

Centre for
Mental Health



The Bradley Report five years on

*An independent review of progress to date
and priorities for further development*

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A report completed on behalf of the Bradley
Commission, supported by Centre for Mental Health

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Foreword by the Rt Hon Lord Bradley

It is now some five years since I published my independent review of the support offered to people with mental health problems and people with learning difficulties in the criminal justice system. In that time, we have seen significant progress towards achieving the vision set out in that report with the clear and unambiguous support of both governments.

I was delighted to be asked by colleagues from Centre for Mental Health to come back and review what has changed since 2009 and look ahead to the next five years to see what remains to be done.

In looking back at what has changed over the last five years, it has been encouraging to see the development of more liaison and diversion teams, both for adults and for children and young people, offering early intervention in police stations and courts across the country. While there is a lot more to be done in making sure liaison and diversion is available everywhere, the commitment of the Department of Health, Ministry of Justice and NHS England to the successful completion of this job has been key to the continued progress we are making.

We are also now seeing the emergence of new and creative ways of supporting people with mental health problems and those with learning difficulties across the criminal justice system. Initiatives like street triage, which offers a more humane crisis response, and youth justice liaison and diversion, which provides support to children and young people when they come into contact with the police. We still have a lot to learn from these as we build the evidence of what makes the biggest difference to people's lives and the most cost-effective use of public money.

I have been impressed ever since I began work in this area with the dedication, creativity and resilience of the people who work in it. Many have personal experience of being in the criminal justice system themselves and now try to help others going through it. Many work in voluntary and community organisations, offering credible alternatives to traditional services, while others are based in the NHS and local government, finding new ways of improving care and support despite the difficult financial climate.

This report looks at what has been achieved so far, at what has changed in the context we work in, and at what still needs to be done. I hope that it demonstrates the value of finishing the vital job we have begun of implementing liaison and diversion nationwide as well as making further progress in less well developed actions.

I would like to thank my fellow Commission members, who have given their time to this project so generously, to visit innovative local services, to take evidence from a range of experts and to listen to the voices of experience in developing the recommendations we have made. I would like to thank Centre for Mental Health for hosting this work and producing the report. And I would like to offer my appreciation and thanks to the people who work day-in, day-out in this field, who continue to inspire us with the work they do and the difference they make to the lives of people who are all too easily written off and ignored.

Finally, I hope that in another five years' time we are able to look back on continued progress and to say with confidence that as a society we respond more effectively and more humanely to the needs of people with mental health problems and people with learning difficulties who are at risk of offending or who come into contact with the criminal justice system.

Executive Summary

The Bradley Commission is an independent review set up by Centre for Mental Health examining the progress made in the five years since the publication of the Bradley Report (DH, 2009a). The report made 82 recommendations for improving the treatment of people with mental health problems and people with learning difficulties in the criminal justice system in England and Wales.

The Commission received evidence from a range of experts, including people with experience of going through the criminal justice system, to examine the progress that has been made since 2009 and to identify priorities for further development. In addition to this report, the Commission produced three briefing papers on specific areas of concern: the needs of people from black and minority ethnic communities; young adults in transition; and people with personality disorders.

The Commission reviewed evidence that has emerged since the Bradley Report was published of the impact of liaison and diversion. It found that while clear evidence of benefits remains unavailable, there is sufficient evidence to justify further service development and research. And there is growing evidence of the importance of liaison and diversion for children and young people.

The Commission found evidence of significant progress in many of the key aspects of the Bradley Report's vision. We reviewed what has been achieved so far, and what remains to be done, under the major headings of the Bradley Report.

Prevention and early intervention:

There is clear evidence of the benefits of effective early interventions to prevent or mitigate severe behavioural problems among children at risk of later offending.

There is growing evidence of the benefits of intervening early when people come into contact with police neighbourhood teams or when the police are called to deal with emergencies under the Mental Health Act.

Police custody:

The development of liaison and diversion services and a single Operating Model by NHS England is a significant change that should bring about major improvements to the criminal justice system.

Courts:

Liaison and diversion services also support people in courts and can bring substantial benefits, for example in preparing court reports.

Some progress has been made in making greater use of the Mental Health Treatment Requirement but further development is needed to improve sentencing and to offer training in mental health and learning disability awareness to sentencers.

Prisons and resettlement:

Prison mental health services are developing a broader focus despite the absence of a national blueprint. Responsibility for prison healthcare now lies with NHS England, which has the opportunity to develop a more standardised model for mental health support in prisons.

There has been some progress in improving access to hospital care for prisoners requiring specialist treatment. But the proposed 14 day maximum waiting time has not been implemented and reform continues to be vital.

Support for offenders ‘through the gate’ from prison to the community is vital. The Commission hopes that the Transforming Rehabilitation programme will improve the support offered to offenders with mental health needs and those with learning difficulties in contact with probation services.

Partnership working:

Successful liaison and diversion depends on the availability of a range of local services for people with multiple and complex needs. Health and wellbeing boards, local authorities and clinical commissioning groups need to ensure effective support is offered to people who are diverted to make the most of the opportunity this presents.

There is growing evidence of the benefits of co-production of support between professionals and service users, with user-led services offering engaging support to people at all stages of the criminal justice system.

The Commission recommends:

1. Assuring adherence to the Youth Justice Liaison and Diversion model:

NHS England should subject this element of the liaison and diversion programme to additional scrutiny from stakeholders with expertise in this area – this could take the form of a youth Justice and mental health reference body with a role in providing assurance to NHS England and partners.

2. Ensuring the availability of Appropriate Adults and Intermediaries:

a) A register of Appropriate Adults should be held in all police custody suites and indeed any facility where a vulnerable person is likely to be interviewed; likewise all courts should hold registers of Intermediaries.

b) Funding arrangements for both Appropriate Adult and Intermediary schemes need to be clarified.

c) The same arrangement that are available for vulnerable witnesses should be applied to vulnerable defendants without any further delay and specific guidance and instruction provided to sentencers.

3. Developing an Operating Model for Prison Mental Health Care:

NHS England should replicate its efforts in achieving standardisation in liaison and diversion services by developing an operating model for prison mental health and learning disability care.

This should include accommodating multiple and complex need, a recovery orientated approach, primary mental healthcare, engagement with service users and co-production of services and the needs of special populations, e.g. women, young adults, people from BME communities, those with personality disorder.

The operating model should support more integrated working with prison substance misuse services and resettlement should be a key part of the model.

4. Making the Operating Model for liaison and diversion an all stage operating model:

a) NHS England should revise the Operating Model to include both prevention and resettlement. It should also include the Mental Health Treatment Requirement.

b) The Operating Model should map both provision and commissioning responsibility to different elements of the model.

c) In addition to the operating model, guidance for CCGs and others should be produced to support their commissioning of diversion pathways.

5. Assuring efficient transfer to and from secure mental healthcare:

NHS England and the Ministry of Justice should review progress towards the 15 recommendations made by Centre for Mental Health on secure care pathways (2011).

6. The Government should establish a review to identify solutions to achieving appropriate accommodation for offenders with vulnerabilities.

This review should consider the viability of a Housing First approach (Centre for Mental Health, 2012).

7. The Department of Health should commission a study of the prevalence of poor mental health, learning disability and other vulnerabilities throughout the criminal justice system.

This study should be all age, cover a broad range of vulnerability and be conducted across all criminal justice settings.

8. NHS England, Public Health England, Department of Health, Department for Education, Department for Communities and Local Government, Home Office and Ministry of Justice should work with health and social care research commissioning bodies to achieve a programme of research to develop the evidence base for liaison and diversion.

9. A new Concordat should be developed committing all key agencies to ensuring all front line workers (e.g. from police, ambulance services, prison service, probation & CRCs, Youth Offending services and Emergency Departments) receive appropriate mental health awareness and regular updated training.

1. Introduction

The Bradley Report was published in 2009 following an independent review led by Lord Bradley into the treatment of people with mental health problems and people with learning difficulties in the criminal justice system in England and Wales. The review was commissioned by the Secretary of State for Justice and after taking evidence from a wide range of sources made 82 recommendations for improvement.

The report set out a vision for better support for people with mental health problems and those with learning difficulties at all stages of the criminal justice system, from early intervention and prevention to police custody, the courts, prisons and resettlement.

There were other themes that are both explicit and implicit within the Report, for example the importance of partnership working and the need to improve consistency and continuity of care and support, and both of these influenced the ‘all stages of diversion’ approach that the Bradley Report proposed. This all stage approach involved reform across all the interfaces between mental health and criminal justice. The Bradley Report went beyond just mental health, but saw the necessity of identifying and placing on an appropriate pathway people with a range of vulnerabilities. The Bradley Report highlighted the need for a pathways approach and saw the Criminal Justice Mental Health Teams (CJMHTs) it proposed as having a role beyond the police station or court. Lord Bradley became keenly aware that many of those people who might benefit from liaison and diversion had experienced a litany of missed opportunities in the community. People with mental health problems face considerable stigma still and those who have ‘offended’ face a double jeopardy of stigma, including in the very public services that should address their needs. Still too few community services see the police stations, courts and prisons in their communities as parts of their communities. Lord Bradley saw the CJMHTs as playing a huge

role in bridging this gap and acting as the ‘glue’ to mainstream services. An example would be providing a through the gate response for some of their clients on release from custody.

But running through the core of the Bradley Report was not only the desire to use any and every opportunity for diversion, but also to divert at the earliest opportunity and to include prevention in the diversion armoury.

The Bradley Report also recognised that poor mental health and learning disability did not occur in isolation and particularly not in the offender population that tends to have complex and multiple problems by default. This multiplicity of need makes it particularly difficult for such people to engage with services or for services to engage with them, as often services are mono problem focussed. Further to this, Lord Bradley recognised that services often set the entry thresholds high and do not recognise complexity.

The aim of the Commission in writing this report is to celebrate the progress that has been made over the past five years in achieving the vision set out by Lord Bradley, and considerable progress has been made; but also to describe the challenges that remain and set out priorities for the future development. The Commission has throughout the past 18 months kept the ‘end user’ at its centre and has striven to go beyond the policy and consider what the actual impact has been on the service user of the various achievements and developments, and to consider what future proposals might hold.

The world has not been still since 2009. The full brunt of the financial crisis has hit our public services, and also the voluntary sector – a critical component for those with mental health problems and those in contact with criminal justice agencies. A change in government has occurred and the commissioning landscape for health and criminal justice services has undergone radical change. The current commissioning landscape is arguably no more complex than before, but it is a different landscape and poses new and different

challenges than those arrangements present in 2009. This report coincides with a dramatic set of reforms to rehabilitation, in terms of who is to be rehabilitated and how rehabilitation is to be delivered; the delivery agencies of probation and rehabilitation remain critical partners in achieving the Bradley vision, but there are new complexities and new relationships to be fostered.

The Commission

The Commission, hosted by Centre for Mental Health, was formed in 2012 to review progress five years on from the publication of Lord Bradley's review, but also to look at some specific themes for which there was limited evidence at the time of the Bradley Report. These themes were:

- The interface between criminal justice and mental health services for people from Black and minority ethnic communities (Centre for Mental Health, 2013)
- Mental health responses for young people aged between 16 and 25 in contact with the criminal justice system (Centre for Mental Health, 2014)
- Services for people with personality disorder in the context of complex need (to be published soon)

Each of the themes and the Commission's findings are subject to separate publications.

The Commission itself consisted of:

- Rt Hon Lord Bradley of Withington, PC – Commission Chair
- Eric Allison - Prisons Correspondent, The Guardian
- Chief Constable Simon Cole (Leicestershire) – former ACPO lead for Mental Health and Disability
- Commander Christine Jones – current ACPO lead for Mental Health and Disability
- Sean Duggan - Chief Executive, Centre for Mental Health
- Lady Edwina Grosvenor
- John Lock JP - Council Member, Magistrates Association
- Gen the Lord Ramsbotham, GCB, CBE -

former Chief Inspector of Prisons

- Jenny Talbot OBE - Care Not Custody Director, Prison Reform Trust

It was never the intention of the Commission to gauge progress in achieving the vision laid out in the Bradley Report in its minutia, by giving a blow by blow progress report of all its 82 recommendations, and this would not be a practical proposition in many cases as the landscape has changed considerably over these past five years. Rather the Commission has chosen to progress against the main thrusts of that vision.

The Commission from the outset adopted a solution focussed approach and aimed to identify evidence of promising practice rather than 'celebrate' the problems and point a finger to gaps in provision. The Commission, supported by a research team, trawled the literature, identified services and experts and conducted a series of interviews and visits. Some experts and services made presentations of evidence and their experience at the Commission meetings. This report summarises that evidence collected through the above activities.

The evidence for liaison and diversion

The evidence for liaison and diversion services is limited. The three most recent reviews of the international evidence (described below - all by UK based research teams) have established this. But all have recognised that liaison and diversion is highly likely to bring benefits. The expectation of such services is that they bring about:

- Improved general and mental health being
- Reduced offending
- Improved social integration

This is evident in the Operating Model (NHS England, 2014) developed in order to achieve a standardised approach across England for liaison and diversion. Previous research by Centre for Mental Health also established this expectation (e.g. Centre for Mental Health, 2009; Durcan, 2014)

The three recent systematic review were

conducted by the Offender Health Research Network (OHRN, 2011), Queens University (Scott *et al.*, 2013) and the Institute of Mental Health (Kane *et al.*, 2013). Each reported there was little high quality evidence to support diversion. Centre for Mental Health had reported previously that this was due to the diversity of scheme types both nationally and internationally, and to the absence of sufficient well conducted multi-site studies. OHRN stated that liaison and diversions schemes “...are universally regarded to be a ‘good thing’, but there is no robust body of research evidence to support the belief that they improve the health, social and criminal outcomes of people who are in contact with them...” (pg 4). Scott *et al.* stated that the evidence “...provides cautious support for the CJLD (Criminal Justice Liaison & Diversion) model. However, the strength of the available evidence is insufficient to endorse fully the diversion of MDOs (Mentally Disordered Offenders)...” (pg 6).

Kane *et al.* conducted their study as part of the English liaison and diversion programme sponsored by NHS England. They found widespread support for liaison and diversion but like the above concluded that the “... published evidence about diversion is not as clear and has some major limitations... A large though methodologically mixed body of literature points to some of the advantages of diversion schemes, including a reduction in the time spent in court and on remand and better access to screening and health services...” (pg 4).

Kane *et al.* adopted a systematic narrative review methodology and were able therefore to include a range of evidence beyond just the highest quality research. They were able to go somewhat further than the other two reviews and indicated the following:

- Diversion should happen at the earliest possible point on the pathway.
- Defendants in the police station/court should be screened face-to-face for mental illness.
- Individuals and their behaviours should

not be inappropriately pathologised, creating stigma, unjustified coercion and unnecessary cost through service duplication and over intervention.

- A clear and bounded definition of the service should be provided with multi-agency commitment to that definition.
- Availability of a service infrastructure into which individuals can be diverted .
- Liaison and diversion services are most effective when commissioned on the basis of joint funding from mental health and criminal justice agencies.
- Liaison and diversion teams should work more closely with substance misuse teams in co-ordinating care.
- Liaison and diversion teams should develop and agree plans for the provision of training in mental health issues and learning disabilities for criminal justice staff and vice versa.
- Liaison and diversion teams should undertake follow-up work as a core part of their business to ensure that their clients engage satisfactorily with the services into which they have been diverted.
- Commissioners and managers of community-based mental health services should ensure that a potential client’s offending history does not act as a barrier, formally or informally, to receipt of these services.

Children and young people

Lord Bradley’s review focussed on adults and therefore made only limited mention of children and young people. Prior to the launch of Lord Bradley’s review, a children’s and young people’s diversion development programme had already been established. This programme was a joint programme between the Youth Justice Board, Department of Health and Centre for Mental Health. It established a model of diversion for children and young people through testing approaches across six pilot sites:

- Halton and Warrington
- Lewisham
- Peterborough
- Royal Borough of Kensington and Chelsea
- South Tees
- Wolverhampton

The Youth Justice Liaison and Diversion (YJLD) development programme established a model that differs considerably from the adult model in that while interventions should be available at all stages there is a much greater emphasis on prevention and reducing the number of first time entrants to the criminal justice system. Ideally, assessments and interventions are conducted away from criminal justice settings.

The pilot programme was independently evaluated by the University of Liverpool (Haines *et al.*, 2012) and its keys findings were:

- Young people engaged in the scheme were slower to reoffend than matched young people.
- YJLD intervention led to significant improvements in reported depression and self-harm.
- Greater contact with the diversion scheme was associated with improvement in health scores.
- A child's intellectual ability, and ability to focus and maintain attention, were associated with ability to engage with services.

Kane *et al.* (2013) reviewed the literature and found American evidence supporting youth diversion schemes in reducing reoffending and in bringing savings to the criminal justice system. UK evidence was found to be less conclusive and variation in schemes made it difficult to interpret outcomes. There was, however support for early intervention and family orientated and holistic care.

The emphasis on prevention of the YJLD model is very much in keeping with the spirit of the Bradley Report, which included prevention and early intervention at its core.

A further 31 YJLD services were funded as part of the initial phase of the national liaison and diversion programme, making 37 of these services in all by 2011.

The current phase of the national programme is embedding an operating model developed by the Offender Health Collaborative and this is attempting to develop, for the first time, a standardised approach to liaison and diversion. Crucially this operating model is for an all age approach and incorporates the YJLD model. A major challenge for the ten pilot sites involved in this phase is implementing a service for children and young people, as most are building on what were adult only focussed services. For example the London pilot is being deployed across eleven boroughs, only four of which had the YJLD model. The pilot is attempting to work with child and adolescent mental health services (CAMHS) and youth offending teams (YOTs) in the other seven boroughs to establish means of achieving the same processes and outcomes as the YJLD model. Arguably London is at something of an advantage as most other nine pilot sites did not have one of the 37 YJLD services operating in their locality.

There has been concern in the stakeholders the Commission spoke to, with expertise in children and young people's mental health and justice issues, that the national development programme has an adult bias, and that there has been a limited knowledge an understanding of the very different needs of young people but also the different legislative and policy agenda.

The Commission also looked at the interface between criminal justice and mental health for young people aged between 16 and 24 (Centre for Mental Health, 2014), some of whom may fall in to the children's sphere but the bulk of whom will fall into adult services. The Commission found that neither children's nor adult services in criminal justice or mental health were taking sufficient account of the different needs of young people and that the transition between children's and adult services was often a difficult one. Services that appeared to work well with young people had the following characteristics:

- A primary focus on emotional wellbeing and communication
- Consistent and continuous relationships
- Prioritising the journey (providing long-term focused work)
- Ex-offender or service user led
- Address multiplicity of need and vulnerability
- Operationalising complexity (through multi-agency commitment)
- Accessible
- Client led engagement and decision making

The Commission made 12 recommendations for young adults:

1. National government should foster a whole systems approach to ensure all young people aged 15-24 years who require specialist intervention should experience continuity of care.
2. Commissioning arrangements should support this agenda by resourcing high quality, measurable person-centred services.
3. Services working with young people of transitional age should facilitate a formal face-to-face transfer of care meeting involving the young person, their family or carers and each service involved in their care.
4. Local police, health and young adult community-based or voluntary sector groups should work together, via mental health, substance misuse and learning disability link workers, to ensure that low-level offenders with mental health, development, learning or substance misuse needs are, where appropriate, referred out of the criminal justice system at as early a stage as possible.
5. As stated in NHS England's Operating Model (2014), liaison and diversion services should run services at weekends and evenings as this is the time of most arrests of young adults. As a minimum, this could be in the form of a telephone support or answer machine service with brief intervention advice.
6. Criminal justice agencies should provide more training for their staff and members of the judiciary on how to support young adults with mental health problems; speech, language and communication needs; developmental problems such as ADHD; and learning difficulties and disabilities.
7. Appropriate Adult services should be extended to meet the needs of young adults with mental health problems and learning disabilities. The support which is currently provided to vulnerable victims and witnesses should be extended to young adult defendants with mental health problems or learning disabilities.
8. Government should increase the range of non-custodial sentencing options, such as Intensive Alternatives to Custody (IAC) and where there are established young adult mental health and learning disability voluntary sector resources available, courts should make referrals to them.
9. The National Probation Service and new private providers should implement a comprehensive mentoring programme for young adults leaving custody with mental health problems or learning disabilities. This should be attached to the 12 month supervision order.
10. Liaison and diversion services should facilitate the participation of children and young adults in the design of services at all levels, including the commissioning of these services.
11. Commissioners should give greater emphasis to addressing the welfare needs of young adults in the criminal justice system (e.g. housing and meaningful work opportunities).
12. Education Health & Care (EHC) Plans should run continuously, including the time while a young adult is in custody, as they will contain a lot of useful information about them that could help different parts of the justice system understand and be responsive to their needs for reasonable adjustments.

Women

Not long before Lord Bradley had been commissioned to conduct his review of diversion, Baroness Corston had reported on her review of vulnerable women in the criminal justice system (Home Office, 2007). The Bradley Report described some of the specific issues facing women and supported the case made in the Corston Report for a different approach for women. A significant achievement of the Corston report was the development of Women's Centres, providing a 'one stop shop' for vulnerable women.

Some women's centres were included in the first phase of the national liaison and diversion programme as were liaison and diversion workers specifically for women in some courts. The London pilot scheme in the current phase of the programme also has specialist workers for women. Where operational these workers screen all women and offer a problem solving approach. The charity Together provides these services for women in London as well as other liaison and diversion services.

People from black and minority ethnic communities

The first theme the Commission sought evidence on was that concerning people from black and minority ethnic (BME) communities with mental health problems who come into contact with the criminal justice system (Centre for Mental Health, 2013). Some groups are over-represented in criminal justice services and are also over-represented in the 'harsher' end of mental health services (e.g. detentions under the Mental Health Act and secure services). Some black people receive their first mental health assessments and interventions only by coming into the criminal justice system.

The Commission identified the following characteristics of services that appeared to work well with people from BME communities with mental health problems and in contact with criminal justice:

- Cultural competence
- Offered person centred intervention
- Holistic engagement
- Provided mentoring and service user involvement
- Worked in partnership with the communities clients come from

The Commission made 10 recommendations:

1. Local police, health and BME community based groups should work together, via mental health and learning disability link workers, to ensure that low level offenders with mental health or learning needs are, where appropriate, referred out of the criminal justice system at as early a stage as possible.
2. Established liaison and diversion initiatives should ensure that they proactively partner local BME mental health and learning disability community-based groups so that expertise can be shared and appropriate account is taken of cultural issues during key elements of the process, such as assessment. Partnerships should be underpinned by referral and information sharing protocols.
3. Established schemes should ensure that BME service providers and local community based BME mental health and learning disability organisations are part of the schemes' governance and consultation arrangements.
4. A comprehensive mentoring programme for people leaving custody with mental health problems or learning disabilities and returning to the community should be established by the probation service.
5. The data collection and monitoring processes of all schemes and initiatives should be governed by a minimum data set which includes not just ethnicity but also faith and preferred language.
6. Schemes should ensure that they act on data collected. It is not sufficient to simply record data, it should be collated and analysed to gain a picture of how the scheme is operating, to assess whether it

is reaching the range of potential service users and to what extent it is meeting need. Schemes should ask: does our service reflect the local community and also the flow of people through the part of the system in which we are located?

7. Service users and carers should be represented at all levels, not just within community-based agencies but also within statutory agencies responsible for commissioning or providing liaison and diversion.
8. Community organisations and liaison and diversion schemes should jointly provide training to court personnel and sentencers about the alternative decision making available to them and the nuances of BME mental health and learning disabilities.
9. Greater use of the expertise of community based agencies should be made in prison establishments and there should be an expansion of 'through the gates' schemes and a similar impetus given to the use of 'peer advisers' within prison settings.
10. Commissioners should give greater consideration to the commissioning of specific community-based services working with BME offenders at all stages of the pathway and to gender specific liaison and diversion services.

2. Prevention and early intervention

Real early intervention and prevention could be argued to start in the cradle and is the function of child and family health and social care agencies. Brown, Khan & Parsonage (2012) reviewed the evidence on children who have marked behavioural difficulties early in life. The behavioural difficulties, without early intervention, will persist often into later life, and these young people will account for a significant proportion of repeat offending and cost in the criminal justice system; they will also use more mental and physical health services than their peers. There is poor evidence for what works with these young people if intervened with later in life, but the evidence for early intervention and prevention programmes and their efficacy is overwhelming.

Effective parenting interventions cost in the region of £1,200 for each child and can save an estimated £225,000 (Friedli & Parsonage, 2007) in public funds that would otherwise be spent over the course of their lives. Most of these savings will be in the criminal justice sector, but savings will also take place in schools and health services.

The Youth Justice Liaison and Diversion model has been described, and it places emphasis on early detection, intervention and prevention and crucially in preventing young people on becoming first time entrants to the criminal justice system by offering interventions for the range of health, mental health and social difficulties these young people experience.

Early intervention for adults was also a key feature of the Bradley Report. Some liaison and diversion schemes responded early to the Bradley Report's all stage diversion approach and developed preventative initiatives, for example working with neighbourhood policing and avoiding arrests. Some of these were included in the first phase of the national liaison and diversion programme. However, a concern for the Commission is that these preventative interventions do not feature in the current

model of liaison and diversion being tested out across England. In part this is because such initiatives fall outside NHS England's funding envelope. Some schemes have reported that the future of these initiatives is under threat and that the new Clinical Commissioning Groups have not necessarily seen it as their role to fund these. It should be noted, however, that some schemes are piloting street triage and some of these are funded centrally.

Section 135 and 136 of the Mental Health Act / street triage

Both Section 135 and Sections 136 of the Mental Health Act are the subject of a current joint review by Home Office and Department of Health, with a particular view to changing the national practice guidance for both England and Wales. Centre for Mental Health is also involved in this review.

The Crisis Care Concordat and work in developing street triage schemes (both to be described later) are responses to the unsatisfactory arrangements that persist for people who are detained by the police and particularly under Section 136. The codes of practice for both England and Wales state that a police cell should only be used in exceptional circumstances as a place of safety, but a recent joint thematic review by four inspectorate bodies (HMIC, 2013) found that in some areas it was the default location and commonly used in others.

A concern that permeates the debate on these sections, and Section 136 in particular, is that few of those detained will remain in hospital after police have brought them there, either as voluntary patients or patients detained under another section of the Act.

The Commission has received evidence that various initiatives, such as mental health practitioners being on patrol with police at peak times and mental health practitioners

having a presence in police control centres, are producing positive results. Such schemes are reported to have reduced the use of Section 136 and increased the retention rate in hospital for those who are sectioned under Section 136. It is also becoming clear that there will need to be a variety of approaches to providing this ‘street triage’ as localities differ, but having mental health practitioners in police control centres seems to be something that all those presenting to the Commission find useful. Where street triage, in whatever form, works well it provides two key components – 1) immediate mental health expertise, and 2) immediate access to information on people known to services. Some areas have taken this latter point further by having miniature care plans for known individuals prominent on the police information system; there are even some examples of advance directives being shared with the police. (NB. An Advance Directive in this case is a set of instructions (or living will) that the author would wish to be complied with in the event of mental incapacity.)

Operation Serenity in the Isle of Wight and Hampshire is an example of such a scheme and has reported positive results.

Neighbourhood policing

The liaison and diversion scheme in Cornwall provides a countywide service for those in courts and police custody but also works with neighbourhood police to support them in working with vulnerable people they identify. A recent internal three month evaluation of the scheme produced the following cautious results:

- Referrals from Specialist and Neighbourhood Policing Teams tended to be for more serious mental health conditions likely to require specialist input. Referrals arising from custody tended to be for those with more moderate conditions such as anxiety, depression and poor emotional control.

- The systemic value of the CJLD-Neighbourhood work is not just earlier intervention and the identification of hidden need; it is also about recognising that vulnerable individuals can also require a criminal response from the police.
- The people who were referred by Specialist and Neighbourhood Policing Teams represented a degree of hidden need that would have been unlikely to come to light until crisis point was reached. Delay in obtaining mental health and social care support can lead to significant reductions in recovery and social capital.
- There were reductions in police activity with individuals who have received CJLD input. This occurs at all stages of the criminal justice pathway.
- There was evidence that this early diversion reduced the escalation of cases to court.
- Within the three month cohort 92% of those referrals offered treatment by local services accepted the offer. Therefore service users with prior histories of poor engagement and relapse fell out of care relatively infrequently if referred by the CJLD to local services.
- The evaluation suggests the CJLD client group are predominantly individuals known to the police for both crime and vulnerability.

(Adapted from Earl, Morgan & Bell, 2013)

The Commission are excited by the potential of such initiatives and the benefits they might bring.

Working with neighbourhood policing and other specialist and enforcement teams (eg those dealing with anti-social behaviour) did feature in the Bradley Report. Indeed the Report recommended that an individual’s mental health or learning disability needs should be accounted for in Anti-Social Behaviour Orders or Penalty Notices for Disorder (PND), and in their breach.

Guidance issued to officers in July 2013 regarding the issuance of PND does not explicitly refer to the mental health or learning disability needs of an individual. There is a general requirement that the person being issued a PND should understand it. Sentencing Council guidance similarly does not explicitly refer to the need for such information prior to issuing or sentencing. Personal mitigation is accepted if the individual “has a lower level of understanding due to mental health issues or learning difficulties” (pg 5- Sentencing Council, 2008). A 2014 inspection of the treatment of offenders with learning difficulties found that “Police information about an offender’s learning disabilities is not routinely passed to the CPS” (pg 24 – Criminal Justice Joint Inspection, 2014). Initiatives such as those described above may be the most effective way of realising the Bradley Report’s recommendations in this area.

3. Police custody

Appropriate Adults

Progress on ensuring access to Appropriate Adults is available for vulnerable people in police custody appears to have been slow. There is no body or agency with a statutory responsibility to provide Appropriate Adult services. In places, this means that response to requests is patchy and ad-hoc, with local social services emergency duty teams responding if they have no higher priorities. A 2014 joint inspection of six areas found that “In some areas custody sergeants said Appropriate Adults were not always available to assist with cases.” (pg 5 - Criminal Justice Joint Inspection, 2014). The report further found that “Appropriate Adults were not always called, even when it was recorded that the detainee had a learning disability...” (pg 17).

Appropriate Adult training is available, for example through the charity National Appropriate Adult Network, to which providers covering the majority (but not all) of England and Wales subscribe. Many non-member schemes also offer training. However there is no requirement for Appropriate Adults to be trained.

Provision of healthcare in custody

The Bradley Report recommended that health provision commissioning within police stations should be transferred to the NHS. All police forces have now agreed and NHS England is assuming responsibility for these arrangements as and when existing contracts come to an end.

Liaison and diversion in police custody

There has been considerable progress in realising the Bradley Report vision for liaison and diversion in police custody (and also in courts). NHS England, in partnership with the Ministry of Justice, Department of Health and Public Health England, is leading a national all ages liaison and diversion programme. Its initial phase involved development support to just over 100 services and the Coalition Government invested £50 million into this programme.

Centre for Mental Health, Nacro, Revolving Doors Agency, the NHS Confederation Mental Health Network and the Centre for Health and Justice at the Institute for Mental Health, University of Nottingham formed the Offender Health Collaborative (OHC) in 2011. The OHC has supported the national development programme and in 2013 produced a standardised Operating Model for liaison and diversion services (NHS England, 2014).

The OHC is now supporting 10 pilot sites in embedding this all age Operating Model. The Government has provided a further £25 million to support this programme. The 10 pilot sites are subject to an evaluation, which is supporting a business case for full roll out to all police custody and courts of this all age approach, and this is anticipated for 2017. A standard minimum data set is part of the Operating Model, which includes collection of outcome data and proxies of such; all those receiving the service will be subject to some tracking post liaison and diversion.

The programme is attempting to establish services that can effectively identify people with poor mental health, learning disability and related vulnerabilities and then place them on an appropriate ‘pathway’.

Another important feature of the Operating Model is the broad range of vulnerabilities that liaison and diversion services are to identify and support.

Adults

Mental health
 Learning disabilities
 Autistic spectrum
 Substance misuse
 Physical health
 Personality disorder
 Acquired brain injury
 Speech, language and communication needs

Children and Young People

Mental health (including conduct disorder, emerging symptoms and multiple risk factors for poor mental health)
 Speech, language and communication needs
 Attention deficit hyperactivity disorder
 Learning disabilities
 Learning difficulties
 Autistic spectrum
 Substance misuse
 Physical health
 Acquired brain injury
 Safeguarding issues/child protection issues

(Taken from the Operating Model, pg 19 (NHS England, 2014))

The 10 sites deploying the Operating Model are currently merging and integrating with existing substance misuse services.

In the Commission's view developing appropriate pathways is the most challenging task as many of those people liaison and diversion services pick up will have multiple and complex need. Each pilot site is therefore attempting to build relationships (and formal agreements) with a range of local agencies (e.g. housing and welfare support, substance misuse treatment, primary and secondary mental health and general health care, employment support and many others). The Commission is concerned that a means be found to ensure that Health and Wellbeing Boards, Local Authorities and Clinical Commissioning Groups acknowledge their responsibilities in this area.

The Commission commends the all age approach but as stated elsewhere are concerned that the programme needs to recognise the different needs of children and the different nature of their liaison and diversion.

Mental health awareness training

The Commission found evidence of various training initiatives across several forces. Without doubt there is a recognition at a senior / strategic level of the need for officers to receive training. Exposure to mental health professionals as much as any formal training seemed to be a route to officers becoming more confident in this area. Liaison and diversion practitioners reported that any training needed to be cyclical and reoccurring as officers who had received training eventually change roles. Regardless of the current activity in this area many officers feel under-prepared for the task.

4. Courts

Intermediaries for vulnerable defendants in court

The Bradley Report proposed that intermediary arrangements for vulnerable witnesses be extended for vulnerable defendants, and there does appear to be some movement in this area. However, the guidance produced by Ministry of Justice (2012) acknowledged that equivalent arrangements to those for witnesses have been more gradual in their implementation but that “the practice has developed in the crown court whereby judges, exercising their inherent jurisdiction to ensure that the accused has a fair trial, have granted applications by the defence to allow the defendant to be assisted by an intermediary during their evidence alone and, in many cases, throughout their trial...” (pg 4).

There has been limited progress in implementing Section 104 of the Coroners and Justice Act 2009 extending the right of the accused to be examined through an intermediary in limited circumstances. However the implementation of this has been delayed until “resource implications” have been considered. A joint inspection in January 2014 focusing on learning disabilities found that, even where courts were minded to give support to vulnerable defendants, “Accredited and registered intermediaries were not always available to support vulnerable defendants with learning disabilities during the trial process” (pg 28 - Criminal Justice Joint Inspection, 2014).

Probation and Transforming Rehabilitation

Witnesses interviewed for this review found that mental health awareness is greater among probation officers that it had been past and that particular training packages had had significant coverage, for example the Knowledge and Understanding Framework (KUF). The KUF consists of a number of different training packages (right up to a master’s degree level) concerning working with people with personality disorder. The KUF awareness training was

reported as widespread among probation staff across the probation trusts that the Commission had contact with. However, the most significant challenge to working with probation in any shape or form currently is the Transforming Rehabilitation (Ministry of Justice, 2014a) reforms. The 35 regional probation trusts are disbanding and at the time of publication of this report the new arrangements will have been implemented in a ‘shadow’ form at least, with full implementation from October 2014. A single national probation trust will work across all courts and will also have responsibility for the management of the highest risk offenders. New Community Rehabilitation Companies (CRCs) are being formed to manage low and medium risk offenders and for the first time to provide support and some supervision for short term sentenced prisoners (i.e. those serving less than 12 months). This latter group, who consist much of the prison turnover, previously received no formal support and could leave prison to unstable housing or homelessness and no or limited funds, leaving aside the range of social and health vulnerabilities they may have suffered. Many probation officers and those who work alongside them have found this current transitional period very unsettling and this is likely to remain the case until after the CRCs have established themselves.

Psychiatric court reports

At the time of the Bradley Report, most courts found it difficult to access reports from those with mental health expertise that would support their decision making. The default was often to request a psychiatrist’s report, which involved several weeks’ delay and added costs and inefficiencies to the criminal justice agencies involved. These delays may also have involved a defendant languishing, perhaps unnecessarily, on remand in a prison.

It is quite well established that a full psychiatric report is often not what is required and the new Operating Model for liaison and diversion services allows for less detailed and more

immediate reporting to sentencers (NHS England, 2014). This in itself will allow for greater efficiency and help ensure that fewer requests for full reports are made and that they are more appropriate when requested. Anecdotal evidence collected by the Commission suggests that while there are still delays there is a shift to more efficient arrangements in some areas. A recent inspection focusing on learning difficulties found that most of reports and assessments were timely, assessed defendant needs appropriately and gave the court the information it required (Criminal Justice Joint Inspection, 2014).

Training for sentencers

Mental health and learning disability awareness is an important recommendation throughout the Bradley Report and sentencers are identified as a key group. Training for the judiciary is now the responsibility of the Judicial College (formerly the Judicial Studies Board). Mental health issues and mental capacity feature as part of several courses offered by the College in the current prospectus, though the targeting of this appears to be towards judges rather than magistrates. However, the College does have oversight of magistrate training. The College has also worked with the Justices' Clerks' Society, the Magistrates' Association, the Prison Reform Trust and Rethink Mental Illness to produce an online guide, *Mental Health & Learning Disabilities in the Criminal Courts*, for which Lord Bradley has written a foreword.

The Bradley Report also referenced specialist courts such as drug courts in several recommendations, and was concerned for how people with so called 'dual diagnosis' are served in these courts. There does not appear to have been the expansion in these courts that the Bradley Report anticipated and there is no published work on dual diagnosis arrangements. This stated, the new liaison and diversion arrangements and Operating Model are attempting to merge and integrate with substance misuse services and do consider 'dual diagnosis' as part of their brief. The

Commission is therefore satisfied that people with concurrent mental health and substance misuse problems will have their needs identified in both police custody and courts if these new arrangements are fully implemented and available to all these settings.

Mental Health Treatment Requirement

Centre for Mental Health produced the earliest reviews (Seymour & Rutherford, 2008; Khanom, Samele & Rutherford, 2009; Scott & Moffatt, 2012) of the then little known and little used Mental Health Treatment Requirement (MHTR). The requirement, first introduced in 2006, is one of three treatment requirements (the others concerning drug and alcohol treatment) that form part of the Community Order options for sentencers. It was and remains the least used. The Commission has found that its use has increased and liaison and diversion services in courts have had a role in increasing sentencer awareness of this as an option and in facilitating its delivery. The requirement itself has been revised and there is a current consultation on its implementation guidance; this has been led by the National Offender Management Service.

The Commission was able to find anecdotal evidence of good practice on this and also on the availability of alcohol treatment (also featured in the Bradley Report), but this appears to vary by locality and equally there was anecdotal evidence to the contrary. So while there has clearly been some progress and ongoing reform to support the increased use of the MHTR, the Commission concludes that the most fundamental challenge in having the MHTR more generally utilised is no longer a legislative or technical one but rather the same challenge that faces liaison and diversion services in creating diversion pathways from police custody and court, and the same challenge that faces prisoners on release from prison, and that is the willingness of mainstream care and support providers to engage with criminal justice agencies and to see these and the people who

have contact with them as part of the community they serve. In the case of the MHTR this will by and large require mental health treatment providers to be readily available to sentencers in order for a treatment offer to be a viable option.

Approved Premises

The Bradley Report made recommendations concerning the understanding of mental health needs and that the then responsible Primary Care Trusts should include this understanding of needs in their commissioning plans. A National Partnership Agreement between The National Offender Management Service, NHS England and Public Health England agreed to review the social care provision for people in custody and Approved Premises (NHS England, 2013b). This review was due for completion in April 2014. Guidance for providers of Approved Premises (and offender managers) also acknowledges the mental health needs of those residing in these and that consideration be given to the availability to meet such need when considering where to place someone. It suggests that: “consideration is given to the actual availability of local services to meet the offender’s health and social care needs, including those with complex mental health needs” (pg 13 - National Offender Management Service, 2014b). Clearly progress is being made, but a fuller assessment of the successful implementation of the Bradley Report recommendations will not be possible until the reforms of Transforming Rehabilitation and its new bodies and structures are in place and fully operational.

5. Prisons and resettlement

Prison mental health care has moved on leaps and bounds since Lord Ramsbotham published *Prisoner or Patient* (HMIP, 1996). These improvements were in evidence and prison mental health care was reasonably well developed at the time of Lord Bradley's review.

At the turn of the century and at the same time as the National Service Framework reforms to mental health services in the community were occurring, there was a programme of introducing specialist mental health teams to all prisons. These teams, while having no blueprint or particular model to follow, were intended to act as the equivalent of community mental health teams in a prison, in other words to provide specialist secondary care provision. It has been recognised that prisoners falling below traditional secondary care thresholds, but suffering from mild to moderate poor mental health, may be as challenging to support as those with more serious mental illness due the tendency for their mental health problems to occur in the context of multiple and complex need. The Commission has gathered evidence suggesting that primary mental health care is becoming more robust and that some prisons now have a merged primary and secondary care service.

There are further developments to prison mental health care that the Commission would wish to see and these are the adoption of a more psycho-social orientated model of care to recognise the multiple and complex nature of need and also to move towards adopting recovery orientated approaches as is national guidance and policy for their community equivalent services. This latter development will involve a greater role for current and former service users ('experts by experience') in designing and delivering care (i.e. co-production).

There has been no extensive review of mental health inreach in prisons or the use of the Care Programme Approach (CPA), a concern for the Bradley Report, but the evidence from prison based witnesses suggest that CPA operates

reasonably well and its application is likely to be no better or worse than that in the community.

Another concern for the Bradley Report were prisoners with indeterminate Imprisonment for Public Protection sentences (IPP) and the reported poor mental health in this population. The Commission is not aware of any review of mental health in this group as the report recommended. However, IPPs were abolished in 2012 and replaced with new determinate sentence options for the most serious offenders and serious repeat offenders. Those sentenced to IPP prior to the removal of these as an option remain on such sentences and 3,549 of these (63%) had exceeded their maximum tariff and still remain in prison (Prison Reform Trust, 2013).

The screening of prisoners for poor mental health and learning disability was also a concern for the Bradley Report. Shortly after the review there was a pilot programme testing out a learning disability screening tool (the LDSQ-7), and this piloting extended to some liaison and diversion sites.

There is, as yet, little evidence of fundamental changes to screening on reception to a prison and by and large the same process takes place. The availability of more liaison and diversion services in the future should increase the volume of information on new arrivals and the introduction of TPP SystemOne Prison, a standardised prison electronic clinical information system, means that the rapid transfer of knowledge can follow a transferred prisoner. In addition there is evidence of more robust secondary screening processes being in place in many prisons, providing another opportunity in the first few days after arrival for problems and vulnerabilities to be identified.

Transfer to the NHS

The Bradley Report recommended that where transfer to the NHS is deemed necessary that this should be done so within a 14 day period. A Centre for Mental Health review of

the pathways to and from secure mental health care revealed that efficient transfers from prison into such care was something of a postcode lottery (Centre for Mental Health, 2011). The annual report of the prisons inspectorate (HMIP, 2013) mentions that “Transfers of patients to NHS secure mental health beds had generally improved but there were still some long waiting times, in particular for some specialised NHS secure services” (pg 39). The 14 days transfer standard has not been adopted and anecdotal evidence given to the Commission suggests that timely transfer remains variable by locality and therefore is unsatisfactory.

The Centre for Mental Health review of pathways made 15 recommendations. It is not clear at the moment to what extent these have been met. However, there is a new contract for secure mental health services (NHS England, 2013a). Some elements of the Centre’s recommendations are evident in that contract. The contract states that medium and low secure services should meet best practice requirements, with annual peer reviews by the Royal College of Psychiatrists’ College Centre for Quality Improvement. It also states that there should be regular reviews for patients transferred from prison or on remand to inform discussions with the Ministry of Justice regarding security and transfer issues. The College Centre for Quality Improvement produced best practice standards for low secure services which includes sections on physical, relational and procedural security. The Commission find this a positive development but recommends that progress is reviewed and changes set out in the Centre’s (2011) report are implemented where they still apply.

Drug and alcohol treatment in prisons

Substance misuse services and mental health services in prisons have in the past (as reported to the Commission) tended to work separately and found it difficult to work in an integrated way, and particularly so in the adult prison estate. The Commission was able to collect some limited testimony on the current situation which suggested that this may still largely be the case. NHS England now has responsibility

for this area and in the Commission’s view this provides an opportunity for driving more integrated working. Such integrated working is being tested out in police custody and courts. Doubtless the approach may need to be different in prisons, but a model of integrated working does need to be developed that recognises the multiplicity of need that is typical in this population.

A positive development is the establishment of health interventions as part of a ‘through the gate’ pilot initiative. This primarily involves substance misuse interventions. The work is under way currently in several prisons and communities in the North West of England (National Offender Management Service, 2014)

Personality Disorder

The interface between mental health and the criminal justice system for people with personality disorder is the subject of a separate Commission briefing paper. There is evidence of significant change. The policy attention remains with those who pose high harm, but treatment pathways are available now to a larger volume of such prisoners and this includes treatment facilities in several prisons (Psychologically Informed Planned Environments - PIPEs) and also some provision post release and within mental health secure care. There has been some development for young people with emerging personality disorder, but further work in collaboration with the Youth Justice Board is required. There is also a specific pathway for women. The programme is a work in progress and is piloting various approaches in different settings. The prevalence of personality disorder is estimated to be very high in the prison population and it remains true to say that there is little or no provision for the bulk of prisoners with such traits. However, it might be anticipated that the programme, as it develops, will have wider benefits, through promoting a more psychologically informed approach and greater skills in the workforce.

Mental Health awareness training

The Commission has not found it possible to locate up to date statistics on the proportion of prison staff who have undergone mental health awareness training and a response to a Freedom of Information request submitted on behalf of the Commission indicated that these statistics are not centrally collected. The training available includes some initial input in all new prison officers' induction programmes, but what is available locally in the way of ongoing and update training is variable. Some prisons had introduced Mental Health First Aid training, but most seem to rely on bespoke training developed by the local mental health inreach team. Although the Commission has not surveyed all those providing training, we have heard consistently that mental health awareness training sessions can be poorly attended and prison officers with a direct prisoner interaction role find it hard to be released from duty for it. This is disappointing given the prevalence of poor mental health in any prison and therefore that prison staff will have day to day contact with many people suffering poor mental health and also with people with learning disabilities. The Commission therefore considers this to remain an area for concern and one to be jointly addressed by NHS England and the Ministry of Justice.

Supporting resettlement

The Bradley Report recommended that the National Offender Management Service and Department of Health produce a strategy for people with mental health problems and learning disabilities leaving prison but not subject to supervision from probation. Transforming Rehabilitation, described previously, provides a real opportunity for this and the contracts for the CRCs provide a vehicle for ensuring a more successful re-entry to society for people with vulnerabilities.

However, the release experience for prisoners with mental health problems and learning disabilities who are subject to probation supervision has often been far from satisfactory. Evidence presented to the Commission from another Centre for Mental Health programme relating to resettlement found that none of the first three people released into the programme had any knowledge of where they would be released to until the day of their release. Communication with probation officers was hard to achieve and though all had been referred to community mental health teams none of these had appointments in the first week or even second week post release. Each of these prisoners suffered severe mental illness but also other vulnerabilities and had little in the way of supportive social networks. Other anecdotal evidence received by the Commission suggests this experience is far from untypical.

Byng *et al.* (2012) conducted research exploring continuity of care for offenders. The research concluded that there was little in the way of procedures designed to ensure that offenders with common mental health problems were being assessed properly and then that was being used to contribute to care once released. The importance of relationships, which can span boundaries and contribute to continuity, was also given emphasis in this study. Byng and colleagues are engaged in a second study looking at follow-up care in the community for offenders (Engager 2. See <http://clahrc-peninsula.nihr.ac.uk/project/55-engager-ii/full.php>).

It is well established that many people in prison have multiple and complex need (e.g. Durcan, 2008) and are likely to leave prison with this range of vulnerabilities. People leaving prison face the same issues as those whom liaison and diversion teams want to place on pathways of support on leaving police custody and court. Not all mainstream community support and care services (including mental health services) yet consider offenders as being part of 'their business'.

Initiatives that offer promise are ones that have been developed to support the general release from prison experience. There are various ‘through the gate’ initiatives across the country. The instigator of many of these was the work in London conducted by St Giles Trust and reported on by Pro Bono Economics (2009). This demonstrated the promise of this type of approach and the people leaving prison supported by St Giles Trust had significantly reduced reoffending when compared with national data on reoffending. The support offered included meeting and assessing need pre-release and then a tailored package of support on release with follow-up. The Through the Gate initiative formed a significant part of the Payments by Results resettlement pilot currently under way at HMP Peterborough (and expanded to HMP Doncaster). The reports on this pilot are positive and indicate reduced reoffending (Ministry of Justice, 2014b).

The Bradley Report’s vision included Criminal Justice Mental Health Teams and saw these as having a role in supporting former clients or those referred by mental health inreach teams. This is currently not within the scope of the liaison and diversion Operating Model. Some liaison and diversion services outside of the ten pilot sites programme do provide this service for people known to them leaving prison. It has been reported to the Commission that this service is vital to those clients as it fills a gap in provision, and provides them with necessary support while the liaison and diversion service advocates on their behalf with mainstream services.

Typically the needs of people leaving prison are in:

- Housing
- accessing finance
- crisis support
- routes to employment
- friendship and leisure
- access to appropriate mental health and health care

The Commission is of the view that an all stages diversion approach should be the aim and that the model of diversion should consider people leaving prison as within scope. Until they are considered such and provided for, there is a significant gap in provision. It may be more appropriate that the funding for this should come from Clinical Commissioning Groups (CCGs), but this in itself should not exclude such provision from the Operating Model.

6. Partnership working

The Bradley Report wanted mechanisms to be developed to support cross-government working as well as arrangements to hold government to account. The Commission is satisfied that there is cross government support and engagement in this area, and commend the efforts of the Bradley Group, an alliance of largely voluntary sector organisations formed from what was the National Advisory Group (which had membership of organisations from variety of public and voluntary services and also professional institutes) that supported the initial phase of development.

The Bradley Report recommended that offenders with vulnerabilities featured in the NHS Operating Framework. The Commission is satisfied that this has been achieved. The final Operating Framework (Department of Health, 2011) did make specific mention of improving offender mental health services, as does the Mandate for the NHS (Department of Health, 2013) which supports “developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community, including through development of liaison and diversion services” (page 25). It is crucial that the Mandate continues to focus on this area in future iterations.

Involving service users

The Bradley Report specifically wanted prisoners and other offenders to have the same access to complaints procedures as other patients, e.g. PALS (Patient Advice and Liaison Services), which is standard through community services. The Department of Health responded with a toolkit to support the implementation of PALS in prisons (2009b), and such services are now accessible to prisoners.

Service user engagement and involvement is also a key component of the liaison and diversion Operating Model, and progress on achieving this is being monitored by

NHS England across all ten pilot sites. The Commission has found much in the way of support for co-produced services between service users and professionals and feels that such approaches are a route to genuine service user involvement.

Joint Inspections

There are several bodies with a role in inspection and monitoring or dealing with complaints in prisons, youth custody settings and police custody (e.g. Care Quality Commission, Her Majesty’s Inspectorate of Prisons, Her Majesty’s Inspectorate of Constabulary, Prison and Probation Ombudsman, Independent Police Complaints Commission Independent Monitoring Boards, Ofsted, Office of the Children’s Commissioner for England, Healthcare Inspectorate Wales and Healthwatch). The Bradley Report saw a role for several of these bodies, and the then five inspectorate bodies in particular, to, where appropriate, work in a joined up way. This is certainly a common feature of inspections. For example a thematic review of the use of police cells for people suffering poor mental health (HMIC, 2013) was the result of joint inspection work by Her Majesty’s Inspectorate of Constabulary, Her Majesty’s Inspectorate of Prisons, the Care Quality Commission and the Healthcare Inspectorate Wales.

Information Systems

The sharing of information and having better developed information systems capable of this sharing was seen as critical by the Bradley Report and featured in the recommendations. Connecting for Health, which featured in a recommendation, and Offender Health IT functions now come under the Health and Social Care information Centre. All prison healthcare departments now have a standardised electronic clinical information system - TPP SystemOne Prison. Having been piloted, this

was introduced across the prison estate in 2011. Prior to this system being in place it was common for medical information not to be transferred when prisoners were. However, the main issue with this system is that it is not linked with other health information systems outside prisons. So a prisoner arriving from court will often arrive with little or no information and there are currently no means of electronically connecting to health knowledge about new arrivals.

Having liaison and diversion practitioners working in police stations and courts has meant that information on previously known service users is now more available to inform decision making. However, the ability to access this information onsite (i.e. while at the police station or court) varies considerably. Mental health practitioners working in police control centres have made clinical information available to front line officers and at the very beginning of their contact with a vulnerable person in the street. The weakness in this is that while many mental health trusts use similar systems, each trust's system is in effect 'standalone' and in areas where there is a more transient population (e.g. urban centres and entertainment zones) those from other areas, even with a history of service use, may not feature on the local mental health trust's system.

Crisis Care Concordat

A significant policy driver for future partnership working is the Crisis Care Concordat (HM Government, 2014), a declaration to provide a better and more consistent crisis response to people with mental health problems, and to do so at the earliest opportunity. The Concordat is a commitment to multi-agency working, particularly by police, mental health trusts and paramedic services, and has been endorsed and signed by 20 national organisations. Central to it is a desire to reduce unnecessary detentions in police custody.

Keys to the successful operationalisation of the concordat are:

- Liaison and diversion and the standardisation of the approach to this via the adoption of the Operating Model
- Street triage
- The Mental Health Action Plan (DH, 2014)
- The Concordat is backed by a 47 point action plan for various public bodies divided into five key areas:
- Commissioning to allow earlier intervention and responsive crisis services
- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well / preventing future crises

The themes pervading the Concordat are early intervention and prevention and a recognition of the multi-agency nature of this.

Complexity and Multiplicity

Centre for Mental Health recently conducted a study (Durcan, 2014), funded by LankellyChase Foundation, exploring how multiple and complex needs of people coming into contact with the criminal justice system might best be met. Service users' views in particular were sought and the study revealed that services most likely to achieve the answer to 'diversion to what?' tended to have the following characteristics:

- A comprehensive knowledge of local social and health economies and relationships with agencies across it
- Engagement as a key activity
- A psycho-social orientation
- Immediate access (within team) to housing and benefits advice
- Service user's view of their needs being at the core of their assessment

- A focus on meeting basic needs first
- Being sufficiently resourced to connect people to a range of services (this might include accompanying people to appointments)
- Pro-activity and assertiveness (services that are active and not just reactive to a client's needs and where possible offer not just a formal appointment based service)
- Providing some indefinite support with a focus on crises and educating service users on averting these
- Providing a drop-in service after the initial intervention
- An interest in outcomes and following up on referrals and signposting
- Understanding the needs of police, probation and sentencers
- Improving mental health awareness among criminal justice agencies and staff.

7. Conclusion

The Commission is pleased to report that much has been achieved over the past five years and very significant progress has been made towards achieving the vision laid out in the Bradley Report. The Crisis Care Concordat, the National Liaison and Diversion Development Programme and its Operating Model, and the Street Triage pilots are considerable achievements and demonstrate a genuine commitment to partnership working.

A common theme emerges from the evidence the Commission has collected on the three themes it has explored and the evidence it has collected on progress towards achieving the full Bradley Report vision. This theme concerns continuity and what happens beyond the prison gate and the doors of the police station and the court. The pathways out of the criminal justice system are the responsibility of a multitude of agencies and their commissioning bodies, not least, some 211 CCGs and 150 local authorities.

Just addressing the mental health problems or learning disabilities of those exiting the criminal justice system would be challenge enough. However, those leaving the criminal justice system tend to have complex and multiple problems and require a response that can address these. Inevitably this needs to be a multi-agency response.

A significant barrier to successful integration into society is access to housing, and the Commission is pleased to see that a requirement for housing expertise in liaison and diversion services features in the Operating Model. It is clear to the Commission, that the question of ‘diversion to what?’ needs to be answered by Health and Wellbeing Boards and their members, and that many are yet to step up to the mark.

The Operating Model for liaison and diversion will doubtless be amended as new evidence emerges, but the Commission feels that revision could and should be made to it now.

The Commission would wish that the Operating Model become much more of a total model, as described in the Bradley Report, and include all stages of diversion, regardless of who funds which elements. How a pathway is delivered will always vary by locality, but a pathway must be in place and it must be an expectation that the responsible commissioning body provide it.

Understanding need is as critical in this area as in any and the Commission would urge that two activities take place. The prison psychiatric morbidity study conducted in 1997, provided for the first time clarity over the size of the problem. The Commission believes this should be repeated, but expanded in scope and include all criminal justice settings, for all ages and cover a broader range of vulnerability. We would also urge that a programme of research to support and develop the evidence base should be created. The Commission has been made aware of an intention to commission research on liaison and diversion, and having a standardised model provides a great opportunity. However, the Commission is also aware that such research has been on the agenda previously only to disappear.

There is considerable activity concerning spreading mental health (and learning disability) awareness across the criminal justice workforce. However, the Commission is unpersuaded that all those prison, police and probation officers that require training receive adequate training. Liaison and diversion workers will doubtless be an important vehicle for this, through regular contact with other front line professionals and through offering formal training. The Commission feels there also needs to be a commitment from agencies whose staff could benefit from the training to releasing staff to attend it.

8. Recommendations

The Commission has made recommendations in each of its briefing papers regarding specific areas of concern. In addition to those, the Commission recommends:

1. Assuring adherence to the Youth Justice Liaison and Diversion model:

NHS England should subject this element of the liaison and diversion programme to additional scrutiny from stakeholders with expertise in this area – this could take the form of a youth Justice and mental health reference body with a role in providing assurance to NHS England and partners.

2. Ensuring the availability of Appropriate Adults and Intermediaries:

a) A register of Appropriate Adults should be held in all police custody suites and indeed any facility where a vulnerable person is likely to be interviewed; likewise all courts should hold registers of Intermediaries.

b) Funding arrangements for both Appropriate Adult and Intermediary schemes need to be clarified.

c) The same arrangement that are available for vulnerable witnesses should be applied to vulnerable defendants without any further delay and specific guidance and instruction provided to sentencers.

3. Developing an Operating Model for Prison Mental Health Care:

NHS England should replicate its efforts in achieving standardisation in liaison and diversion services by developing an Operating Model for prison mental health & learning disability care.

This should include accommodating multiple and complex need, a recovery orientated approach, primary mental healthcare, engagement with service users and co-production of services and the needs of special populations, e.g. women, young adults, people from BME communities, those with personality disorder.

The Operating Model should support more integrated working with prison substance misuse services and resettlement should be a key part of the model.

4. Making the Operating Model for liaison and diversion an all-stage Operating Model:

a) NHS England should revise the Operating Model to include both prevention and resettlement. It should also include the Mental Health Treatment Requirement.

b) The Operating Model should map both provision and commissioning responsibility to different elements of the model.

c) In addition to the Operating Model, guidance for CCGs and others should be produced to support their commissioning of diversion pathways

5. The Government should establish a review to identify solutions to achieving appropriate accommodation for offenders with vulnerabilities.

This review should consider the viability of a Housing First approach (Centre for Mental Health, 2012).

6. Assuring efficient transfer to and from secure mental healthcare:

NHS England and the Ministry of Justice should review progress towards the 15 recommendations made by Centre for Mental Health on secure care pathways (2011).

- 7. The Department of Health should commission a study of the prevalence of poor mental health, learning disability and other vulnerabilities throughout the criminal justice system.**

This study should be all age, cover a broad range of vulnerability and be conducted across all criminal justice settings.

- 8. NHS England, Public Health England, Department of Health, Department for Education, Department for Communities and Local Government, Home Office and Ministry of Justice should work with health and social care research commissioning bodies to achieve a programme of research to develop the evidence base for liaison and diversion.**
- 9. A new Concordat should be developed committing all key agencies to ensuring all front line workers (e.g. from police, ambulance services, prison service, probation & CRCs, Youth Offending services and Emergency Departments) receive appropriate mental health awareness and regular updated training.**

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