be shared, how it should be shared, what happens to information which is shared, and the circumstances where information can be shared without a person’s consent. The protocol should be agreed by the police, probation, mental health services, local authority, local medical committee, courts, CPS, housing providers, voluntary sector, and prisons.4,5

---

**Nacro survey findings – sharing information**

Thirty-six per cent of schemes did not have a policy on sharing information between agencies.6
Part 6 Links and resources

- **Conveying people to hospital from the police station and court** – This should include the criteria for the request, how the transfer will be carried out, and the circumstances in which the police accompany the transfer. It should be jointly agreed by the police, local authority, courts, and ambulance service.

- **Risk assessment and risk management** – This should include criteria on what risk is to be assessed, how that should be done, what outcomes are possible, how these should be managed, criteria for the calling of case management meetings and how these operate, and criteria for referral to MAPPA. This should be agreed by police, probation, mental health services, social services, local medical committee, courts, CPS, housing providers, voluntary sector, and prisons.

- **Recording and monitoring** – The scheme should develop a recording and monitoring system that provides information about the activity of the service and helps evaluate its effectiveness. This might be a system currently used by one agency or a system that is developed solely for use by the scheme. Whichever method is chosen, the system should be such that it records information useful to all relevant agencies and is easily interrogated. (Part 8 of this guide, recording and monitoring, deals with this subject in greater depth, page 39.)

- **Obtaining assessments under the Mental Health Act 1983** – This should include the criteria for making a referral, the process for requesting an assessment, how the assessment is to be carried out, and target response times for all agencies. These should be recorded and monitored. The protocol should be agreed by the police, mental health services, social services, forensic physicians, and the courts.

These protocols are the minimum that should be in place. They should be jointly agreed with the relevant agencies and regularly reviewed by the scheme’s steering group, the local/countywide MDO group or similar relevant body. The review should take account of changes in working practice and legislation, and the development of new resources. The protocols should be revised as necessary in the light of the review.

**Complaints and disputes**

The scheme should have a written complaints procedure that can be used by service users, and agencies working with mentally disordered offenders. The procedure should contain details of how and in what form complaints should be registered, to whom the
complaint should be addressed, and how complaints will be investigated and resolved.

Where the scheme does not have its own complaints procedure it might be appropriate to use the procedure of the agency which funds the scheme or employs the worker.

The scheme might also want to agree, with the relevant agencies, a formal or informal process for resolving disputes that might occur over particular cases or as part of the wider operation of the scheme.

Notes
1. The difficulty in a criminal justice liaison service being able to access admission to hospital was one of the concerns raised by the Michael Abram inquiry (2001): *Report of an Independent Inquiry into the Care and Treatment of Michael Abram by Knowsley Services* (Chair, Dr Geoff Roberts) St Helens and Knowsley Health Authority
5. See also Safe and Secure at www.ohcsportal.co.uk
People with mental health problems are one of the most marginalised and excluded groups in society. This is compounded for mentally disordered offenders, who are excluded by both their mental health problem and their offending. Diversion and liaison schemes offer an opportunity to intervene and provide positive outcomes that may reduce the level of social exclusion. However, for this to happen, such schemes need to ensure that they are able to meet not only the needs of mentally disordered offenders generally but also the needs of specific groups who may face discrimination and disadvantage from both the criminal justice system and the mental health system. These groups would include: women; people from black minority and ethnic (BME) communities; children and young people; people with a learning disability; and people with a diagnosis of personality disorder.

**Women**

Women’s experiences of both the criminal justice system and the mental health system are likely to be different to those of men. Therefore schemes should consult widely with women service users to identify how best they can meet women’s needs and what alternative options may be most appropriate and effective. Although most schemes would say that they are sensitive to the needs of women, it is unlikely, for example, that all schemes would be able to provide a choice of worker to assess and work with female mentally disordered offenders or have access to women-only services. Additionally, few schemes actively record and monitor outcomes specific to women nor analyse whether these meet their needs.
Diversion and liaison schemes – criteria for women

Diversion and liaison schemes should:
- record, collate and analyse data by gender
- seek specific feedback from women services users in contact with the scheme
- develop proactive links with women-specific projects including those for housing, employment and training, and childcare
- receive training to assist in identifying concerns such as self-harm, eating disorders, depression, and anxiety
- be aware of the special needs of women from BME communities
- understand the link between physical issues and mental health problems, eg, post-natal depression

The Care Services Improvement Partnership’s (CSIP) report, *Women at Risk*, recommends that primary care trusts (PCTs) and relevant partners provide appropriate community services linked to non-custodial sentences, to divert women in contact with the CJS rapidly into appropriate services and from further criminal activity.1

Black and minority ethnic (BME) groups

The Sainsbury Centre for Mental Health2 noted that BME communities often access services through aversive – ie non-voluntary or coercive – care pathways, which can influence both the nature and outcome of treatment and the willingness of communities to engage with mainstream services. Diversion and liaison schemes may be the first point of contact in ensuring that BME service users access appropriate services which meet their specific needs.

Diversion and liaison schemes – criteria for people from BME communities

Diversion and liaison schemes should:
- have a system for monitoring contact with the scheme and one that is able to feed into the local tracking system and/or other mechanisms for tracing BME people with mental health...
problems who come into contact with the criminal justice system. This will contribute to building up a full picture of the numbers of BME service users in contact with the criminal justice system, their experiences and what options are made available to them. Such a picture will ensure that services develop to provide equitable provision to meet the needs of this group.

- incorporate anti-racist practice into the planning and delivery of their service
- have developed a range of appropriate responses in collaboration with BME communities to meet the needs of BME service users
- ensure that their recommendations for outcomes following intervention and assessment reflect the cultural needs of the individual
- liaise with BME service providers, including the voluntary sector, to ensure appropriate account is taken of cultural issues and access to a wide range of resources is available
- ensure that their development and service delivery reflects their organisation's race equality scheme and diversity agenda
- ensure that their operational protocol and associated policies include statements on equality and diversity

**Children and young people**

The level of mental disorder among children and young people who offend remains disturbingly high. Ninety per cent of those who were imprisoned have shown evidence of some mental disorder.³

Where there is no dedicated provision for the youth court, diversion and liaison schemes should work in collaboration with youth courts, Yots, and child and adolescent mental health services (CAMHS) to assess need and, where appropriate, provide advice and assessments. Information gathered by the scheme, the Yot and CAMHS might be used to argue for the development of a specific scheme to meet the needs of children and young people.

**People with learning disabilities**

People with learning disabilities who become involved in the criminal justice process create similar, although not the same,
challenges for criminal justice agencies as mentally disordered offenders. They are both more vulnerable to being drawn into the criminal justice system and more vulnerable when within it.

To improve services for offenders, reduce the likelihood of reoffending, and ensure the most appropriate and effective use of resources across all agencies, it is imperative that people who have learning disabilities are identified as early as possible. While this could be achieved by developing specific diversion and liaison schemes responsible for people with a learning disability, a practical initial way to meet this need would be to appoint specialist workers to existing generic diversion and liaison schemes. These workers could assist with the identification of people with a learning disability, provide advice and guidance on possible outcomes, and link people into appropriate services.

**Personality disorder**

Personality disorders are one of the most contentious and difficult to define categories of disorder; it is unlikely that any other mental disorder carries a greater stigma. The Government's response,\(^4\) is that all trusts delivering mental health services should consider how to meet the needs of people with a personality disorder.

---

**The Criminal Justice Mental Health Team in Norwich**

The Criminal Justice Mental Health Team (Norwich Magistrates’ Court) was commissioned from the local Learning Difficulty Trust and is operated by a single court practitioner managed by the Learning Difficulty Community Team. This court service complements another provided by the local authority social services department to the police station.

Statistics for 2004, the first year of the recommissioned court liaison service, show 10.9% of all contacts (42 out of 383) to be with people with a learning disability. Increased recognition of the new service has since seen referrals for, and contacts with, people with a learning disability increase to 24%.

Norwich Criminal Justice Mental Health Team, Norwich Magistrates’ Court, Bishopsgate, Norwich NR3 1UP. Tel: 01603 679559
The role of diversion and liaison schemes in relation to people with a diagnosis of personality disorder is likely to be twofold. Firstly, they should look to ensure that this client group has their needs addressed as appropriately and effectively as possible. Where there are local personality disorder services, service users should be referred directly and schemes should work closely with these services. Where no such services currently exist, schemes will need to be champions in ensuring that all relevant agencies come together to provide a multi-agency approach to individual clients. In such cases the scheme may also need to allay practitioners' fears and help reduce the stigma the label carries.

Secondly, schemes may be well placed to assist with the gathering of information about the local demand for personality disorder services.

References
1 Care Service Improvement Partnership (2006) Women at Risk: The mental health of women in contact with the judicial system London: Department of Health
Recording and monitoring activity is essential for any service. Without access to hard data it is impossible to be sure how the service is operating and to identify gaps in provision. However, it is not enough simply to record information, it must also be scrutinised: many schemes record contact with individuals but little of this is collated or analysed, so no overall picture is built up of how the scheme is operating.

**Monitoring activity**

There are a number of things that schemes should monitor on each individual person they assess or offer advice about. This information should be recorded, collated and analysed in a way that makes it easily understandable. It should be made available on a regular basis to commissioning and planning bodies as well as to the scheme’s steering group, its funders and stakeholders, and other relevant local groups and bodies. Ideally, this should be every three months but should be annually at the very least. To ensure that this information is useful and practical, there should be a degree of consistency in what is monitored and the way it is recorded with statistics collected by other parts of the criminal justice system and by health and social care.

Information from the statistics collected by schemes should be made available in a format useful to relevant agencies and bodies. This might include being broken down by month with the ability to cross-reference by gender, age, ethnicity, diagnosis, recommendations and outcomes. This would allow schemes to see whether there were particular patterns in demand over time or from particular client groups and to plan services accordingly.

Where such information is shared and made available, it should be done in such a manner that meets the requirements under the *Data Protection Act 1998* and where ownership of the information is clearly understood. 

---

1. Part 8 Recording and monitoring

  Liaison and diversion for mentally disordered offenders
Part 8  
Recording and monitoring

- **What to monitor**

  Information that is monitored should include:
  
  - date and time of initial assessment
  
  - personal details – including name, address, age, gender, ethnicity, employment status, and accommodation status
  
  - site of intervention – whether at police station, court, prison, probation centre, or hostel, etc
  
  - which agency the referral came from, including details of the person who made the referral and reasons for the referral being made
  
  - mental health state – including diagnosis (if known), mental health status (ie whether under a section of the Mental Health Act 1983), previous contact with mental health services, care co-ordinator, responsible medical officer (RMO), and treatment (if relevant)
  
  - subsequent assessment details – including response times (if subsequent mental health assessment required) and time of assessment
  
  - criminal justice history – including details of current involvement with the criminal justice system
  
  - risk factors – including risk of suicide and self-harm or risk to others
  
  - drug and alcohol concerns – including details of any involvement with services
  
  - recommendation – including ideal recommendation if services and resources were available
  
  - outcome

Details should also be recorded about how long any involvement with the individual took, whether there is a difference between the recommendation and the outcome, and reasons why this might have occurred.
Analysing results and taking action

Once the data has been collected and analysed, the operation of the scheme may need to be modified or there may be training requirements for the scheme workers.

For example, the data may be scrutinised to see whether the scheme is assessing as many people as it had expected to or as compared with other schemes operating in similar sized geographical areas or locations within the criminal justice system. If the numbers assessed are higher than anticipated, this will obviously have implications for resources and should be fed into the commissioning process.

It is important to analyse very carefully the reasons for any gaps or problems identified by monitoring before identifying the appropriate response. For instance, if monitoring shows up a significant difference between scheme recommendations and actual outcomes, the reasons for this would need to be investigated further. It might be that sufficient and appropriate resources are not available to allow the recommendations to be acted on (another case for the commissioners). Alternatively, it might mean that the scheme is making inappropriate recommendations that the court is not able to follow or that written reports to court do not provide all the information that would allow magistrates to act on the recommendation (training required for the scheme workers). Yet again, it might mean that magistrates are not aware of the relevant issues in respect of mentally disordered offenders (training required for the magistrates).

Reference

Ideally, all schemes and other arrangements for mentally disordered offenders should be subject to external evaluation and audit. Any audit should cover the operation of the scheme itself, statistical analysis of data, supporting strategic arrangements, and associated protocols and policies.

In the absence of external evaluation, either the scheme itself or the scheme’s steering group should conduct a self-appraisal of the service. This should be completed annually and be used to measure progress, identify gaps and concerns, and inform any future development plan or work programme.

The checklist below can be used to measure the effectiveness of a scheme and how well it provides a service to mentally disordered offenders and those agencies working with them.

If the process raises concerns about any element of the scheme, reference should be made to the relevant section of this good practice guide to assist in resolving those concerns.

This process cannot measure the clinical outcomes or the quality of the assessments carried out by the scheme’s practitioners. Rather that is a matter for the provider’s own clinical governance arrangements and the practitioner’s clinical supervision.

The checklist is divided into ‘high’ and ‘lower’ priority questions. All these questions need to be addressed and the results acted on, but the high priority questions highlight those areas where any gaps or concerns should be addressed as a matter of urgency.
1. **At which points in the criminal justice system does the scheme operate?**

- Police stations
- Magistrates’ court
- Crown court
- Youth court
- Prisons*
- Probation centres
- Bail hostels

* If the prison has their own in-reach or mental health team, does the scheme have formal links with them?  Yes [ ] No [ ]

**Good practice note:**
For intervention and diversion to be effective and to prevent people falling through the net, the scheme needs to operate at a variety of points of intervention in the criminal justice system. The more sites it covers, the more effective it is likely to be.

If the scheme does not have a physical presence at any of these sites then there should be an effective referral process or other arrangements in place.

2. **How many days does the scheme operate?**

- Once per week
- 2-3 days per week
- 4-5 days per week
- 6-7 days per week

**Good practice note:**
The more days the scheme is operational, the greater the opportunities there are to identify people with mental health needs. Ideally, this should be at least from Monday to Friday with supporting arrangements for referrals outside these days.

Those schemes that may only operate one or two days a week may, in effect, force the court to remand someone in custody in order to reappear when the scheme is next able to make an assessment.

The scheme should try and provide an out of hours service either by operating an ‘on-call’ system or by linking with other existing out of hours services, eg, the emergency duty team or the crisis service.
What is the staff make-up of the scheme?

Consultant psychiatrist
Specialist registrar
Psychologists
Community psychiatric nurse
Approved social worker
Probation officer
Drug/alcohol worker
Learning disability nurse
Support staff
Administrator

Good practice note:
The ideal scheme should mirror that of a community mental health team with a variety of staff from different disciplines.

Where this is not possible or practical, the good scheme will have close links and formal arrangements with a range of practitioners to ensure their input into cases, especially those cases where there is complex presentation.

Equally, the role of the administrator is vital. Not only does the administrator provide support for the scheme and its workers but also acts as a contact point for other agencies and referrers.

If there is no psychiatrist attached to the scheme, is the scheme able to access a psychiatrist?

Easily
With some difficulty
With considerable difficulty
Not at all

If there is no approved social worker (ASW) attached to the scheme, is the scheme able to access an ASW?

Easily
With some difficulty
With considerable difficulty
Not at all

Good practice note:
It is essential that schemes are able to access psychiatrists and ASWs both easily and speedily especially where an assessment is needed prior to possible admission to hospital.
**Good practice note:**

Those schemes that are able to screen as many points in the criminal justice system as possible are always going to be more effective than schemes that rely solely on referrals from other agencies. Referrals are dependant upon non-mental health professionals identifying a problem. While many staff are able to do this, it is likely that they will only pick up the most obvious cases and there will always be people that are missed.

---

### How does the scheme operate?

<table>
<thead>
<tr>
<th></th>
<th>Screen</th>
<th>Referral</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police station</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magistrates’ court</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown court</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth court</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Does the scheme have a steering group?

- [ ] Yes
- [ ] No

### If yes, are the following represented on it?

- [ ] Police
- [ ] Probation
- [ ] Courts
- [ ] CPS
- [ ] Social services
- [ ] Health
- [ ] Prison
- [ ] Service users

### Does the steering group have the following formally described?

- [ ] Aim(s)
- [ ] Terms of reference
- [ ] Work programme
- [ ] Reporting structures

**Good practice note:**

If the scheme is to be robust it must have an effective management structure. Schemes need to have a steering group that can oversee their day-to-day operation and steer future development. The group must include representatives from all relevant stakeholders, have aims, terms of reference, and a work
programme. It must also be able to report directly to relevant agencies and other bodies.

The scheme should actively recruit service users to be part of the steering group. This will give a voice to the people the scheme has been established for and allow for direct feedback on whether the scheme is able to meet the service users' needs. It also gives a different and often unique perspective on the development of the scheme as well as giving it a legitimacy through this direct contact.

The above list would be the minimum number of agencies to be represented on the scheme’s steering group. The scheme should also develop links with other agencies and services including: accommodation providers; solicitors; advocacy schemes; Yots; carers; drug and alcohol services; community safety partnerships; and MAPPA.

10 Who is able to make referrals to the scheme?

- Court staff
- Magistrates
- Probation staff
- Crown prosecutors
- Solicitors
- Gaolers/custody services
- Self-referral
- Family, friends and carers
- Accommodation providers
- Prisons
- Police
- Forensic physicians
- Arrest-referral workers
- Appropriate adults
- In-patient units
- Community mental health teams
- Alcohol and drug services
- Yots

Good practice note:
The greater the range of referrers, the more likely an effective intervention will be made.
Lower priority

11 Are there formal links with the following?

☐ In-patient units
☐ Social care providers
☐ Bail and probation hostels
☐ Accommodation providers
☐ Drug and alcohol services
☐ Voluntary sector providers
☐ Day centres
☐ Service users and carers groups
☐ BME service user groups
☐ BME providers
☐ Translation services
☐ Forensic services
☐ Community mental health services
☐ MAPPA

Good practice note:
To allow for effective liaison and to ensure a range of appropriate disposals – including community options – schemes must have formal links with a wide range of providers.

12 If there is no learning disability worker attached to the scheme are there formal links with learning disability services?

☐ Yes
☐ No

13 How easy is it access learning disability services?

☐ Easily
☐ With some difficulty
☐ With considerable difficulty
☐ Not at all

14 Are there formal links with women’s services?

☐ Yes
☐ No
### Good practice note:

If schemes are to meet the needs of all service users who might otherwise be further disadvantaged, it is vital that they establish good links with specialist services for people with a learning disability, women, and people from black and ethnic minority communities.
### Liaison and Diversion for Mentally Disordered Offenders

**Is there a written protocol on obtaining mental health assessments at police stations and courts?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If yes, is this jointly agreed by the following?**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forensic physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Good practice note:**
The above are the minimum protocols that should be in place. They should be jointly agreed with the relevant agencies.

**Is there a written protocol on conveying to hospital from police stations and courts?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If yes, is this jointly agreed by the following?**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Good practice note:**
The scheme should have a range of materials to publicise itself and generate referrals.

**Does the scheme have its own publicity material?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What happens next?
Following the review of the scheme there needs to be an honest appraisal of what works well and what does not. The review should also assist in identifying gaps in provision. An action plan should be devised highlighting those areas where improvement is needed. The plan should identify: how these are to be achieved; who is responsible for ensuring development; and a timetable for action. Progress should be measured against set tasks and an agreed timescale.
Tom was arrested with four other people following a fight outside a pub in which a person was stabbed and received serious injuries. The circumstances of the fight and who committed the stabbing were initially confused. Tom was seen at the police station by the duty solicitor who agreed to represent him.

The criminal justice mental health liaison scheme (CJLS) was contacted because the custody sergeant felt that ‘things just aren’t quite right with Tom’.

The CJLS practitioner was able to check the records of the local mental health trust and found that Tom was known to services and was currently receiving care from a community mental health team (CMHT). The practitioner spoke with Tom’s care co-ordinator and was given relevant background and clinical information in line with the locally agreed information sharing protocol.

The practitioner then visited the police station and spoke with the custody staff and arresting officers before interviewing Tom. The practitioner felt that a further assessment under the *Mental Health Act 1983* was necessary and this was arranged following discussion with the police and the forensic physician. Tom and his solicitor were informed of this decision.

The assessment team saw Tom but felt that admission to hospital was not necessary at that time and that his care should continue from the CMHT. If the police wished to process Tom through the criminal justice system they agreed that it would be appropriate but that any interview should take place in the presence of an appropriate adult.

Following discussion with Tom’s solicitor and the Crown Prosecution Service (CPS), the police decided to release Tom on bail for two weeks to allow them time to gather further information. The CJLS practitioner passed this information on to Tom’s care co-ordinator. The other men were also released.

After two weeks the police informed Tom, his solicitor, and the CJLS that they had a number of witnesses who had identified Tom.
as the person who committed the stabbing and that they wanted to question him in connection with this. The CJLS facilitated a discussion between the police, the CPS, Tom’s solicitor, and his clinical team on Tom’s mental state and what action would be appropriate. It was agreed that Tom should be questioned and, if there was evidence of an assault, charged. The CJLS ensured that an appropriate adult with knowledge and experience of mental health issues was present during the interview.

During the interview, which was conducted in the presence of Tom’s solicitor and an appropriate adult, Tom admitted that he had carried out the stabbing. He was charged with the offence and held in custody to appear at the magistrates’ court the next day.

The CJLS prepared reports for the court and identified a package of care as an alternative to a remand in prison. This was made available to Tom’s solicitor, the CPS, and the court. The practitioner appeared at court the next day to support Tom and to offer advice to the magistrates. The court decided to remand Tom to prison for a subsequent trial. The practitioner informed Tom’s care co-ordinator of the outcome and passed relevant clinical material to the prison’s health care centre and the prison mental health team with Tom’s consent and in line with the locally agreed information sharing protocol.

While Tom was on remand, the CJLS liaised with the prison mental health team and the care co-ordinator about the progress of the case, Tom’s mental state, and the production of reports and other relevant material. The CJLS liaised with Tom’s solicitor and other agencies over the production of the reports. A further mental health assessment was arranged which found that Tom was fit to stand trial and that a specific disposal under the Mental Health Act 1983 would not be appropriate.

Along with Tom’s responsible medical officer (RMO), the CJLS practitioner attended the court case to provide information and assist the court. Tom pleaded guilty to the stabbing and was remanded in custody for the preparation of a pre-sentence report (PSR). The CJLS liaised with the probation service and Tom’s solicitor to ensure that relevant information from Tom’s clinical team and other agencies was included in the PSR. Tom was later sentenced to three years in prison.

Following a review, it was agreed that the CJLS would hold Tom’s case and would process any subsequent requests for assessment or advice. In turn, the CJLS would liaise with the prison mental health team and arrange for Tom’s previous clinical team to attend care programme approach (CPA) meetings prior to his release from prison.
Part 11 Conclusion

Diversion and criminal justice mental health liaison schemes are an effective and appropriate means of dealing with mentally disordered offenders and providing a service to agencies working with them. Where such schemes have been evaluated they have been shown to: identify people with serious mental illness as well as people with mental health needs generally; re-engage people with services; reduce reoffending; reduce delays; and meet the needs of victims. While there may not be one ‘ideal model’ for a diversion and liaison scheme, it is vital that any scheme is structured in such a way that it meets local need and engages effectively with the criminal justice system.

**Scheme protocol**

All schemes should:

- have agreed aims and be part of a local strategy on mentally disordered offenders
- have a robust management structure linked to commissioners and planners
- have secure, long-term funding
- be integrated with mainstream services including community services
- be linked into a network of operational arrangements – particularly for referrals
- operate at as many points in the criminal justice process as is practicable
- both screen people and take referrals from a range of agencies
- have access to a range of resources including beds
- be staffed by, or have input from, a variety of professionals including support staff
- have a recording and monitoring system that can assist with the evaluation of the scheme and provide information for planners
Appendix Diversion routes

These diagrams show, in simplified format, how diversion at the police

Diversion at the police station

Reactive scheme

Custody officer suspects mental health problem

Diversion/liaison scheme notified

Assessment carried out

No mental health problem

Continue with the criminal justice process

Yes
Criminal proceedings may still be considered at a later stage

Informal admission

Compulsory admission. Further assessment needed

Other option including outpatient appointment, community provision, etc

Proactive scheme

Diversion/liaison scheme screens detainees

Mental health problem identified

Diversion considered with CPS, police and clinical team

No

Proceed with investigation ensuring safeguards, eg appropriate adult

Consider bail rather than remand in custody. Ensure medical reports attached to CPS files
station and the court might be carried out

**Diversion at the court**

**Reactive scheme**

Mental health problem suspected by court staff, prison staff, solicitor, CPS, etc

Diversion/liaison scheme notified

Assessment carried out

No mental health problem

Continue with the criminal justice process

Diversion agreed

Informal admission

Compulsory admission. Further assessment needed

**Proactive scheme**

Diversion/liaison scheme screens files/cases

Assessment carried out

Mental health problem identified

Oral/written report prepared to assist discussion with CPS and for court if case proceeds

Diversion considered with CPS

Not appropriate

Court case proceeds

Health disposal considered

Other option including outpatient appointment, community provision, etc
Other Nacro mental health publications

Available from www.nacro.org.uk/publications/form-order.htm or phone Nacro Publications on 020 7840 6427 or email publications@nacro.org.uk

  
  "This must-have for appropriate adults working with vulnerable adults who are suspected of committing a criminal offence... Excellent"  
  Community Care magazine


- **Mental Illness and Personality Disorder in Convicted Male Sex Offenders** (2005)  
  24 pages, ISBN 0 85069 210 5, £5.00


- **Working with Mentally Disordered Offenders: A training pack for staff in criminal justice agencies, health and social care, and the voluntary sector** (2005): 260pp, CD-Rom, £15.00

  "...an effective and well thought out training pack."
  Community Care magazine
Nacro’s Mental Health Unit

Nacro believes that responses to mentally disordered offenders should focus on their care and treatment rather than on punishment. There are many obstacles preventing mentally disordered offenders from getting the care they need – lack of resources, agencies not working together effectively, lack of specialist skills in the criminal justice system, problems around information sharing, and a reluctance on the part of key staff who might not want to work with a group that can be difficult and unrewarding. There are also difficulties in balancing the needs of the individual offender with safeguarding the interests of the community.

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

Contact the Unit on 020 7840 6718, 020 7582 6500 or mentalhealth@nacro.org.uk.

Visit Nacro’s specialist mental health website which provides an interactive knowledge exchange offering information and support for practitioners and policy-makers working in the field of criminal justice and mental health.

www.nacromentalhealth.org.uk
Liaison and diversion schemes for mentally disordered offenders play a vital role in simplifying the links between criminal justice and other agencies – to the benefit of the agencies and the individuals caught up in the system.

*Liaison and diversion for mentally disordered offenders* sets out for commissioners, managers and practitioners how schemes should be established, funded and organised. It identifies the elements that make up a good scheme – able to meet the needs of different groups and individuals – and provides a checklist to evaluate schemes’ operation.