Havering
LONDON BOROUGH

**REPORT OF THE CRIME AND DISORDER SUB-COMMITTEE
TOPIC GROUP TO REVIEW HOW THE CRIMINAL JUSTICE SYSTEM DEALS WITH OFFENDERS WITH MENTAL HEALTH ISSUES.**

1.0 BACKGROUND

1.1 At its meeting on 24 September 2015, the Crime & Disorder Sub-Committee agreed to establish a topic group to look at how people with mental health issues were supported by the Justice System. One of the main reasons why the topic group entered into discussion of this topic was, the Bradley Report highlighted that one of the main weakness/failures of the current court disposal system is that the Judge has 13 different means of disposal for individuals with mental health issues. These routes are very rarely used because in most instances there is not any qualified psychiatric professionals available, to write a report in support of individual's needs. It was on this basis that the members were exploring the difference made to the service support through having a Court Liaison Psychiatric Nurse team, being available for the aforementioned. This is used in what was South Essex Partnership Trust. The Sub-Committee indicated that information should be sought from the North East London NHS Foundation Trust, the Clinical Commissioning Group, Public Health as well as obtaining an understanding of what happens in the custody system and how magistrates handle complex cases.

1.2 All members of the Committee indicated a desire to serve on the Topic Group.

1.3 The topic group met on five occasions, inviting two of the stakeholders to each meeting.

2.0 SCOPE OF THE REVIEW

2.1 The Topic Group:

- was looking to identify weaknesses, if any, and make recommendations to partners on ways to tackle those weaknesses;
- was looking to assess how the various agencies deal with offenders with mental health issues;
- was seeking to identify ways in which the process could be improved; and
- investigated the various stages at which the Justice system interacted with people with mental health issues.

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3.0 FINDINGS

3.1 **Metropolitan Police**

3.1.1 For most persons who commit an offence, their first interaction with the Justice System is likely to be with the police.

- A lawful arrest by a police constable requires two elements:
  - a person's involvement, suspected involvement or attempted involvement in the commission of a criminal offence; and
  - reasonable grounds for believing that the person's arrest is necessary.

3.1.2 At this stage, the arresting officer has the responsibility to make a preliminary assessment. A decision may be made that the offender needs to be taken to a place of safety as defined by section 136 of the Mental Health Act 1983. A place of safety can be a hospital or a police station. The police can do this if they think the offender has a mental illness and is in need of care.

3.1.3 If the decision is taken to arrest the offender he/she would be transported to the Custody Suite where the Custody Officer would carry out an assessment. The Custody Officer has the support of a Liaison and Diversion Officer (Mental Health Practitioner). Only the larger Custody Suites have a Nurse Practitioner available.

3.1.4 Custody suites were managed by the Metropolitan Police Detention Service, a centrally provided resource separate from the Borough Command.

3.1.5 The Liaison and Diversion (L&D) programme is a cross-government initiative, with partners from NHS England, Department of Health, Home Office, HM Courts and Tribunals Service, National Offender Management Service, Public Health England, the Offender Health Collaborative (OHC) and the Bradley Review Group.

3.1.6 Liaison and Diversion services are intended to improve the health and criminal justice outcomes for adults and children who come into contact with the criminal justice system where a range of complex needs are identified as factors in their offending behaviour. Liaison and Diversion services should ensure that these individuals can access appropriate interventions in order to reduce health inequalities, improve physical and mental health, tackle offending behaviour including substance misuse, reduce crime and re-offending, and increase the efficiency and effectiveness of the criminal justice system.

3.1.7 If the Mental Health Practitioner has concerns they may:

- Call the Forensic Medical Examiner;
- Call an Approved Mental Health Practitioner;

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- Refer the offender to a Community Worker;
- Provide an Early Intervention;
- Involve a Drug or Alcohol Worker; or
- Refer the offender to their GP.

3.1.8 Whatever the outcome the case notes were shared with the Court Liaison and Diversion Officer. The aim is to ensure that the offender receives the correct support.

3.1.9 Once an offender is secured in a cell the level of care does not diminish. The Detention Service has 4 levels of supervision based on their assessment of the level of risk associated with the offender:

- Viewed every ½ hour;
- Visited and aroused every half hour;
- If an offender fails to arouse in 2 hours a decision can be taken to call for the Forensic Medical Examiner and ambulance; and
- Constant supervision – Dedicated Detention Officer will physically sit in the cell with the offender.

3.1.10 Before an offender is released there will be a pre-release assessment.

3.1.11 By 2017/18 every custody suite would have a Mental Health Practitioner available.

3.2 <u>Youth Offending Service</u>

3.2.1 When a Young Person is arrested the arresting officer will assess whether they have any emotional well-being needs. The Young Person will then be referred to the Liaison Officer at the Police Station. The Liaison Officer is employed by the 'Together Partnership' commissioned by the North East London Foundation Trust (NELFT).

3.2.2 Provided the Young Person gives their consent, the Liaison Officer will complete an assessment. If the assessment indicates any emotional or well-being concerns, the Young Person will be referred to the Children and Adolescent Mental Health Services (CAMHS) triage team.

3.2.3 An email would be sent to the CAMHS Youth Offending Service (YOS) Nurse Practitioner, so the YOS were aware of the Young Person before charge/sentence at Court. The CAMHS YOS Nurse Practitioner would liaise with the YOS Police Constable to ensure joined up working.

3.2.4 The Young Person has the choice to engage with, and obtain support from Mental Health Services as early as arrest. This enabled concerns to be highlighted at the earliest opportunity to avoid reoffending.

3.2.5 This holistic assessment provides support for the young person in all areas of their life and is used by the liaison officer to provide professional support.

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3.2.6 There were some gaps:

- The liaison service only operates 9.00am to 5.00pm on Mondays to Fridays, with a limited service available on Saturdays and Sundays.
- Young Persons arrested outside these hours may 'fall through the net'.
- A young person can refuse the service; meaning early intervention is made more difficult.
- After the initial assessment, the Young Person can be bailed for months or not charged – where is the follow up?
- There is currently no liaison officer engaging Young People at court. This meant that there was no follow up on the arrest assessment and no support for Young Persons who present in the cells with emotional well-being needs.
- YOS felt that this service had been withdrawn because it was considered that the CAMHS YOS Nurse Practitioner would be managing the young person. However, there was no support for that Young Person if they did not come through to the YOS.
- All Young Persons coming through pre-court or post court will have an assessment by a YOS practitioner.

3.2.7 The Youth Justice Board required all Youth Offending Teams to establish a written agreement with the Primary Care Trust setting out how Children and Adolescence Mental Health Services (CAMHS) could be accessed for young people known to the Youth Offending Team with assessed mental health needs.

3.2.8 The CAMHS YOS Nurse Practitioner spoke about her role.

- Any significant concerns identified around emotional well-being would be referred to the CAMHS YOS Nurse Practitioner;
- She would clarify the mental health issues and where necessary prepare nursing reports for Youth Courts, as addendums to the Pre-Sentence Reports;
- Where mental health has been identified as the primary reason for offending, the CAMHS YOS Nurse Practitioner would work with the YOS worker to provide support and specialist interventions;
- As necessary she would make referrals to specialist services for further assessment and specialist interventions;
- Provide support and advice to young people, families or main carers with identified mental health needs;
- Provide training and education;
- Attend the weekly Risk Review Panel meetings;
- Offer assessments to the parents/carers or siblings of the young people accepted on to their caseload;
- Facilitate groups e.g. Anger Management, Self-Harming;
- Attempt to maintain therapeutic contact with Young People in custody in the following circumstances:
  - If the Young Person was going to be released into the community

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with emotional well-being needs;
    - If the Young person is open to working with CAMHS prior to a custodial sentence
- Whilst the Young Person is in custody, there would be focus on establishing and maintaining a relationship.
- A major challenge facing the system was the transition from Young Person to adult. NELFT started preparing for transition 2 years prior to the time to ensure a smooth a transition as possible.

3.3 North East London NHS Foundation Trust (NELFT)

3.3.1 NELFT had two section 136 suites available and these had always proved adequate.

3.3.2 Compared with other Trusts, NELFT maintained a relatively small number of mental health beds. This had never caused a problem because they prefer to engage patients in the community.

3.3.3 If an offender with mental health issues needed to be detained, NELFT's Police Triage Team would undertake a preliminary assessment and refer the patient to Goodmayes for a detailed assessment.

3.3.4 Patients may be detained under either section 2 or section 3 of the Mental Health Act. Patients must be seen by an Approved Mental Health Professional first before detention. Section 2 lasted for 28 days; if a patient needed to be detained longer the detention would need to be upgraded to section 3.

3.3.5 Under section 3, a patient cannot refuse treatment and on discharge they can receive free aftercare.

3.3.6 If a doctor feels a patient must be upgraded from section 2 to section 3 the patient's family must give their consent.

3.3.7 If a patient presents multiple symptoms i.e. drugs and mental health, the clinicians need to tackle one problem at a time.

3.4 National Probation Service

3.4.1 Across London a project was being run in partnership with Together with Mental Wellbeing, the Forensic Mental Health Service, Community Mental Health Service and the Prison Mental Health Service to assist offenders with personality disorders.

3.4.2 The process followed for offenders referred to the Probation Service was as follows:

- An offender enters the system when convicted;
- The court can ask for an assessment which might direct the offender to a hospital for treatment or into the criminal justice system;

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- The Probation Service can recommend a specialist;
- Offenders with a high risk of harm will be dealt with by the National Probation Service;
- Offenders with a medium or low risk will be dealt with by the Community Rehabilitation Company (CRC);
- When assessing an offender, the criteria of the Multi-agency public protection arrangements (MAPPA) are also looked at;
- There are three categories of offenders who will be subject to MAPPA:

  - Registerable sexual offenders, regardless of the sentence they received (Category 1);
  - People convicted of a violent or other sexual offence (even if nobody was actually hurt), who are not registerable sexual offenders, with a 12 month or more prison sentence or hospital order, for a schedule 15 offence (Category 2);
  - Offenders who do not fall into either of the above categories, but are considered by the authorities to pose an on-going risk of serious harm to the public based on their past behaviour (Category 3).

- Offenders serving a Custodial Supervision have access to an in-reach team. There will be regular meetings and treatment will be provided;
- If as part of the licence conditions an offender has Community Supervision, they can be referred through either their GP or the Community Mental Health Team. A Care Plan would be drawn up.

3.5 **London Community Rehabilitation Company**

3.5.1 The transition between custody and return to the community was a difficult one. Communication between all parties had improved but in some cases the delay in an offender being released and the community team being informed could be as much as three months.

3.5.2 Three different treatment options were open to offenders depending on their problem. The two most common related to alcohol and drugs, the third was the Mental Health Treatment Referral (MHTR). Unfortunately the take up of the MHTR was low, with less than 1% of those likely to be helped by this being referred.

3.5.3 A number of barriers prevented the full use of the MHTR. The first of these was poor process at the court stage. It was only in a limited number of courts that an assessment service was available. A report needed to be prepared by mental health services for consideration by the court. In the absence of a court Forensic Mental Health Service this could be unreasonably delayed. A second barrier was the unwillingness of some offenders to participate with psychiatric services. In Havering there seemed to be a lack of knowledge of this option and poor liaison between Probation and Mental Health Services. There needs to be buy in at the highest levels and recognition of the benefits to every one of the use of the right treatment. If an offender was already engaged with mental health services it was easier to navigate. *However, for someone not previously known to Mental Health Services it was more difficult*

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and problematic. How effective this was depended on where an offender lived (postcode lottery). The process worked better with high risk offenders who were subject to containment.

3.5.4 Personality Disorder was now recognised as a condition which could be treated. Learning Disability and Autism Spectrum were still not recognised.

3.5.5 Anyone can access Tier 1 services through their GP. The criminal process will wait until inpatient treatment was sufficient to show an offender was fit to be in court.

3.5.6 The Topic Group were informed of the work of the London Pathways Partnership, a joint NHS/NOMS initiative. Most of these cases involved offenders who were most at risk of harm. These cases represented 10%/20% of the workload. If an offender is screened into the project they would have access to specialist provision.

3.5.7 Those who suffered from Personality Disorder and previously seen as untreatable where now receiving treatment. Historically those who did not receive treatment were locked away in large institutions and picked up by GP's. Since many of these had been closed these people had found their way in to the criminal justice system. They were vulnerable, distressed and acted out their behaviour, they were also misunderstood.

3.5.8 The environment had changed with the changes in the probation service. This was especially so with the Community Rehabilitation Company (CRC).

3.5.9 Assessment would determine an offender's pathway. Those assessed as either low or medium risk would be directed towards the CRC.

3.5.10 With regard to the MHTR, there was a high level intention to see these used but delivery at local level is very patchy. Since 2005 when these became available only 160 offenders had been given MHTRs. No MHTRs had been issued in Havering and Barking & Dagenham, just one in Redbridge and 2 in Hackney.

3.6 Havering Clinical Commissioning Group

3.6.1 The Sub-Committee were given a summary of the work and involvement of the CCG. This included:

- Forensic Mental Health commissioned by NELFT.
- Community Recovery teams work with mentally ill offenders.
- The CCG commissions services from within the NHS.
- The John Howard Unit (Hackney) provides medium secure provision for a wide area which included Havering.
- Step-down provision (S.117 Mental Health Act). The CCG agrees placements after identifying needs.

3.6.2 S.117 obliges the NHS and local authorities to provide support for those on

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Step-down coming from low and medium secure institutions. A Local Authority social worker would identify need and prepare the necessary paperwork. This would cover both medical and accommodation needs. In response to questions, the Sub-Committee were advised that the nearest provision was in Hornchurch. There were a number of independent providers giving secure, one-to-one support. Any package was worked out and agreed by the CCG with costs being apportioned.

3.6.3 The Topic Group were advised that placements were determined initially on security and safety grounds, after which effort was put into the person's work towards recovery. The aim was to 'control' bad behaviour – whatever that emanated from - but the main aim was the provision of psychiatric services before moving patients on.

3.6.4 NELFT had recently introduced 'street triage' which had been welcomed by the police as it helped them swiftly identify and address issues more effectively. Currently it was not a 24/7 provision but it might become so.

3.6.5 The Topic Group were advised that officers were aware of the provision which was a positive contribution and helped break the cycle of assessment and release which had meant that those affected were being passed between services, none of which could effectively address the problems and then being left in the same predicament that they were in at the outset.

3.6.6 There was also an increase in psychiatric liaison with 24/7 coverage in hospitals within the Trust. This was a relatively new provision and was based in A & E. It had only been 24/7 since October 2015. The Topic Group was informed that a Mental Health Programme Board had recently been set up to address issues under the Mental Health and Criminal Justice system. They were looking to put together a package which would embrace mental health, drugs and alcohol addiction/abuse.

3.7 'Delivering Integrated Mental Health Care in the Criminal Justice System'

3.7.1 Councillor de Wulverton had attended a seminar organised by Inside Government dealing with the above. The seminar had looked at the same issues being considered by the Topic Group. Councillor de Wulverton advised that the starting point for most of the speakers was the Bradley report 'Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.'

3.7.2 Lord McNally, Chair of the Youth Justice Board addressed the issue of Youth Offenders with mental health conditions. One of the keys to success was the effective integration of services. Over the last 15 years the Youth Justice Board has seen a reduction in the number of youth offenders from a high of 80,000 to 20,000. There had been a similar drop in the number of youth offenders detained in Youth Offender Units from 4,000 to 1,000 of whom 100 were young girls. This had been achieved by the introduction of early intervention and diversion. In recent years cases were tending to be more

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complex and offenders more needy.

3.7.3 The ‘Future in Mind’ paper published by Norman Lamb stated that under 18’s, with mental health issues, should not be placed in custody but dealt with under section 136 and taken to a place of safety.

3.7.4 Christina Marriott, Chief Executive, Revolving Doors Agency and former national lead for Health Inequalities spoke about improving rehabilitation for Offenders with Mental Health conditions, during which she gave a some statistics:

- Between 20% and 30% of police time was taken up dealing with offenders with mental health issues;
- 72% of males and 71% of female prisoners suffer 2 or more mental health problems;
- 39% of probationers have a mental health condition.

The extent of the problem was therefore clear. In her opinion criminal behaviour was a manifestation of emotional and mental disorders caused by childhood trauma.

3.7.5 For rehabilitation to be successful the service needs to work. So, how do we stop the ‘revolving door?’ She highlighted 10 emerging principles of effective support:

- **‘Someone on your side’;** consistent, positive & trusting relationships;
- **Building on strength:** strengths-based approach, more than a ‘bundle of needs and problems’;
- **Trauma Informed:** understands the emotional and behavioural and behavioural impact of trauma, facilitates reflective practice and builds resilience;
- **Tailored:** Personalised approach that addresses the full range of need, and is sensitive to particular needs of different groups;
- **Coordinated and seamless:** Brokerage & advocacy, pulls services together around client, avoids gaps in care;
- **Flexible & responsive:** Flexible approach to support and an ability to react quickly in a crisis;
- **Assertive and persistent:** Engaging outside of formal settings, continuous and consistent support;
- **‘No wrong door’:** If a service cannot provide support they take responsibility for connecting the client with someone who can;
- **Co-Produced:** Designed and delivered in partnership with service users, includes peer support;
- **Strategically supported:** Has the buy-in of senior strategic stakeholders.

3.7.6 The question was how do we deliver this approach? The Bradley Report provided answers:

a) Community based support & alternatives to custody – cost savings were required – we have to make the case!

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b) ‘Through the Gate’ – transition points were key, transforming rehabilitation gave a huge opportunity, a distinct approach for short-sentence prisoners.

3.7.7 Other speakers represented Together for Mental Wellbeing, a charity which works with the Criminal Justice service to deliver services. Their work includes:

- Early identification & Prevention;
- Liaison & Diversion
- Probation;
- Integrated Offender Management;
- And working with women.

They are the lead agency for the North and East London Liaison and Diversion Hub in partnership with North East London NHS Foundation Trust. Cluster 3 serves Ilford, Barking and Romford and provides workers in Barkingside Magistrates Court, Barkingside Youth Court and Snaresbrook Crown Court.

3.7.8 The seminar was also addressed by Jonathan Miller, Service Manager for Criminal Justice Mental Health Services, Greater Manchester West Mental Health Foundation Trust. He talked about the success of Liaison & Diversion. This needed to start at arrest, to be followed up by courtside probation services. After custody IOM was essential to reduce the risk of reoffending.

3.8 **NHS England (London Region)**

3.8.1 Hong Tan, Head of Health in the Justice Service addressed the Topic Group providing the NHS England perspective.

3.8.2 Health in the justice system affects us all:

- 70% of prisoners were not registered with a GP;
- Hep B rates were 30% higher than the general population;
- HIV rates were 12% higher than the general population;
- TB rates were 50% higher than the general population.

3.8.3 Commissioning of services was shared between four bodies:

- NHS Commissioning Board (27 Area teams) – *Commissioning majority of health services for people in ‘prison and other places of detention’, through 10 LATs)*
- Clinical Commissioning Groups (212) – *Commissioning majority of health services for offenders managed in the community or released from custody;*
- Local Authorities (152) – *Commissioning public health and care services for offenders managed in the community and released from custody;*
- Health and Wellbeing Boards (152) – *Key strategic and planning role in*

bringing together local authorities , the local NHS and communities (with other key partners) to produce Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) to underpin local commissioning plans and service planning.

3.9 **Avon And Wiltshire Mental Health Partnership**

3.9.1 Avon and Wiltshire Mental Health Partnership no longer collect data on Mental Health Treatment Referrals or on Court outcomes (NHS England no longer require this). The Senior CARS Practitioner advised that from his experience they do not often arrange Mental Health Treatment Requirements and he only knew of one that had been put in place as a result of Liaison and Diversion since he joined the Team (around 18 months). From his personal experience, the problem with MHTRs was that they required the agreement of the individual and the Team providing the care; on the few occasions he had approached care team managers to get their agreement for a MHTR they have pointed out that if the individual had agreed to a Treatment Requirement, then they are likely to be willing to work with the care team without a Court Order and it would be preferable for them to engage with the Team without being forced to. For that reason many care teams do not support a MHTR being put in place. This was just his personal experience.

3.9.2 Previously they had a Practitioner based in the Courts every day; however in the last 2 years they have moved into the Police Custody Suites in order to intervene at an earlier stage. This has been very effective as it meant that people with mental health problems were not held overnight in cells or put before the Court when they should be receiving treatment instead. Currently, once someone was assessed in Police Custody a report would be written and submitted to the relevant Court so that when the individual attended the next morning, the Judge or Magistrate would have some idea about the individual's current mental state, risk, social situation, mental capacity and any support they were currently receiving. The individual's consent was required in order to do this, however if they declined, they would still share pertinent risk information with the Court and Prison (if necessary).

3.9.3 Although they no longer had a Practitioner regularly based in the Courts, they would still respond to the Court when someone had not been picked up the previous day in Police Custody and was obviously unwell in the Court cells. In this case they would attend and assess at Court prior to their hearing. When appropriate, they would divert the individual to Hospital prior to their hearing, via the Mental Health Act.

3.9.4 Another service they provided was prearranged assessments with service users whose needs had been identified at an earlier stage, either by the Probation Service, Legal Team or by the Magistrate/Judge at an earlier hearing. In these cases they would contact the individual concerned, provide them with an appointment and then write a report based on this assessment which they would submit to the relevant parties (Defence Team, Court or Probation Officer).

3.9.5 They also provided liaison between the Courts and mental health services in arranging Psychiatric or Psychological Reports. This would be for more serious offences where the Judge felt a more in depth view of an individual's mental health was required. Either to gain insight into someone's current mental state, their mental state at the time of the offence or to look at sentencing options (such as a Hospital Order or MHTR).

4.0 CONCLUSION

4.1 A Court Liaison Psychiatric Nurse team is used in what was the South Essex Partnership Trust, whose presentation to the topic group supported the Member's hypothesis and the findings of the Bradley Report. This area needs further comparison with other NHS Trusts using Court Liaison Psychiatric Nurse teams and Havering's current care pathway, for individuals presenting at court who are not previously known to services and not registered with a GP.

4.2 Further discussion/action on this topic could not be auctioned on account of members unavailability to attend any further meetings in the run up to the Local Elections.

5.0 RECOMMENDATIONS

5.1 Metropolitan Police Service and NHS England to continue to work together to provide Mental Health Practitioners in custody suites.

5.2 North East London NHS Foundation Trust, the Youth Offending Service and the Probation Service to work together to ensure a smooth transition process for young persons in the criminal justice system to ensure continued access to mental health services.

5.3 North East London NHS Foundation Trust to continue to provide Child and Adolescent Mental Health Services (CAHMS) Youth Offenders Services Practitioner Service.

5.4 Public Health and Clinical Commissioning Group to continue to work together to ensure adequate services available locally for offenders with mental health and substance abuse issues.

6.0 ACKNOWLEDGEMENTS

During the course of its review, the topic group met and held discussions with the following people:

- Elaine Greenaway, Senior Public Health Strategist, London Borough of Havering
- Inspector Cavanaugh, Metropolitan Police Detention Service
- Liz Micalap, Mental Health Practitioner

- Tim Churchyard, YOS Manager, London Borough of Havering
- Janet Chapman, CAMHS Nurse Practitioner
- Wellington Makala, NELFT
- Anita-Grant Williams, National Probation Service
- Sonja de Groede, National Probation Service
- Yasmin Lakhi, London Community Rehabilitation Company
- Bob Barr, Havering Clinical Commissioning Group
- Bernard Natale, Mental Health Commissioning, LBH
- Hong Tan, NHS England

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