



A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders

November 2021

Contents

Foreword	4
Contextual facts	6
Executive summary	7
Recommendations	12
1. Background	14
2. The voice of the individual	24
3. Policing - Key findings	35
4. Liaison and diversion services (England) and criminal justice liaison services (Wales) – key findings	39
5. Prosecution and court – Key findings	43
6. Probation – Key findings	47
7. Prisons and resettlement – Key Findings	50
Additional Information	53
3. Policing	53
3.1. National Strategic leadership	53
3.2. Local senior leadership and strategic partnerships	54
3.3. Local processes and behaviours	57
4. Liaison and diversion services (England) and criminal justice liaison services (Wales)	69
4.1. Leadership	69
4.2. Staffing and training	70
4.3. Services	71
4.4. Information and facilities	72
4.5. Quality of service delivery	74
5. Prosecution and court	76
5.1. CPS oversight and training	76
5.2. Quality of information provided to the CPS	76
5.3. Quality of information provided to defence lawyers	77
5.4. Information-sharing	78
5.5. Identification of mental health	79
5.6. Service delivery at court	79
5.7. Intermediaries and special measure applications	80
5.8. Unrepresented defendants	80
5.9. Liaison and diversion reports	81
5.10. Psychiatric reports	81
5.11. Probation pre-sentence reports	82

6. Probation	85
6.1. Leadership.....	85
6.2. Skills of probation practitioners.....	86
6.3. Services.....	87
6.4. Information and facilities	89
6.5. Casework	91
7. Prisons and resettlement.....	96
7.1. Identification and assessment	96
7.2. Service delivery.....	97
7.3. Prisoner views.....	97
7.4. Training and development.....	98
7.5. Treatment	98
7.6. Resettlement	100
7.7. Release	101
7.8. Mental health services on release	101
References	103
Annexe 1: Glossary	107
Annexe 2: Methodology	111
Annex 3: Expert reference group.....	117

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Foreword

In 2009, the Bradley Report (Bradley, 2009) provided a comprehensive review of the experience of a person with mental health and learning disabilities in the criminal justice system (CJS). According to its author, *'failure to adequately address the mental health needs of offenders is a fundamental cause of the chronic dysfunction of our criminal justice system'*. In the same year a joint criminal justice inspectorate report focusing on the services provided before sentence made five recommendations and echoed a number of the Bradley review findings.

This new inspection was a significant undertaking, with input from the four criminal justice inspectorates and the healthcare inspectorates in England and Wales. It follows the progress of individuals through the CJS from first contact with the police to release from prison. Over 300 cases were reviewed in total and some 550 professionals interviewed. Penal Reform Solutions, a user engagement consultancy, interviewed 67 individuals with mental health problems who had progressed through the CJS as arrestees or convicted persons. A report of their findings is published alongside this one. Our combined work highlights some disappointing findings and makes clear that not enough progress has been made in the 12 years since the Bradley review and our last joint inspection.

There continues to be no common definition of mental health used in the CJS and this leads to individuals' needs being missed as they progress through the system. The absence of a common definition affects how cases are flagged in different agencies, with a number of individuals being missed early in the process. Information from the police to the Crown Prosecution Service about an individual's mental health needs is often not clearly communicated or transferred at all, even when it is identified. This makes timely and appropriate charging decisions more difficult and can have an impact on court proceedings. Following court, the mental health flagging system used by the probation service is not helping practitioners to fully identify the risk and level of need presented.

Strategic leaders across the CJS must make better use of the data that is available but not always systematically collected or used to inform service delivery on the ground. Incorrect interpretation of data protection regulations means that important information is not exchanged, leading to poorer assessments and poorer mental health outcomes. A Memorandum of Understanding on information-sharing needs to be agreed urgently with all partners involved in managing this journey through the CJS.

Courts face concerning delays in the timely production of psychiatric reports. There is a shortage of good-quality mental health provision and unacceptable delays in accessing services. Judges expressed frustration and concern that defendants with mental ill-health sometimes had to be remanded in prison to await an assessment or receive other support due to a lack of appropriate alternatives.

Further, and most distressingly, acutely unwell prisoners who require urgent transfer to a secure mental health inpatient hospital for treatment experience long waits in prison. Seriously mentally unwell prisoners are being held in conditions that worsen their mental health.

Mental ill-health can pose significant challenges for criminal justice agencies, particularly at the front-end. There have been some improvements since Lord Bradley's review – in particular, the roll-out of mental health liaison and diversion services in police stations and courts and a reduction in the use of police custody as a 'place of safety' for people in mental health crisis, through the use of 'section 136' beds. And we found that police officers had a good understanding that minor crime, particularly crime caused by the mental health crisis itself, could be swiftly discontinued in favour of a health care approach.

The Covid-19 pandemic has undoubtedly had a significant impact on staff and on services to support wellbeing. All inspectorates acknowledge the challenges this has created and recognise the humanity with which staff have carried out their work. Staff recognise the impact that poor mental

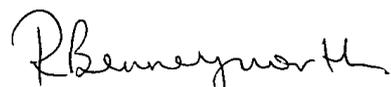
health can have and how it can increase offending. However, in every agency, there are learning and development needs which, if addressed well, will support better mental health outcomes.

We hope that our findings, while challenging, will act as a driving force to bring about changes in practice and performance.



Justin Russell

HM Chief Inspector of Probation



Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care Quality Commission



Andrew T. Cayley

Her Majesty's Chief Inspector of the Crown Prosecution Service Inspectorate



Alun Jones

Interim Chief Executive Healthcare Inspectorate Wales



Charlie Taylor

Her Majesty's Chief Inspector of Prisons



Wendy Williams CBE

Her Majesty's Inspector of Constabulary

Contextual facts

Mental health in the criminal justice system: key facts

Police	
159	Number of detentions in England and Wales under section 136 of the <i>Mental Health Act 1983</i> , where a police station was used as a place of safety, 2019/2020 ¹
29%	Percentage of those in police custody identified as having a current mental illness ²
Liaison and diversion	
71%	Percentage of those referred to a liaison and diversion scheme who had a mental health need ³
Courts	
1%	Percentage of all requirements commenced under community orders and suspended sentence orders that were Mental Health Treatment Requirements, England and Wales, 2020 ⁴
Prison	
52%	Percentage of prisoners with self-reported mental health problems during the pandemic ⁵
22%	Percentage of prisoners who responded that it was easy to see mental health workers during the pandemic ⁶
691	Number of self-harm incidents per 1,000 prisoners in 2020 ⁷
67	Number of self-inflicted deaths in prison, 2020 ⁸
Probation	
36%	Percentage of inspected probation cases (2018/2019) where mental health needs and disorders were identified as a disability ⁹
38%	Percentage of inspected probation cases (2016/2017) where emotional wellbeing was identified as a priority need ¹⁰

¹ Home Office. (2020). *Detention under the Mental Health Act (1983): Police powers and procedures, 2019/20*. Includes those initially detained for offences and subsequently detained under section 136 of the Mental Health Act.

² Figure based on a cohort of 134 people. Samele, C. et al. (2021). 'The prevalence of mental illness and unmet needs of police custody detainees', *Criminal Behaviour and Mental Health*, 31(2), pp. 80–95.

³ Disley, E et al. (2021). *Outcome Evaluation of the National Model for Liaison and Diversion*. Santa Monica and Cambridge: RAND Corporation.

⁴ Ministry of Justice. (2021). *Offender Management Statistics Quarterly: Probation, October to December 2020, England and Wales*.

⁵ HM Inspectorate of Prisons. (2021). *HM Chief Inspector of Prisons for England and Wales: Annual Report 2020–21*. London: HM Inspectorate of Prisons.

⁶ Ibid

⁷ Ministry of Justice. (2021). *Safety in Custody Statistics: self-harm annual tables 2004-2020, England and Wales*.

⁸ Ministry of Justice. (2021). *Safety in custody Statistics: Deaths annual tables 1978-2020, England and Wales*.

⁹ Unpublished analysis of HM Inspectorate of Probation data.

¹⁰ HM Inspectorate of Probation. (2019). *The availability and delivery of interventions (probation services)*.

Executive summary

Why should the Criminal Justice System be concerned with the mental health of those passing through the system?

We know that rates of mental ill-health are high among those who pass through the CJS. Around a third of people¹¹ who find themselves in police custody have some form of mental health difficulty, as do 48 per cent of men and 70 per cent of women in prison.¹² Some 38 per cent of people on probation supervision are recorded as having a mental health issue.¹³

But why does this matter?

First, because people with a mental illness need and deserve treatment. Entry into the CJS can provide a second chance for people who have been missed by other services to access that treatment and an incentive for them to take up that offer.

Second, because mental illness and the symptoms associated with it can trigger criminal behaviour and therefore bring a person into contact with the CJS. Decisions then need to be made on whether a criminal charge is in the public interest or whether an alternative disposal (such as diversion into mental health treatment) would be more appropriate.

Third, mental illness, particularly the more severe forms, can affect an individual's ability to understand and participate in the criminal justice process. They may need additional support to understand the questions put to them during an investigation or at trial or they may lack the mental capacity to plead or stand trial.

Fourth, the criminal justice process itself, for example the experience of custody, can have a severe and negative impact on someone's mental health, particularly if they are already suffering a mental illness. In these circumstances, there is a duty of care to try to mitigate these wherever possible. This includes a duty to reduce the risks of suicide and self-harm, which we know to be high in criminal justice populations.

For all these reasons, it is essential that those with a mental health condition or disorder are identified as early as possible in their journey through the CJS, particularly where that problem is severe. Once the mental health issue is identified, information relevant to that issue must be shared between agencies so that appropriate support and treatment can be offered, and the right decisions made at each step of the journey from arrest to sentence and post-sentence supervision in custody or in the community.

This inspection, the first on this topic to involve all of the criminal justice inspectorates, and to consider post-sentence supervision, as well as the period leading up to trial, focuses on these critical issues:

- Are people with a mental illness identified when they first come into the CJS?
- Is this information passed on through the rest of the system from the police and defence lawyers to the Crown Prosecution Service (CPS) and the courts or from the courts to the probation and prison services so that the right decisions can be made about next steps?
- Are people with a mental illness entering the CJS being properly assessed and then referred for help or treatment where this is identified as necessary?

¹¹ Figure based on a cohort of 134 people. Samele, C. et al. (2021). 'The prevalence of mental illness and unmet needs of police custody detainees', *Criminal Behaviour and Mental Health*, 31(2), pp. 80–95.

¹² Prisoner survey 01 April 2019 and 30 June 2020 (HMI Prisons).

¹³ HM Inspectorate of Probation. (2019). *The availability and delivery of interventions (probation services)*.

- What is the quality of support they are getting? Is it timely and adequately resourced or are people having to wait many months to get it?
- Are the most seriously mentally ill people being looked after in appropriate settings and places of safety, or is custody still having to be used?

Methodology

This joint inspection looked at the work carried out by each part of the CJS at six locations: Birmingham, Croydon, Durham, Exeter, Greater Manchester (Bolton) and Gwent, Newport. It covered the corresponding CPS areas, police forces, liaison and diversion (L&D) schemes, probation services and prisons. Due to the Covid-19 pandemic, most of the inspection was completed remotely, with interviews and focus groups conducted online over video platforms like MS Teams. In total, 45 cases were jointly inspected by all four criminal justice inspectorates, with a further 270 cases being reviewed by single inspectorates. We interviewed some 550 staff working across the different agencies. These included operational staff (such as police officers, probation practitioners, prison officers, and key workers) middle managers (such as police sergeants, lawyers, and service provider managers) senior leaders (including judges and prison governors), and commissioners.

Children being supervised by youth offending teams, witnesses and victims were not included in the scope of this inspection.

In addition, the organisation Penal Reform Solutions was contracted to undertake remote interviews with individuals journeying through the CJS as arrestees, defendants or convicted persons. Its consultants interviewed 67 individuals (of whom nine were women and 12 identified as black, Asian or minority ethnic). A copy of their report is published separately. A detailed breakdown of our methodology can be found in Annexe 2.

Joint inspection findings

There is no common definition of mental health used across the CJS. This leads to inconsistencies in identification along all stages of an individual's criminal justice journey. When mental ill-health is identified at one stage, at the next stage it is often not. In too many instances mental ill-health is only partially identified when it should be fully identified. This results in poorer assessments and needs not being met. It also means that there is no accurate picture of the numbers of people with mental health needs and disorders in the CJS. The mental health flagging system used by probation services is muddled and the application of flagging varies considerably from one part of England and Wales to another. The registration of flags is not appropriately reviewed, and the same flags stay on case files for years without explanation. Agencies that have face-to-face contact with individuals use a range of different screening and assessment tools but do not always fully explain the purpose of the questions being asked of individuals. Therefore, the quality of the information they receive varies, leading to inaccurate decisions.

Poor information exchange

Significant problems in information exchange occur in every agency in the CJS and at every stage of an individual's criminal justice journey. This part of the system is broken and needs to be fixed urgently. The transfer of mental health information, where available, by the police to the CPS to support charging decisions is generally weak. Officers often do not include relevant material and, when the CPS asks for further information, this inevitably causes delay. This then has a negative knock-on effect in court.

There appears to be some confusion among agencies in all sectors about the General Data Protection Regulation (GDPR) restrictions. Partners need to produce a joint national Memorandum of Understanding and resolve these issues if they are to achieve better mental health outcomes. Probation practitioners are often hindered in their work by community mental health service providers who do not 'allow' them access to information held on individuals they are working with. Similarly, where there are different commissioning arrangements for custodial and

community-based mental health services, information exchange is not seamless and those being released or taken into prison do not receive the timely interventions they need.

Committed staff but many need better training and supervision

Staff are committed, passionate, resilient and want to help people to lead more fulfilling and happy lives. They show considerable humanity to individuals who have often reached the lowest point in their personal circumstances. Many, during the pandemic in particular, have gone the 'extra mile' to ensure that basic needs are met and that no one is ever alone. Some staff disclosed their own mental health struggles during the pandemic, and this was appreciated by those going through the CJS. For them, a trusting and healthy relationship with a professional, and a safe environment to talk about their traumas, help them to grow into a better life. These thoughts and feelings must be heard and used to inform effective practice.

While differing learning and development opportunities for staff exist across the CJS, not all of these are making a difference to better equip practitioners and managers to deliver high-quality services. Police officers whose primary role it is to investigate offences had received little specific input on the mental health of suspects and how this may affect decision-making. Lawyers are familiar with the CPS Code for Crown Prosecutors and the revised policy and they have access to mental health leads and policy experts if they need specific guidance. Although the guidance is clear, having some specific face-to-face training, particularly to enhance the practical aspects of identifying and dealing with these cases, would be helpful. Probation practitioners lack effective motivational interviewing skills to help individuals struggling with their emotions, and prison officers are not supported well in their continuous professional development in working with prisoners with mental health vulnerabilities. During the past 12 months, remote learning has been made available but not all has been at a sufficient level and standard to meet the needs of all CJS staff.

The personal support that staff receive from their managers is generally good. However, the quality of clinical supervision is variable and management oversight of work is not always effective. This often leads to individuals going through the CJS not obtaining the care and treatment they need. For practitioners, opportunities for learning are missed and they continue to make similar mistakes in their practice repeatedly.

Court reports need improvement and more sentences should include treatment

Information provided to courts, for example by L&D assessment reports, pre-sentence reports and psychiatric reports, varies in quality. Far too many reports contain very little analytical information about mental health needs and disorders. The exploration of trauma caused by life events is inadequate. Furthermore, the reports do not give enough attention to each individual's diverse needs and rely far too much on self-reporting. These deficits need to be removed. Some judges consider that the sentencing recommendations in the reports often lack detail about how mental health needs will be addressed. Sentencers do not consider Rehabilitation Activity Requirement conditions to be a credible way of dealing with mental health needs and disorders. However, Mental Health Treatment Requirement orders are viewed far more favourably. We are pleased that the number of Community Sentence Treatment Requirement sites are increasing. We endorse the expansion of these sites and the making of Mental Health Treatment Requirements and combined orders, where appropriate, to address dual diagnosis needs.

The alternative delivery pre-sentence report model being piloted across a number of magistrates' courts in England and Wales is welcomed. It should result in mental health needs and disorders being identified much earlier in the sentencing process and support better mental health outcomes. The process may also help to cement partnership working and more effective information-sharing.

Assessment and diversion services in police custody have improved but they need to link to the rest of the criminal justice system

There is very good coverage of L&D services across England and Wales in police custody. L&D provision in courts is not always on site and, indeed, during the pandemic the majority of assessment work has been carried out remotely. Assessments completed by L&D staff are not widely shared with partner agencies in the CJS. This causes strain. L&D teams need to be better engaged with court user groups to improve relationships. This will strengthen cross-system integration, which is much needed. The effectiveness of L&D service delivery during Covid-19 has been impeded by the loss of community mental health services. However, where L&D and community mental health services are provided by the same trust/board, service delivery has been better.

Triage services, where mental health professionals and/or social workers support policing with the initial response to incidents, exist in many locations. The provision varies between forces and few schemes are established and settled. Many are in flux and, in particular, there has been considerable withdrawal of street services in favour of control room services for efficiency reasons. The control-room-based services offer a good service, provide added value and are appreciated by police officers. The inconsistency and instability of these services is a concern, as they are considered an important tool for all forces and partners. This needs to be addressed.

A shortage of good-quality mental health provision and unacceptable delays to access it. This has worsened during the pandemic.

Individuals reported that probation and prison are the two agencies most likely to give them the mental health support they need. However, help is often not timely and access to services has been a substantial problem during the pandemic. With some notable exceptions, a shortage of good-quality mental health services, combined with cases being closed, has resulted in very few interventions being delivered. There is a shortage of specialist services for ethnic minority people, such as culturally informed interventions, and little has been done to rectify this problem for many years.

Offender Personality Disorder (OPD) pathways have been used in the National Probation Service (NPS) to help practitioners better understand the mental health needs of individuals. These are providing some benefits, especially in the current environment. However, the Community Rehabilitation Companies (CRCs) did not have this facility. Following unification of these separate probation services into a single national service at the end of June 2021, there is an opportunity to make these pathways available to all who need them. Psychologists based in these OPD teams have led additional remote learning related to mental health, but this has not yet improved the overall quality of work. The Intensive Intervention and Risk Management Service, available in a number of regions, is now working much more effectively. We welcome this additional investment.

Prisons continue to be used as a place of safety, and Mental Health Act transfers out of prison custody are taking far too long. This is totally unacceptable. Shortages of local mental health beds for longer-term care remain a problem in a number of areas. This leads to vulnerable individuals with complex needs being kept in prison custody for far too long without timely assessments.

Mental health provision in prison has improved but post-release treatment and support are poor

Healthcare practitioners appropriately use nationally approved screening tools to assess the mental health needs of prisoners arriving in custody. Referrals for services generally follow thereafter. The impact of Covid-19, however, has resulted in long waiting lists for interventions. In-cell telephones were used extensively by mental health services to provide support during the restrictions; however, not all prisoners had access to an in-cell telephone.

Psychologically informed interventions, when delivered, are impressive and helping those in custody. Relationships with providers of mental health and substance misuse services are good and

this presents a foundation from which to address comorbidity issues. Prisoners who are extremely unwell and need an urgent transfer to a secure mental health inpatient hospital for treatment continue to experience unacceptable waiting times. This needs to be remedied.

The continuity of mental health care from custody into the community is generally poor. Waiting lists for services in the community are long, leaving very vulnerable people having to cope without the help they need. They often reoffend and return to prison not long after being released. RECONNECT Care after Custody is a positive initiative and needs to be nationally embedded.¹⁴

Cross-system management and leadership need to be better

Each agency in the CJS has a range of management information systems, but cross-system data is not systematically collected and analysed to promote joint working and improve mental health outcomes. Much more needs to be done to fully realise the benefits of data to inform and drive change.

Agencies across the CJS have a range of strategic intentions and governance structures linked to mental health. These are informed by policies and procedures but are not always effective in delivering positive mental health outcomes. Vulnerability is well understood. Partners come together at a number of boards. Health boards provide a focus for mental health coverage and generally work better. The impact on service delivery, however, too often depends on individual relationships with commissioners and partners rather than a drive for planned change.

Note on terminology

Our 2009 joint inspection on work prior to sentence with offenders with mental disorders (Criminal Justice Joint Inspection, 2009) noted that there was no universal agreement on the definition of an offender with a mental disorder, something that caused challenges in getting consistent estimates of the number of these offenders in the CJS. As such, for the purpose of the inspection it was decided to use the definition initially put forward by the National Association for the Care and Resettlement of Offenders (NACRO), one that was later adopted by Lord Bradley in his review of people with mental health problems and learning difficulties in the CJS (Bradley, 2009):

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

¹⁴ Information on RECONNECT Care after Custody is available on the NHS website: <https://www.england.nhs.uk/ltphimenu/wider-social-impact/reconnect-care-after-custody>

Recommendations

Recommendations should be completed within 12 months, unless otherwise stated:

The Department of Health and Social Care, Home Office, Ministry of Justice and Welsh Government should:

1. agree the most appropriate definitions to define the scope of people in the criminal justice system with mental health problems, to enable consistent identification and screening of mental health needs at different stages of an individual's journey through the criminal justice system. Nationally endorsed definitions appropriate to the criminal justice system will enable agencies to identify and flag cases consistently on local recording systems.

The Department of Health and Social Care, NHS England and Improvement and Welsh Government should:

2. ensure an adequate supply of medium and high secure beds to reduce the unacceptable waiting times for transfer from custody.

NHS England and Improvement as commissioner and Welsh Government should:

3. ensure that the needs of people in the criminal justice system are given proper regard when commissioning mental health assessment and treatment provision.

Ministry of Justice and Home Office should work with the Department of Health and Social Care and Welsh Government to:

4. develop a multi-agency Memorandum of Understanding on information sharing in order to promote better joint working and better outcomes for people with mental health problems.

The Ministry of Justice should work with NHS England and Improvement and Welsh Government to:

5. immediately ensure that acutely unwell prisoners who require secure mental health inpatient hospital treatment are transferred within 28 days, in line with NHS guidelines
6. end the inappropriate use of prison as a place of safety, and ensure that alternatives to prison are available for sentencers in line with the Mental Health Act white paper.

Her Majesty's Court and the Tribunals Service should:

7. amend the Better Case Management form so that it can record mental health conditions, to avoid unnecessary delays in charging decisions
8. ensure that Liaison and Diversion teams are included in local liaison arrangements to improve understanding of the provision and joint working relationships
9. improve the arrangements for the commissioning and monitoring of psychiatric reports in order to ensure that delays in sentencing are minimised, especially when the individual is held in custody.

Local criminal justice services (police, CPS, courts, probation, prisons) and health commissioners/providers should:

10. develop and deliver a programme of mental health awareness-raising for staff working within criminal justice services. This should include skills to better explain to individuals why they are being asked questions about their mental health so that there can be more meaningful engagement
11. jointly review arrangements to identify, assess and support people with a mental illness as they progress through the CJS to achieve better mental health outcomes and agree plans for improvement.

Local criminal justice boards should:

12. agree, produce and analyse cross system data sets to inform commissioning decisions and promote joint working
13. ensure that Liaison and Diversion mental health assessments undertaken in police custody are provided to the Crown Prosecution Service and defence lawyers to help inform charging decisions, representations for diversion and sentencing decisions.

The police service should:

14. ensure that all dedicated investigative staff receive training on vulnerability which includes inputs on responding to the needs of vulnerable suspects (as well as victims). This should be incorporated within detective training courses
15. dip sample (outcome code) OC10 and OC12 cases to assess the standard and consistency of decision making and use this to determine any training or briefing requirements and the need for any ongoing oversight
16. review the availability, prevalence, and sophistication of mental health flagging, to enhance this where possible, and to consider what meaningful and usable data can be produced from this
17. assure themselves that risks, and vulnerabilities are properly identified during risk assessment processes, particularly for voluntary attendees. They must ensure that risks are appropriately managed, including referrals to Healthcare Partners, Liaison and Diversion and the use of appropriate adults
18. Police leadership should review MG (manual of guidance) forms to include prompts or dedicated sections for suspect vulnerability to be included.

The probation service should:

19. review its mental health flagging guidance to help probation practitioners to identify and accurately record a person's mental health needs (within six months)
20. improve the quality of pre-sentence reports to ensure that they contain a comprehensive analysis of trauma, mental health needs and where indicated proposals for appropriate treatment
21. work with NHS and HMCTS to increase the use of Mental Health Treatment Requirements across England and Wales.

Her Majesty's prison service should work with NHS England and Improvement and Welsh Government to:

22. tackle the long waiting lists caused by the Covid-19 pandemic including for mental health assessments, psychological treatment, counselling and therapeutic group work.

1. Background

Many thousands of people with a mental illness will come into contact with the CJS each year. In the interests of justice and public protection most will still need to go through that process, and in our previous 2009 joint inspection, we found no demand from either criminal justice or health professionals for diverting more individuals from prosecution. However, the interests of justice also demand that people's mental health is acknowledged and supported through the criminal justice journey, so that people get the support they need and that justice outcomes are fair.

The relationship between mental illness and offending is complex (Brooker et al., 2012). However, it has been established that levels of mental illness among prisoners and others in the CJS are higher than those in the general population (National Audit Office, 2017). This link is important because:

First, people with mental illness in the CJS don't get the services they need

People with a mental illness in the CJS are what Public Health England has described as an 'underserved' population,¹⁵ with services provided that are not appropriate or accessible to them. This can be due to personal and structural barriers such as stigma, low levels of help-seeking behaviour or complex commissioning arrangements leading to fragmented pathways, as well as challenging personal and social circumstances. This lack of access to support can restrict the opportunities for early detection, monitoring and treatment of health and social problems, resulting in the health needs of this population going unmet and often escalating levels of conflict with law enforcement.

Second, the CJS itself can harm people's mental health

The criminal justice process itself, for example the experience of custody, can have a severe and negative impact on someone's mental health, particularly if they are already suffering a mental illness and there is a duty of care on the system to try to mitigate these wherever possible. This includes a duty to reduce the risks of suicide and self-harm, which we know to be high in criminal justice populations.

Third, mental illness can affect an individual's ability to understand and participate in the criminal justice process

People suffering from the symptoms of a severe mental illness may find it difficult to understand the process they are going through, including what they are being accused of or their rights to due process. And where that illness comes on top of a learning disability – and the two are often associated – that issue may be compounded.¹⁶ They may need additional support to understand the questions put to them during an investigation or at trial or they may lack the mental capacity to plead or stand trial.

¹⁵ Public Health England. (2018). *Health matters: reducing health inequalities in mental illness*.

¹⁶ Criminal Justice Joint Inspectorate. (2021). *Neurodiversity in the criminal justice system. A review of evidence*.

Fourth, the symptoms associated with mental illness can trigger criminal behaviours and therefore bring a person into contact with the CJS – particularly at times of crisis

As an emergency response service, the police, in particular, will often find themselves responding to reports of people who are suffering from an acute mental health crisis. Decisions then frequently need to be made on an appropriate place of safety and on whether a criminal charge is in the public interest or whether an alternative approach would be more appropriate. Police forces with the most advanced flagging report that mental health issues are involved in up to 13 per cent of the incidents they record and up to 24 per cent of the crimes.

In their recent academic insights paper *Maximising positive mental health outcomes for people under probation supervision*, Dr Coral Sirdifield and Professor Charlie Brooker (2020) highlight a number of reasons why maximising positive mental health outcomes is important for this population:

1. to improve the health and wellbeing of these individuals
2. as part of a wider agenda to reduce health inequalities across society
3. to improve compliance with probation
4. to reduce reoffending and thereby future criminal justice costs
5. to produce a wider community dividend through benefits such as reduced fear of crime and reduced NHS costs.

Covid-19

The impact of the Covid-19 pandemic has left no part of the UK untouched and the CJS is no exception. Exceptional delivery arrangements have been put in place and staff have worked at home where possible. Others have had to maintain frontline services in person. The most vulnerable individuals, with complex needs, have struggled, especially during the first national lockdown. Our inspections have shown that this period saw much reduced service provision or a switch from face-to-face to 'remote' delivery of services by phone or video link (for example, delivery of L&D services in police custody). A range of services are now being reintroduced through the cautious easing of restrictions, but the long-term effects, for example of being locked up in a prison cell for 23 hours a day, are yet to be fully realised. The impact on courts has been significant, with lengthy delays, especially at Crown Court. Such delays could have had a further negative impact on mental health.

Race and mental health

NHS England's report *The Five Year Forward View for Mental Health* comments that 'for many, especially black, Asian, and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital' (Mental Health Taskforce, 2016, p. 3).

People from minority ethnic groups are more likely to:

- be diagnosed with mental health problems
- be diagnosed and admitted to hospital
- experience a poor outcome from treatment
- disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health (Public Health England, 2019).

Black, Asian and minority ethnic communities have been found to be at comparatively higher risk for mental illness, as well as being disproportionately affected by associated social detriments. A recent review of the evidence around racial disparities in mental health (Bignall et al., 2019) found that:

- people from African Caribbean communities are three times more likely to be diagnosed and admitted to hospital for schizophrenia than any other group
- Irish Travellers are six times more likely to die as a result of suicide.

Individuals from black, Asian and minority ethnic groups are disproportionately represented at all stages of the CJS and those from black communities in particular have also been found to be overrepresented in mental health services (Nacro, Clinks, the Association of Mental Health Providers and the Race Equality Foundation, 2017).

When compared to the White population, those from minority ethnic groups face a greater likelihood of criminal justice involvement, including having higher chances of being stopped and searched, arrested, taken to court, and given custodial sentences (Nacro, Clinks, the Association of Mental Health Providers and the Race Equality Foundation, 2017).

Gypsies, Romany and Travellers were more likely to feel victimised in prison, more likely to be experiencing mental health problems, and less likely to feel safe in custody (HM Inspectorate of Prisons, 2014).

Previous inspection findings

The last joint thematic inspection of mental health was conducted in 2009, and was carried out by HM Inspectorate of Probation, HM Inspectorate of Court Administration, HM Inspectorate of Constabulary, and HM Crown Prosecution Service Inspectorate (Criminal Justice Joint Inspection, 2009). It examined cases where a mental disorder was identified before sentencing in order to consider how these had been handled in practice. The report found that, in almost all examined cases, concerns about the individual's mental health, even those at the lowest level of need, were followed up and considered during the pre-court and sentencing stages. However, there was no demand from either criminal justice or health professionals for diverting more individuals from prosecution. Most felt that the majority of such individuals should be expected to take responsibility for their actions, and that treatment should be alongside, rather than instead of, court action.

The recommendations from the inspection and disappointing progress achieved are shown in the below table:

2009 recommendation	Progress and any supporting evidence
We therefore recommend that the Department of Health, Department for Children, Schools and Families, the Ministry of Justice, the Youth Justice Board and the Home Office adopt a common definition that defines the scope of offenders with mental disorders.	No common definition has been adopted.
We therefore recommend that the Office for Criminal Justice Reform (OCJR), in collaboration with the Home Office, Ministry of Justice and Department of Health ensure effective cross-cutting work with offenders with mental disorders by the development	Effective information-sharing between agencies remains a significant issue. Mental health data, where collected, is not sufficiently analysed to promote joint working. Cross-cutting agency data is not systematically collected.

and implementation of guidance to local criminal justice organisations through the National Criminal Justice Board on the rigorous and systematic collection of data to promote joint working.	
We therefore recommend that police forces, in collaboration with local health and social care agencies, develop joint protocols on the location and operation of places of safety, to include agreement on the exceptional circumstances under which a police station is to be used.	Legislation and guidance have since changed. Police forces can only use custody as a place of safety in exceptional circumstances. This review found that there was compliance with this policy. However, there remain difficulties in prisons and for individuals going from court.
We therefore recommend that criminal justice organisations, in liaison with local social care organisations, engage with their local Primary Care Trusts (PCTs) to ensure that assessment and treatment facilities for offenders with mental disorders are available promptly and of good quality.	This remains an ongoing issue, with significant delays in accessing community mental health services and inpatient beds. HM Inspectorate of Constabulary and Fire and Rescue Service (HMICFRS) reports an improving picture, with some exceptions where geography, combined with lack of investment, prevents this. There is a gap in 'parity of esteem' between physical and mental health.
We therefore recommend that the Ministry of Justice and the Department of Health review the arrangements for the commissioning and monitoring of psychiatric reports in order to ensure that delays in sentencing are minimised and that the reports are of good quality.	Defence lawyers are required to apply for funding to commission a psychiatric report. They then have to find a psychiatrist who is willing to assess the defendant. It can, depending on their schedule, take time to obtain a comprehensive diagnosis and report. The experience of lawyers shows that there are fewer psychiatrists who are willing to prepare reports for the legal aid costs.

In 2015, HM Inspectorate of Constabulary (HMIC) undertook an inspection of the welfare of vulnerable people in custody, including those with mental health needs and disorders. It considered the end-to-end process of police custody, from the first point of contact to release or transfer to court or prison. Inspectors found clear evidence that custody could have been avoided for many vulnerable adults had other services been available to support them. Time limitations on call handlers and the lack of access to useful information from other agencies meant that police officers were often responding to vulnerable individuals and making decisions on whether to arrest them with little background knowledge of their circumstances. In the custody suite, police officers and staff depended on their own judgements when identifying and responding to vulnerable people, rather than being able to refer to official training or guidance. Pre-release risk assessments were not always satisfactory. Some forces did, however, have L&D teams in custody suites to arrange support for people with mental health problems when leaving custody.

HMICFRS published its *Policing and mental health: picking up the pieces* report in 2018. While the police were found to be good at recognising when people are in crisis, they lacked an understanding of the need for specialist mental health services. Inspectors called for a radical rethink of the Crisis Care Concordat, in order to guarantee that health services will

provide a timely response to mental health crises. They described the fact that people are calling the police to access healthcare as 'untenable'.

Policy context

In 2009, the Bradley Report (Bradley, 2009) provided a systematic and comprehensive review of the experience of a person with mental health and learning disabilities within the CJS. According to its author, 'failure to adequately address the mental health needs of offenders is a fundamental cause of the chronic dysfunction of our criminal justice system' (p. 12). Key themes that run throughout the report include the need for early assessment and identification of mental illness, continuity of care and support for offenders throughout their time in the CJS and joined-up partnership working, which includes timely information-sharing. Following his review, Lord Bradley made a number of recommendations as to what was needed to reduce the level of mental health issues in prisons and future reoffending (2009).

Five years on from the Bradley Report, the Centre for Mental Health conducted an independent review of improvements made and priorities for further development (Durcan et al., 2014). In the foreword, Lord Bradley noted that there had been significant progress towards achieving his recommendations. However, the report found that, while some advances had been made in making greater use of Mental Health Treatment Requirements, further development was needed to improve sentencing, with training in mental health awareness recommended for sentencers. Again, progress was seen in improving hospital care for prisoners requiring specialist treatment, but the proposed maximum waiting time of 14 days for transfer from prison had not been implemented. The report was hopeful that *Transforming Rehabilitation* would improve the journey of individuals with mental health needs and disorders during resettlement.

Mental health support in the criminal justice system

In more recent years, the government and various public bodies have highlighted ways to improve mental health support for those involved in the CJS. NHS England's report *The Five Year Forward View for Mental Health* (Mental Health Taskforce, 2016) recommended a health and justice pathway to deliver integrated interventions in the least restrictive settings, appropriate to the crime committed. The intention was for this to build on the roll-out of L&D schemes, which achieved 100 per cent coverage across England by March 2020.

Separate research into the effectiveness of L&D schemes has been conducted. Recently, the Rand Corporation published Outcome evaluation of the national model for liaison and diversion,¹⁷ which concluded that L&D schemes were cost-effective but included a finding that 'referral to L&D services does not appear to reduce reoffending'. NHS England also recommended an increase in the uptake of Mental Health Treatment Requirements as part of community sentences for all those who could benefit. Finally, mental health services in prisons and the interface with the secure care system were identified as in need of improvement. Continuity of care on release was deemed essential to support individuals' return to the community.

The National Institute for Health and Care Excellence (2017) has published guidance on assessing, diagnosing and managing the mental health requirements of adults involved in the CJS, with the aim of improving the mental health and wellbeing of this population. It

¹⁷ Disley, E. et al. (2021). *Outcome Evaluation of the National Model for Liaison and Diversion*. Santa Monica, CA: RAND Corporation. Available at: https://www.rand.org/pubs/research_reports/RRA1271-1.html.

also promotes more coordinated care planning and service organisation. Its guidelines, *Physical health of people in prison* (National Institute for Health and Care Excellence, 2016), cover mental health as part of the first-stage health assessment for people going into prison as well as continuity of mental health care for people leaving prison.

In Wales, responsibility for health (including mental health) is devolved to local health boards who have autonomy to respond to local priorities. In 2019, Welsh Government also provided an additional £1.2million (total amount, re-occurring annually) to health boards supporting public sector prisons in Wales for health services in the prisons. Health boards were asked to prioritise prison health in line with the Partnership Agreement for Prison Health. The Partnership Agreement was developed collaboratively between Welsh Government, HMPPS, the health boards and Public Health Wales – and includes four key priorities, which are: taking a whole prison approach and the wider prison environment to promote health and wellbeing, developing new standards for mental health services in the prisons, developing a new Substance Misuse Treatment Framework, and medicines management.

The Welsh Government's *Together for mental health* strategy¹⁸ places an emphasis on partners adopting preventative measures while being responsive to individual crises. Guidance on implementing the policies that flow from this strategy has been published for the following areas: mental health criminal justice liaison services; mental health services for prisoners and veterans; and children requiring mental health services within the youth justice system.

Together for mental health sets out the following (page 40):

People in the CJS with mental health needs and disorders have an equal right to treatment and support. To do this effectively will involve:

- police, health services and social services working together to implement good practice in the arrangements for the use of appropriate places of safety under sections 135 and 136 of the Mental Health Act 1983
- further development of Criminal Justice Liaison Services in police custody suites and courts to identify those in mental distress and facilitate access to care and treatment
- timely and appropriate mental health advice and reports to custody suites and the courts
- good-quality information to offenders with mental health problems and learning disabilities
- primary and specialist care services planned and delivered through partnership with health boards, local authorities, Her Majesty's Prison Service (HMPS) and other custodial contractors in line with Part one of The Mental Health (Wales) Measure 2010
- timely transfer of prisoners to general acute mental health hospitals and specialist secure hospitals under the Mental Health Act 1983

¹⁸ Welsh Government. (2012). *Together for mental health*. Available at: <https://gov.wales/together-mental-health-our-mental-health-strategy>

- multi-disciplinary risk assessment and case management undertaken prior to and at the point of release from prison for those with mental illness and co-occurring conditions such as substance misuse
- effective support with rehabilitation and resettlement prior to and at the time of release from prison.

Commissioning of mental health services for people in the English criminal justice system

Commissioning arrangements for mental health services are complex and fragmented. This can make data-sharing and continuity of care between different criminal justice settings difficult. The largest part of NHS mental health spending in England goes to clinical commissioning groups (CCGs) – groups of GPs, other doctors and nurses who buy health services for their local area based on need. The rest is spent on specialised services by NHS England, which are often services that there is less widespread demand for.

In 2016 the government published its plan for the next five years of mental health care. This highlighted that around a quarter of NHS care in England goes towards mental health, with the NHS spending about an eighth of its budget on mental health services in hospitals.

Since April 2013, responsibility for commissioning all healthcare services for prisoners in England has rested with the Health and Justice Directorate of NHS England, which in turn lets regional contracts with a range of private and NHS trust providers for provision in individual prisons.

The Health and Justice Directorate of NHS England has also been responsible for commissioning L&D services in courts and police custody, aimed at identifying, assessing and referring on people with a mental illness following arrest and detention. In 2013/2014, expenditure was £12.5 million and in 2019/2020 had risen to £66.2 million as a result of schemes being rolled out more widely.

Mental health beds

People with a serious mental illness judged to require treatment and present a risk to the public or themselves (including people transferred from prison or other parts of the CJS) may be held under the Mental Health Act in secure NHS facilities. These are contracted separately by the NHS.

Since 1987/1988, the number of mental health beds in England has fallen by 73 per cent, from around 67,100 to 18,400. In comparison, over the same period there has been a 44 per cent reduction in general and acute hospital beds, from 181,000 to 101,000. Mental health bed occupancy currently exceeds 90 per cent.

Acute hospitals for physical conditions have managed their decreasing bed numbers and increasing demand by reducing the average length of stay per patient. By contrast, while the average length of stay in a mental health inpatient unit has varied over the past 15 years it has not fallen. The reducing number of beds available in mental health services have therefore been managed largely through a reduction in the number of people admitted to hospital, and in some regions by the use of out-of-area placements.

The thresholds for admission to a mental health bed have increased; the level of mental ill-health of people admitted to hospital in 2018 was higher on average than that of

individuals admitted in 2013. Furthermore, patients discharged in 2018, although deemed clinically fit for discharge, were on average less well than patients leaving hospital in 2013.¹⁹

CCGs are accountable for commissioning healthcare for local communities, and those on probation are generally expected to access the same healthcare services as the rest of the local population. CCGs have, however, been given explicit guidance that they should purchase healthcare for those on probation.²⁰ In Wales, local health boards commission healthcare services in public sector prisons and are responsible for commissioning mainstream healthcare services that offenders in the community will access.

Further changes at the commissioning level in England will impact on how individuals in the CJS receive services. In April 2021 the current migration from CCGs to Integrated Care Systems (ICS) commissioning and provider arrangements was completed. This is likely to have potential significant implications for commissioning of mental health services. ICS partnerships bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. It is imperative that these new bodies pay due regard to the needs of individuals in the CJS.

Mental Health Act 1983

The *Mental Health Act 1983* (MHA) covers the assessment, treatment and rights of people with a mental health disorder. More specifically, it provides the legislation by which people diagnosed with a mental disorder can be detained in hospital or police custody, and have their disorder assessed and treated against their wishes if this is necessary to keep them or the public safe.

The MHA was significantly amended by the *Mental Health Act 2007*. This included the introduction of a single definition of mental disorders; extended powers of compulsion in the community – community treatment orders; broadening the range of professionals who can take on specific professional roles in relation to the 1983 Act; and changes to provision on the nearest relative. Specific to Part III, the main change from the 1983 Act regards the ‘treatability’ of a patient. Under the 1983 Act, detention and treatment on the grounds of mental impairment or psychopathic disorder could only be sanctioned if the treatment was deemed ‘likely to alleviate or prevent a deterioration’ in the patient’s condition. This could potentially exclude those with personality disorders perceived to be a danger to the public, who could not be detained, as their condition was not deemed treatable by this definition. This has now been replaced by the requirement for the availability of ‘appropriate medical treatment’ to alleviate or prevent deterioration.

In 2017, Sir Simon Wessely²¹ carried out an independent review of the MHA 1983, and concluded that the Act does not always work as well as it should, either for patients or for their families and carers. The review stated that current legislation goes too far in removing people’s autonomy and is insufficient to protect people and support them in influencing decisions about their own care. The review set out the changes that needed to be made –

¹⁹ Royal College of Psychiatrists. (2019). *Exploring Mental Health Inpatient Capacity across Sustainability and Transformation Partnerships in England*.

²⁰ Brooker, C. and Ramsbotham, D. (2014). ‘Probation and mental health: who cares?’, *British Journal of General Practice*, 64(621), pp. 170-171.

²¹ Wessely, S. (2018). *Modernising the Mental Health Act: Increasing choice, reducing compulsion*.

both in law and practice – to ensure the delivery of a mental health service that respects the patient’s views and empowers them to have control over their own care and treatment.

Recommendations that are relevant to those involved in the CJS include:

- Magistrates’ courts should have additional powers to bring them in line with Crown Courts, including being able to remand on bail someone for assessment without a conviction under section 35 of the MHA²² and to remand them for treatment under section 36 of the MHA.²³
- Prison should never be used as a ‘place of safety’ for individuals who meet the criteria for detention under the MHA.
- The time from referral for a first assessment to transfer from prison should have a statutory limit of 28 days.

Following this independent review, a white paper proposing changes to the MHA was published in 2021.²⁴ These changes are based on the four principles developed by the review and were developed in partnership with people with lived experience:

- choice and autonomy: ensure that the views and choices of service users are respected
- least restriction: ensure that the MHA’s powers are used in the least restrictive ways
- therapeutic benefit: ensure that patients are supported to get better in order that they can be discharged from the NHS
- the person as an individual: ensure that patients are seen and treated as individuals.

The white paper notes that benefits of reform will also be extended to people with serious mental illness who come into contact with the CJS, with a focus on public protection, rehabilitation and a reduction in reoffending. This includes rapid diversion to mental health care and treatment from court or from custody. Where people in prison require treatment in a mental health hospital, the transfer will take place within an appropriate timeframe to facilitate necessary care and recovery.

The review also recommends the development of a Patient and Carer Race Equality Framework (PCREF), an organisational competence framework, to improve mental health service access and outcomes in ethnic minority people. It is encouraging to note that there are additional recommendations on establishing the provision of culturally appropriate advocacy services²⁵ in partnership with local authorities and others, to determine the best way to represent the mental health needs of ethnic minority groups.

It is anticipated that the proposed changes will be supported by the NHS Long Term Plan,²⁶ which has pledged £2.3 billion of new investment for mental health services a year by 2023/2024. The plan also makes provision for better crisis care. Once enhanced services are

²² Section 35 is used to detain someone to hospital for assessment of their mental health, resulting in a report and recommendations to the court.

²³ Section 36 can be used to send someone to hospital for treatment instead of remanding them to custody.

²⁴ Department of Health and Social Care. (2021). Reforming the Mental Health Act. GOV.UK (www.gov.uk).

²⁵ House of Commons Library Briefing Paper. Number CBP 07547, 26 May 2021, Mental Health Policy in England

²⁶ NHS. (2021). *The NHS Long Term Plan*.

in place, legislation will end the use of police cells to hold someone experiencing a mental health crisis.

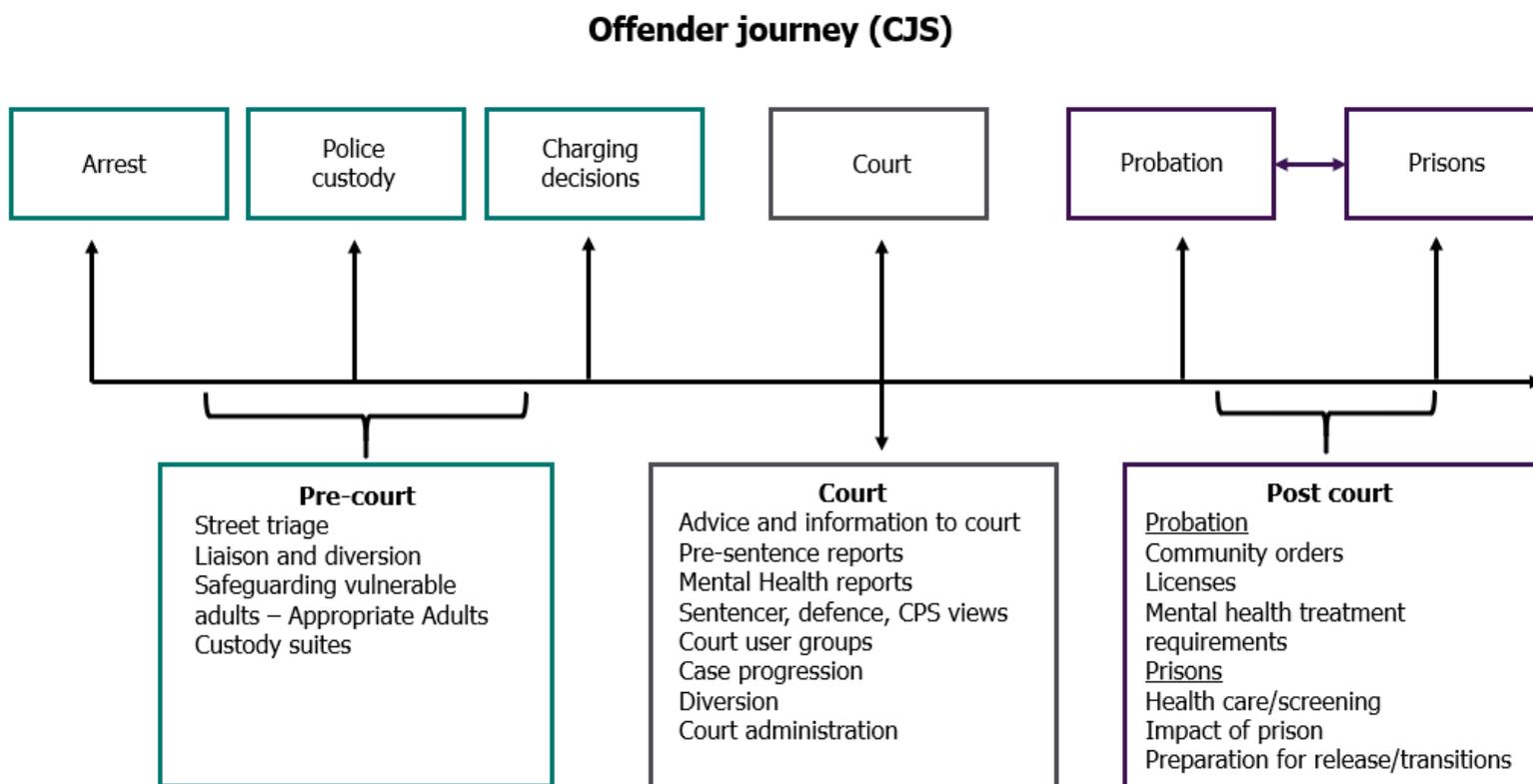
The Welsh Government and multi-agency partners established the Mental Health Crisis Care Concordat (2019),²⁷ which set out how they would improve care and support for people experiencing or at risk of mental health crisis who are likely to be detained under section 135 or section 136 of the *Mental Health Act 1983*.

²⁷ Welsh Government and Partners. (2015). *Mental Health Crisis Care Concordat*. Available at: <https://gov.wales/sites/default/files/publications/2019-03/mental-health-crisis-care-concordat.pdf>

2. The voice of the individual

Where are the opportunities to intervene and make things better?

At every stage of the criminal justice journey, as the graphic below shows, there are a number of opportunities where accurate mental health identification, good decision-making, and interventions can make a significant difference to identifying and meeting the needs of people with a mental illness.



Our report will follow this process, but we begin with the experience of the individual.

How does the criminal justice system feel to people with a mental illness?

The below case study, although not taken from our inspection sample, reflects the experiences of a family supporting an adult with mental health needs in the criminal justice system.

Case study – poor experience

Daniel, a young man with no experience of the criminal justice system, was diagnosed with bipolar disorder while at university. This was subsequently followed by more than 50 stays in his local psychiatric hospital, including some periods of being sectioned. Throughout this 20-year period, Daniel was never on remand or in prison, only in hospital or in the community.

A local community mental health outreach team engage Daniel, now in his 40s, who has become increasingly distressed following the closure of the local psychiatric hospital. Shortly after, he self-harms, attempting to take his life for the first time. Daniel is assessed by a psychiatrist who reports he is not ill enough to be sectioned. However, his mental health continues to decline. In this period, Daniel regularly calls out the police and ambulance service. There are periods of short in-patient stay in hospital. On one occasion he is discharged home summarily without the outreach team being notified.

The disturbed pattern of behaviour escalates resulting in cautions for physical assault, then incidents of criminal damage and assault. Following being detained overnight in police custody, Daniel is not given bail and is remanded in prison for some weeks, awaiting court. He becomes exceedingly disturbed despite being held on the wellbeing wing. His family offer support and engage with services at each stage.

Whilst Daniel is on remand a mental health case conference is held and concludes that he cannot be managed in the community or an acute psychiatric ward, with a recommendation for a period in a residential setting with sustained psychological support. This requires Daniel's agreement, funding and an appropriate place.

Three weeks later, Daniel appears in court. He is convicted for affray, criminal damage and assaulting a police officer. He is sentenced to one day in prison and is fined. No one in court is told about the conclusion of the case conference three weeks earlier. Daniel is immediately released from court, without medication, and without alerting the mental health services. After an extremely chaotic week, Daniel trashes his council flat and sets fire to it, causing significant damage. He is again detained in custody and charged with reckless arson. Two months later, Daniel is deemed fit to plead by a forensic psychiatrist and Daniel pleads guilty. The family do not get to see the report that apparently states that Daniel may now have a personality disorder in addition to the mental illness.

The family report that when Daniel had been under the care of the community mental health outreach team, they have his agreement that the team can talk openly to the family. In contrast, as Daniel is moved into the prison system, 'patient confidentiality' is cited as a reason not to disclose information.

Daniel is given a four-year sentence for arson and serves two years in a prison setting mostly in the well-being unit. Attempts to move him to a general wing break down – he disturbs other prisoners with protest banging at night and is bullied and self-harms.

Before being released on probation, a meeting is held involving the family, a prison officer, a mental health nurse and a service provider. The locum prison psychiatrist is unavailable, nor are representatives from the outreach team in the area to which he is to be discharged – which is not where he was living before prison. Positively, throughout his time in prison input from the prison family liaison officer helps the family attend to the practical issues connected with Daniel’s accommodation and financial circumstances.

Daniel finds the transition from prison to freedom extremely stressful, and he attempts suicide within one week of release. He is then sectioned. However, he is now in a new area, having only resided there for a week. His diagnosis is also in question. After uncertainties over funding that lasts over a year, he is eventually (after 20 months and four different units/wards) transferred to a specialist facility where he is finally receiving the specialist care that he clearly needs. Twelve months on, he is now making really good progress with a stable location and support team.

The below case study is taken from our inspection sample:

Case study – good experience

Craig is a young man on licence from prison for an offence of threatening behaviour in front of his former partner and children. He was assessed by the probation service as posing a high risk of serious harm and had a number of complex issues including ADHD, anxiety and depression, substance misuse and issues of self-harm.

Craig struggled to understand his prison licence conditions and his probation officer took the time to explain them clearly and check his understanding. Formal assessments were comprehensive, covering both the risk he presented to himself and others. The risk to Craig’s former partner and children was appropriately identified and managed, along with Craig’s mental health needs, learning disability and vulnerability.

Specialist personality disorder services were consulted and advised his probation officer. Craig was referred to and engaged with the local facility for mental health treatment in the community. He also received support with substance misuse. Children’s social care services were kept informed and engaged, given the impact on his family.

The final outcome was positive, with no further offending and improved mental health and wellbeing. Craig maintained engagement with the substance misuse service, mental health services and probation and retained contact with his children and former partner with the support of children’s social care. Craig appreciated the support given and reflected on the progress made and the positive changes in himself.

Penal Reform Solutions

A report for this thematic inspection from Penal Reform Solutions based on their interviews with 67 individuals going through the justice system is published alongside this report and can be found [here](#). Key findings and quotations have also been incorporated in this report.

Below are the voices of some of these individuals as they passed through different stages of their criminal justice journey.

About the police

"It's only reflecting back I realised how bad it was ... It traumatised me for a long time, how I was handled (in the police station) and treated ... I was disassociated, detached and suffering psychosis and anxiety. How they didn't notice ... they interviewed me anyway. For months after I've had panic attacks and nightmares". (Sammy)

"Whilst I was at the police station, I felt like they were taking advantage of my vulnerability, this made me feel weak as an individual, which played on my mind and made me doubt myself. They are not the law; they are there to enforce it". (Phil)

About courts

"Courts are eerie places, everything feels unnatural and on edge and that doesn't help with anyone's mental health, even if you consider yourself to have good mental health". (George)

"I don't hang around ... just get in and out". (Maria)

About probation

"She [probation officer] has taken into consideration my view and has given me the feeling that I have a voice ... [this] impacted massively on my mental health". (Filip)

"Probation knew my struggles with drink and have played a key part in helping me stay sober and finding a healthier way to deal with my mental health". (Brian)

"I didn't really know what was going on until I met my probation officer, who explained everything". (Cooper)

About prison

"I am not alone in experiencing grief during the pandemic, but prison is an awful place to deal with loss and empathy has been in short supply". (Steven)

"I have met some fantastic prison officers and keyworkers; some really do go above and beyond ... they have all helped me long the way. A kind word or gesture could be a lifeline for many men behind bars". (James)

"It's ok to cry, its ok to be different ... it's not ok to deny someone help who is begging for it. My cell bell has been going off for over four hours before and all I wanted to do was talk to somebody, a listener. It was the lowest point of my prison mental health life ... felt like I have been denied air to breath!" (Steven)

"Heartbreak that manifested itself physically, triggering muscle weakness, exhaustion, insomnia and anxiety attacks. And the feeling you're going to die ... Distressed to the point that made you sob in the shower or under the blanket where the segregation staff couldn't hear my desperate sobs and gasps". (Fergus)

“Unbearable, shocking ... full of worry and fear”. (Filip)

“Exhausting, confusing, and frightening and scary”. (Marcus)

*“I gained understanding [about myself] thanks to the teacher, who I owe my sanity too”.
(Wilson)*

“The impact of the loss of gym and exercise from lockdown had a massive effect on those who used it as an escape or an opportunity to let off steam ... having the gym taken and exercise restricted due to lockdown played havoc with my mind, those hour slots were my escape, they kept me sane and saw me through the day”. (Karl)

“I don’t like talking to people outside of my own group and as I can’t read or write I couldn’t put an app in. I spoke with the traveller’s rep and he helped me deal with health care and get some pills”. (Alfie)

About mental health services

“The mental health team were fantastic, brought over a food package in spite of the distance ... they were terrific, so, so kind ... [They did know me from Adam].” (Jane)

“A therapeutic community really opened my eyes and aided me in addressing some of my demons, the lessons I learnt during that time will stay within me always”. (Steven)

Joint inspectorate findings: the joint sample

In addition to interviewing people with a mental illness who have been through the system themselves, we also took an in-depth look at a random sample of cases in the six inspected areas to see how these individuals had been assessed and supported as they passed through the criminal justice process.

From a sample of cases known to probation services whose case record showed a mental health condition, 45 were reviewed in detail, of which 30 had been released on licence following a period in prison and 15 had been sentenced to a community sentence:

- fifteen licence cases (short prison sentence) were reviewed by all inspectorates
- fifteen licence cases (long prison sentence) were reviewed by HM Inspectorate of Prisons and HM Inspectorate of Probation
- fifteen community cases were reviewed by HMICFRS, HMCPSP, HM Inspectorate of Probation and CQC/HiW.

This qualitative review focused on the identification of mental health problems and the quality of the services provided.

Joint sample: key characteristics

- Twelve of the 45 cases were female and aged between 22 and 52. Four of the 12 female cases had recorded issues of self-harm and/or suicide registered on the case file.

- Males accounted for 33 of the 45 cases in the joint sample. Nine of the 33 cases had recorded issues of self-harm/and or suicide registered on the case file.
- Thirty-five of the 45 cases in the joint sample were white. In one case the ethnicity of the person on probation was not recorded. The remaining nine cases in this joint sample were from a minority ethnic background and only one of these cases was of a woman.
- Thirteen of the 45 individuals in the joint case sample were interviewed by Penal Reform Solutions.
- Twenty-six individuals had coexisting conditions, including substance misuse and/or neurodiversity.

A detailed breakdown is provided in tables in Annexe 2.

Joint sample: mental health diagnosis/condition by type, where known

The most frequent diagnosis was anxiety and depression, with eight cases (18 per cent) experiencing this condition. Suicide and self-harm were the second most frequent mental health issues identified, affecting seven individuals (16 per cent of the sample). Experience of trauma was the joint third most frequently found condition impacting on mental health. It was experienced by six individuals (13 per cent), and the same number in the sample were also involved with the OPD pathway.

Identification of mental health

It is essential that mental health needs and disorders are correctly and consistently identified, as the journey through the CJS can trigger a range of reactions, especially for those individuals who have existing mental health needs. When reviewing the 45 cases, inspectors were asked to indicate whether they believed that mental health needs had been sufficiently identified. Our findings are shown in the table below.

Inspectors' judgements on whether mental health needs were sufficiently identified in inspected cases

		Police custody	Health	Prosecution and court	Probation	Prison
Licence cases (short prison sentence), 15 cases ²⁸	<i>Were mental health needs sufficiently identified?</i>					
	Yes, fully identified	2	9	1	10	11
	Yes, partly identified	7	0	0	2	0
	No, but should have been identified	3	2	0	0	0
	No, not applicable at this time	2	3	14	3	2
Case not accessible	1	1	0	0	2	
Licence cases (long prison sentence), 15 cases ²⁹	<i>Were mental health needs sufficiently identified?</i>					
	Yes, fully identified	-	-	-	10	7
	Yes, partly identified	-	-	-	3	0
	No, but should have been identified	-	-	-	1	0
	No, not applicable at this time	-	-	-	1	3
Case not accessible	-	-	-	0	5	
Community cases, 15 cases ³⁰	<i>Were mental health needs sufficiently identified?</i>					
	Yes, fully identified	7	7	1	6	-
	Yes, partly identified	6	4	6	6	-
	No, but should have been identified	2	4	8	3	-
	No, not applicable at this time	0	0	0	0	-
Case not accessible	0	0	0	0	-	

²⁸ For the purpose of this inspection, a short sentence was defined as two years or less. It was agreed that this would still make prior involvement of the police and prosecution/courts relevant. As such, these cases were reviewed by all inspectorates.

²⁹ For the purpose of this inspection, a long prison sentence was defined as anything over two years. It was felt that, after two years, activity which had taken place within police custody and prosecution/court would be less relevant. As such, these cases were reviewed by HM Inspectorate of Prisons and HM Inspectorate of Probation.

³⁰ As individuals in these cases had been given community sentences, these cases were reviewed by all inspectorates except HM Inspectorate of Prisons.

Key points:

- Many cases where mental health issues had been fully identified by the probation service had not been flagged earlier in the process.
- For example, inspectors judged that mental health needs were fully identified in only a third of the inspected cases in police custody (9), although in almost half of the cases these needs had only been partly identified (13).
- CPS files do not include a mental health flag. In the short prison sentence sample, only one case had been fully identified. This was also true of the community sample, albeit that in a further six cases mental health needs had been partly identified.
- CQC/HIW inspectors who reviewed the patient pathway within police custody judged that the needs had been fully identified in half (16) of the cases and partly identified in another four.
- Of the 45 probation cases reviewed, only 26 of the individuals had had their needs fully identified, and a further 11 were partly identified. Despite the sample coming from a list of probation cases with mental health identifiers, inspectors found four cases where mental health needs had not been sufficiently identified on the case record.
- For those in prison, inspectors were unable to access five cases in the sample. For the remainder, mental health needs, where applicable, had been fully identified (18 cases).
- Issues in accessing prison records meant that it was not always possible to conclude whether mental health needs that were apparent on release had been correctly assessed while the individual was in custody.

As shown in the table above, mental health needs can be identified at any time in the defendant's journey through the CJS for a number of reasons. In some instances, mental health needs were not identified early on because they were being sufficiently managed by medication, or because individuals were embarrassed by their illness and therefore did not initially mention this to the police or their lawyer. In some instances, individuals had been assessed in police custody by a healthcare professional or the L&D service and they concluded that there were no mental health needs or that, although the police had identified mental health needs, they were not deemed to have contributed to the commission of the offence and therefore were not flagged as an issue for the prosecution and court. It is clear that for these reasons cases could be missed. Information-sharing when mental health needs are identified will be explored later in the report.

If a case does not 'present' in such a way that mental illness can be easily identified and recorded using the available 'tick box' forms from an agency, then mental health can also be missed.

Assessment of mental health

Each agency used different assessment tools and criteria to determine mental health need. This difference resulted in varying conclusions about the severity of the problem or level of need. Despite this, we did see some good examples of appropriate mental health assessments being carried out at each stage.

Sadly, however, individuals with mental health needs and at risk of self-harm said that the treatment they received from staff did not always match the level of care required. This could include being left in a police cell for lengthy periods of time despite disclosing suicidal

thoughts. Additionally, sometimes prison staff did not respond to cell buzzers in emergencies, as experienced by Lily:

“There’s times when you’re pressing the buzzer and no one replies because it goes straight through to the control room because there’s no one in the office, so then you’re consistently pressing it because I was having a panic attack at the time and I just remember thinking god, it’s really, really difficult”.

Referrals for specialist assessments were not always made as required. Some individuals were scared to admit that they were struggling in case it made things worse for them, for example with the police. Others would have liked staff to have asked more questions and encouraged them to seek help. Several men said that they did not find it easy to talk about their mental health and needed reassurance that it was ok to ask for help. Furthermore, practitioners often failed to explain fully the reasons for the questions they were asking about mental health. On occasions, needs were not fully identified due to staff not reading all the available information. When people are repeatedly having to tell their story, their vulnerability can be overlooked, with the focus much more concentrated on risk management. Probation staff had not always included information from pre-sentence reports and other sources in their assessment. This meant that vital information was missed, which may or may not be picked up at a later stage.

Where criminal justice staff took the time to build a rapport with an individual, trust was developed and led to more accurate disclosure of mental health issues.

Communication and information-sharing

Individuals appreciated information being shared to allow for the continuity of their care. However, inspectors identified some worrying problems regarding the accurate transfer of information on mental health needs. In some of the inspected cases, despite mental health assessments being completed in police custody and needs being identified, these were not flagged clearly for the court.

Difficulties frequently arose for individuals who were receiving care from an out-of-area mental health team and too much reliance was placed on the individual’s self-report. Prison Through the Gate work often fell short when planned communication with service providers in the community did not take place. This left many without appropriate accommodation or the medical support they needed. Healthcare providers in custody did not always make contact with specialist mental health workers or GPs.

Examples of effective communication and information-sharing:

1. Court staff communicated suicide and vulnerability risks to prisons and other establishments.
2. Where L&D and existing community care were offered by the same provider, practitioners were able to access the patient’s full history as well as their care plans and planned interventions.
3. In cases where individuals were already receiving care in the community, there were good examples of communication between criminal justice and community mental health teams.
4. There were robust prison discharge arrangements, including liaison with mental health services in the community.

Provision of appropriate support

Individuals were most likely to be offered mental health support in prison and from the probation service. This was mostly because they spent longer with these agencies. The experience of police arrest and custody is, by its nature (and in comparison), unexpected and sometimes shocking and disorientating. Inspectors did, however, find examples of support in police custody. One individual, who disclosed that he had autism, reported how reassured he felt that the police officer had tried to understand his condition. This helped him to stay calm. Another individual spoke about how a police officer had helped her to secure suitable accommodation and this benefited her mental health.

For some individuals who were subject to probation supervision, the focus of work was more on risk, supervision and control, as opposed to addressing mental health needs effectively. Short prison sentences created challenges in providing any meaningful mental health interventions.

Individuals noted that, despite being asked about their mental health needs at various stages of their criminal justice journey, even when a need was identified, this did not mean they necessarily received the appropriate support. One described assessment as *“a box ticking exercise”*, with another saying they did not feel staff were genuine when they asked if they had any mental health needs.

Within the prison context, individuals referred to the application process for accessing help. For many, this was not working. Some had submitted multiple applications, but many had not received a response. This contributed to a worsening of mental health and a feeling of hopelessness. One individual said:

“As the flame of hope and love was completely extinguished, it made me feel like I was going crazy and suicidal for a long time”.

Individuals with a dual diagnosis of mental health and substance misuse needs were not served well. In some cases, substance misuse was treated by itself, with no support or consideration being given to mental health issues. Those who tried to access mental health support were told they could not be treated while they were under the influence of substances. A number of individuals reported that they were using drugs because their mental health was poor.

The importance of relationships

Having a relationship founded on trust between criminal justice staff and individuals is seen as being of vital importance to supporting positive change and improving emotional wellbeing. Individuals reported that ‘having someone on your side’ facilitated their recovery. One individual noted how a five-minute conversation with his prison keyworker made him feel better, believing that someone cared about him and was interested in him. A number of individuals remarked on the positive relationship they had with probation staff and the value they placed on feeling heard. Where relationships between individuals and criminal justice staff were not positive, this had a detrimental impact on the individual’s mental health. Many individuals reflected on the lack of relationship and compassion at the point of arrest, with one individual stating he was left alone in a cell for three days despite disclosing suicidal feelings. Those attending court noted that the formality caused them additional anxiety and trauma. In prison, rushed and shallow relationships with staff often left individuals feeling isolated.

Professional curiosity

Where there were no previous records available, staff across all agencies mostly relied on the individual's self-disclosure of mental health needs. Some serving prisoners spoke about how it was difficult to disclose in prison, saying that it was almost impossible to show oneself as vulnerable in these spaces due to the environment. Several described *"suffering in silence"*, stating that, even though they did have mental health issues that were documented on the system, they did not feel safe to discuss these when asked. In several cases, staff seemed uninterested.

There were examples where individuals demonstrated actions associated with potential mental health issues. However, these behaviours were not fully explored by staff, particularly within police custody. In one case, the individual had called his former partner from his car. He had threatened to pour petrol on himself and set himself on fire. The health care professional (HCP) did not record any mental health needs. The case resulted in a Mental Health Treatment Requirement being imposed, in recognition of his presenting behaviour. At times, individuals exhibited behaviours that were very challenging, such as violence/aggression towards staff or dirty protests in cells. Too often it was decided that a mental health assessment was not necessary.

Considering the impact of trauma

Criminal justice staff, particularly at the probation stage, did not routinely take into consideration the impact of past/current trauma on the individual's mental health. This often included sexual abuse, childhood neglect and being a victim of domestic abuse. Individuals also noted how the experience of going through the CJS had added to their trauma. For one individual, it was the way she was treated at the police station, and how she was interviewed. She stated that, although she had been experiencing quite severe mental health difficulties, including psychosis, *"they didn't notice"*. A long prison sentence could also be traumatising: *"the story of heartbreak ... of how life as you knew it had ended"*. Vicarious trauma was also experienced in prison, including witnessing another person self-harming. Finally, having to retell one's story to numerous different probation officers triggered trauma, especially when it meant having to repeatedly revisit painful memories.

Conclusions and implications

There are inconsistencies in the identification of mental health needs along all stages of an individual's journey through the CJS. These are compounded by the absence of a common definition of mental health. In far too many instances, mental ill-health is only partially identified. This contributes to poorer assessments and needs not being met. As shown, when mental ill-health is identified at one stage, at the next, it may not be considered relevant or not identified at all. There are no robust or effective cross-agency information-sharing protocols and consequently information exchange about mental ill-health was generally poor.

Too often the purpose of the assessment is not explained to individuals well, and different degrees of engagement result: a missed opportunity to intervene early.

Probation and prison are seen by individuals as the agencies most likely to give them the mental health support they need. However, help is often too slow. This has been a notable problem during the pandemic, given the reduction in service provision. Notwithstanding this, a number of individuals felt that they had been treated with humanity and this shows what can be achieved.

3. Policing - Key findings

Introduction

As an emergency response service, the police will often be the first criminal justice agency to come into contact with a person with a mental illness entering the CJS – either as a suspect or a victim (or both). Often this may be when that person is in crisis and their symptoms are at their worse and they are at their most vulnerable. Difficult and rapid decisions will be needed on what medical care or crisis support is needed and on whether an arrest or criminal charges are appropriate. And research suggests that this is a growing part of police business, with emergency calls to the police relating to mental health increasing. In 2019/2020, forces with the most advanced flagging reported prevalence of mental health incidents recorded at up to 13 per cent and crimes recorded at up to 24 per cent.

Once a crime has been investigated, a decision will have to be made on whether the case should be diverted to a non-criminal-justice disposal, whether it is suitable to be charged by the police, or whether advice should be sought from the CPS on an appropriate charge. At this point all relevant information about a person's mental health should be provided with the case file that is sent by the police to the CPS and to the court so that a properly informed decision can be made.

People with mental health problems need expert support. Those in crisis need to be cared for in a healthcare setting. They shouldn't be locked in a police cell or held for hours in the back of a police car for their own safety. This expert help needs to be available whenever people need it.

During this inspection, HMICFRS inspectors inspected six police forces and interviewed approximately 180 staff, including custody staff, investigators, managers, adult safeguarding and commissioned service partners. Additionally, 382 case records were reviewed. The views of people who had been through police arrest and custody themselves were collected by Penal Reform Solutions to gain their side of the story.

Overview

We found that the police generally felt healthcare accommodation was available for those in crisis (although this was still a concern in one force we visited). This was better than we expected. But the threshold for accessing these healthcare places is very high. As a result, police still have to deal themselves with very complex and troubling cases and distressed individuals, who either don't meet this threshold, or whose drug or alcohol use means they're not currently suitable for a health assessment. This results in the police having to carry and manage the risks of either detaining the person and progressing an investigation or releasing someone from their care when they have significant concerns about their safety. Generally, we found policing manages both scenarios very well.

There is a national and local policing focus on working in partnership to respond effectively to people who are vulnerable, including those who have mental ill-health. However, we found that the greatest focus, statutory support and funding goes towards safeguarding children or (within adult safeguarding), on protecting vulnerable victims or managing crisis. Mental health considerations relating to offenders were generally seen as a lower priority – particularly by partners. This prioritisation is commensurate with the comparative risk. Where risks are higher and where there are benefits for policing, a range of measures have been put in place, particularly within the custody environment or in relation to diverting offenders from crime.

The majority of police officers in response and neighbourhood roles are 'generalists', with a wide range of responsibilities. We found these officers had received general mental health training appropriate to their role. Those whose primary role it is to investigate offences received little specific input on how considerations of the mental health of suspects and offenders might affect police decision-making. This is a training gap, although specialist officers had received more input on this. Forces often recognised this but relied instead on the availability of policy and guidance products and internal and external expert advice. We found the availability of guidance and advice to be generally good.

We found inconsistencies in how forces make decisions about the best course of action for people with mental ill-health, and in the approaches to meeting their needs. For example, we found significant differences in when our fieldwork forces accessed AA provision, an HCP or L&D services.

Guidance on how to progress investigations and prosecutions is necessarily broad. Instead of relying solely on this, officers are guided to treat each case on its merits and to consider a range of factors. Officers have some discretion in less serious cases regarding whether and how to progress a case, or how to dispose of it. For the majority of offences, charging decisions should be referred to the CPS. We found officer understanding of factors and decision-making generally to be good, but this was not universal. We often found insufficient oversight of police decisions to not proceed with cases.

We discovered some significant problems in relation to the passing of mental health related information between the police and the CPS. There is an expectation on police to do this where mental health is a factor in a case or an issue for the suspect, but the boundaries for what constitutes a factor or issue are unclear. This relates back to the lack of a consistent definition for mental ill-health. A primary concern is that officers often do not include any relevant information and systems and processes do not support the consistent provision of this. We also found a lack of clarity about what the police should do when the suspect doesn't consent to information being shared, and about what information can and can't be shared with criminal justice partners. When the CPS seeks to clarify information, police avenues for obtaining such information are sometimes unclear and/or complex.

We found an extensive suite of diversion opportunities and pathways for offenders with mental ill-health within every force that we inspected. However, these varied across and sometimes within forces. Some such pathways were facilitated by dedicated health and justice commissioned services, but many relied on referral to 'standard' public provision. We found limits in what this could offer. This was partly because of capacity problems, particularly if the offender did not consent to engage with the process.

Our inspection of policing highlighted the following strengths and areas for improvement:

Strengths

- Police leadership of mental health at a national level is comprehensive and well-coordinated through the National Police Chiefs' Council (NPCC). Most forces had accessible mental health leads either at force level, local level or both.
- Forces have arrangements for patrol/response officers to access either 'at scene' advice via street triage vehicles or remote advice via control room triage.
- In all forces, the commissioned services included a L&D service based within police custody.
- In most forces, the availability of 'place of safety beds' had improved or was improving, so police facilities are now only being used as a place of safety (for adults) in exceptional circumstances. These were very rare occurrences that were fully and properly justified.

- Police officers had a good understanding that minor crime, particularly crime caused by the mental health crisis itself, could be swiftly discontinued in favour of a health care approach.
- There is an extensive suite of diversion opportunities and critical pathways in every force, although their use varies, and officers do not always take advantage of the specialist help available.
- Police custody staff take screening and managing detainee risk very seriously and this featured heavily in custody staff training and in custody management systems.
- HMICFRS's rolling custody inspection programme, undertaken with HM Inspectorate of Prisons, has found risk assessment to be of a generally good standard. As a result of the risk assessment and healthcare process, custody staff took necessary steps to safeguard the detainee and others.
- We found that most forces have extensive healthcare coverage in all sites.

Areas for improvement

- Police officers are not clear about the mental health information that needs to be passed to the CPS when they are seeking charging advice. This had been done well in only 25 per cent of cases we examined.
- There is no prompt for officers to include this information on the papers and they did not routinely ask L&D services for this information.
- We found a variable picture in relation to mental health training.
- Data relating to mental health within policing is limited. Mental health flagging is available on systems across policing, but these systems did not universally allow for subcategories, specific conditions or qualifying information, which limited their usefulness.
- In most forces, recording of pertinent information in custody records was inconsistent.
- Identification and assessment of mental ill-health were poorer for suspects who were not detained in custody but invited to attend at a later date for interview ('voluntary attendance' cases). This group was significantly less likely to be referred to a healthcare professional or an L&D scheme for assessment.

What needs to happen next – our recommendations

The police service should:

14. ensure that all dedicated investigative staff receive training on vulnerability which includes inputs on responding to the needs of vulnerable suspects (as well as victims). This should be incorporated within detective training courses
15. dip sample (outcome code) OC10 and OC12 cases to assess the standard and consistency of decision making and use this to determine any training or briefing requirements and the need for any ongoing oversight
16. review the availability, prevalence, and sophistication of mental health flagging, to enhance this where possible, and to consider what meaningful and usable data can be produced from this
17. assure themselves that risks, and vulnerabilities are properly identified during risk assessment processes, particularly for voluntary attendees. They must ensure that

risks are appropriately managed, including referrals to Healthcare Partners, Liaison and Diversion and the use of appropriate adults

18. review management guidance forms to include prompts or dedicated sections for the suspect's vulnerability to be included.

Further detailed findings on policing.

4. Liaison and diversion services (England) and criminal justice liaison services (Wales) – key findings

Introduction

In his 2009 review, Lord Bradley recommended the creation of a national liaison and diversion (L&D) model. This model was implemented in 10 trial sites in England in 2014 and has covered all parts of England and Wales since the end of March 2020.

The L&D programme contributes to savings in the CJS, but not in the healthcare system. L&D services appear to directly contribute savings of between £13.1 million and £41.5 million in the CJS through diversion from custody and consequent increases in productivity.³¹ Overall, 88 per cent of people referred to L&D services had at least one vulnerability identified. Almost three-quarters, 72 per cent, of those referred had a mental health need, and just over half, 52 per cent, experienced drug or alcohol misuse.³²

L&D services, known as criminal justice liaison services in Wales, identify individuals who have mental health needs, learning disabilities, substance misuse issues or other vulnerabilities when they first come into contact with the CJS as suspects, defendants or offenders. The service then helps them through the early stages of their criminal justice system journey, refers them to appropriate health or social care or enables them to be diverted away from the CJS into a more appropriate setting. L&D services try to improve overall health outcomes for people and to support them in reducing the likelihood of breaking the law in the future. They seek to identify vulnerabilities early in the process and make sure that the right support can be put in place from the start. The aim is to reduce the prospect of someone reaching a crisis point.

L&D practitioners are ordinarily based at a police station or in court and come from different occupations. They include nurses, paramedics, social workers and doctors. Referrals are made by the police, L&D teams or in some cases through self-referral. L&D staff carry out assessments to provide advice. This information is then shared in court and, where appropriate, people are given information about agencies that can support them. During the pandemic, staff have been working from home and carrying out assessments remotely by phone or video link. Face-to-face interviews have often been conducted through police cell doors to comply with social distancing rules. These changes have not enabled effective engagement. For emergency assessments or healthcare 'out of hours', police will call an out-of-hours medical practitioner, who may not have mental health expertise.

During this inspection CQC and HIW inspectors visited six areas, reviewed 33 patient records and interviewed approximately 58 staff, including NHS commissioners, L&D managers and practitioners, community mental health team psychologists, street triage staff and healthcare practitioners.

³¹ Disley, E. et al. (2021). *Findings from the national evaluation of Liaison and Diversion services in England*. Santa Monica, CA: RAND Corporation. https://www.rand.org/pubs/research_briefs/RBA1271-1.html.

³² Disley, E. et al. (2021). *Outcome Evaluation of the National Model for Liaison and Diversion*. Santa Monica, CA: RAND Corporation.

Overview

L&D services were in place in every inspected police force. Services were consistent with national expectations, but most provided a core or basic service only. L&D providers and custody staff told us there were not enough resources to meet the needs of people with mental health problems in police custody and court settings. L&D arrangements in England mean practitioners see people with all vulnerabilities, not just those with mental health needs – this further stretches the resource.

We were pleased to find that individuals detained under the Mental Health Act were very rarely brought into police custody. However, the use of L&D services varied widely. Of 183 inspected custody cases where mental health issues were identified, 45 per cent had been referred to L&D services and the vast majority of these were seen while still in custody. But there were some very notable variations between police forces in the use of L&D, from two out of 10 cases in one force to seven out of 10 cases in two others. This is unexplained and the inconsistency is concerning.

We found that leaders and staff are dedicated and passionate about delivering high-quality personalised care. There is a rich mix of skills across L&D teams – a significant improvement since our last inspection. All L&D service providers have robust systems for mental health learning and development, and staff have good access to this training. Staff told us they felt empowered to make their own decisions and had someone they could call for advice or to escalate a concern; we agree that management oversight is strong.

Improved information-sharing is needed among different providers, partners and police officers to ensure relevant data is accessed and shared in a timely way. This includes tackling misunderstanding about GDPR rules. Some L&D staff in custody suites reported IT issues that made it difficult to access their own case systems to update patient records and complete online learning – this needs to be resolved as quickly as possible.

We found custody staff generally refer detainees to L&D services, and we also found positive examples of L&D staff proactively scanning custody records to highlight potential service users. There were missed opportunities to maximise input from L&D services; for example, we found little direct interaction with investigating officers, who could use L&D as a source of advice or information relating to detainees. Facilities were often lacking, limiting contact between custody and L&D staff.

Our inspection of local L&D services highlighted the following strengths and areas for improvement:

Strengths

- There is good coverage of L&D services across England and Wales.
- Staff were passionate about supporting individuals in custody, and we saw proactive work to identify anyone who may need support who had not already been referred to services.
- Commissioners held providers to account and regular contract review meetings gave providers the opportunity to raise and discuss any concerns or issues.
- We found a rich mix of skills across L&D teams, which was significant progress since the last inspection. All L&D teams included mental health nurses, and social workers and assistant psychologists were regularly involved. Learning disability nurses were also employed in some areas.

- We heard positive feedback from individuals regarding the support they received from peer mentors, who helped individuals engage with local agencies and could provide advice from their own experience.
- Access to training for L&D teams was good and, in some areas, had improved during the pandemic as more remote learning resources were provided.
- Management oversight was strong, with good governance systems to ensure a high-quality service was delivered.
- Relationships with custody staff were generally good, with a greater understanding of the work L&D teams do. The quality of referrals from custody staff had improved since our last thematic inspection.
- Individuals detained under the Mental Health Act (MHA) were very rarely taken to police custody as a place of safety. Instead, they were taken to the local designated place of safety.
- In custody, assessments were completed to a good standard and were holistic and personalised; there was clear evidence in electronic records that individuals were involved in their assessments.
- Onward referral pathways were robust, including where an MHA assessment was requested. Where individuals were known to local mental health services, there was good communication with care coordinators.

Areas for improvement

- There was an unexplained and concerning variation in police use of L&D in our fieldwork areas, from 20 per cent of the potentially eligible cases we looked at in one force to 70 per cent in two others.
- L&D providers felt that there were not enough resources to meet the needs of those with mental ill-health in police custody and court settings. Either more staff or more hours on site were required to meet demand.
- Services were limited by coverage, access and ambition. Out of hours services were less certain and not equitable to those seen in person.
- There were not enough doctors available in all areas to meet the demand for Mental Health Act assessments either during the day or within emergency duty teams' out of hours provision. This meant that some individuals may have been released from custody without an assessment.
- Systems and processes did not always support the delivery of effective care. Each area had multiple providers for L&D, healthcare, peer mentoring and outreach work. Each provider used its own system for electronic records. Effectiveness was hampered by the challenge in agreeing information-sharing protocols and systems access across multiple providers.
- Timeliness of assessments was an issue across all areas we visited in England. An increase in demand for services during the pandemic and in the severity of needs meant there were not always enough staff or hours in the working day to be able to see every individual who was referred.
- IT issues in some custody suites meant that staff could not easily access their own intranet to complete online learning. They also struggled to consistently access patient records.

- There were long waiting lists to access mental health support in the community for those identified as needing help by an L&D scheme. This had worsened significantly during the pandemic.
- Providers continue to encounter challenges in accessing inpatient beds for individuals assessed for detention under the MHA. We found evidence of patients being remanded to prison as a place of safety, when someone in court was assessed to be detained under the MHA but no inpatient beds were available.
- Due to a lack of capacity, individuals requiring an MHA assessment were often held in custody overnight to await day-time teams to carry out assessments. In turn, individuals referred for an MHA assessment later in the day would often wait for the out-of-hours emergency duty team to be seen.
- There was confusion and misunderstanding about GDPR confidentiality rules and requirements. This led to key partners being unnecessarily denied access to assessment information and ultimately individuals suffered further. Neither the police nor L&D staff were clear of the status of existing information-sharing protocols or how police officers could obtain more detail, such as a history of referrals.
- The Covid-19 pandemic had significantly impacted on the way in which L&D practitioners worked. They could no longer see patients face to face in private in most areas due to social distancing guidelines.
- Support for patients with dual diagnosis needs continues to be an issue. L&D practitioners described challenges in referring individuals to mental health teams if they were misusing drugs or alcohol. Referrals were rejected until those issues had been addressed, leaving individuals with no support.

What needs to happen next – our recommendations

Her Majesty’s Courts and Tribunals Service should:

8. ensure that L&D teams are included in local liaison arrangements to improve understanding of the provision and joint working relationships.

Local criminal justice boards should:

13. ensure that L&D mental health assessments undertaken in police custody are provided to the CPS and defence lawyers to help inform charging decisions, representations for diversion and sentencing decisions.

[Further detailed findings on liaison and diversion services](#)

5. Prosecution and court – Key findings

Introduction

The next stage of an individual's journey through the CJS is that they are charged. The police can charge in certain cases and send the case straight to the magistrates' court. The CPS is responsible for reviewing these cases to determine whether there is sufficient evidence, whether the charge is correct or whether the evidence supports an alternative charge. Where the police do not have power to charge, they have to refer the case to the CPS for charging advice. For people who have mental ill-health, it becomes essential that the information provided by the police to the CPS accurately includes details of their mental health. This may include behaviour displayed at the point of arrest, in police custody or identified by L&D and other assessments. Where CPS lawyers find there is some evidence to suggest a mental health condition or disorder and this has not been identified by the police, they will request additional information from the police. If the police do not identify or do not provide the CPS and the court with sufficient information, there is a risk that those who are already suffering with enduring mental health problems may go undetected and become more unwell as they remain in the CJS.

At court, magistrates' or Crown, individuals have to decide whether they are going to plead guilty or not guilty. Sometimes individuals are represented by defence lawyers and at other times they are not. People with mental health issues often find the court experience traumatic and need legal and other support during trial and sentencing. Mental health needs should be flagged within court records, and the legal adviser should make sentencers aware of this information.

Determining an individual's fitness (capacity and capability) to make a plea for an alleged crime will sometimes require psychiatric and/or medical reports. Where defence lawyers assess that their client needs such a report, they will make a request to the court. They then have to find a psychiatrist who is willing to carry out an assessment to determine fitness to plead. Psychiatric reports are also required to determine whether an individual who is severely mentally ill should be sectioned under the MHA.

Sentencers and defence lawyers often ask for reports from the probation service (pre-sentence reports) and medical services (psychiatric/psychological reports) to assist them with sentencing. These reports should provide relevant mental health information about the individual and what sentence is most likely to help the individual to address their mental ill-health and reduce the risk of further offending. The probation service has a range of options available to it when making recommendations to the court, including supervision and treatment requirements.

During this inspection, the HMCPSI inspector reviewed 30 CPS case files in the six areas inspected, supported by a business manager from Her Majesty's Courts and Tribunal Service (HMCTS), who reviewed the court files for the same individuals. HMCPSI interviewed approximately 63 staff, including resident judges, district judges, CPS charging lawyers, CPS court advocates, and defence lawyers. HM Inspectorate of Probation inspectors reviewed 60 pre-sentence reports and held two focus groups of six report writers to better understand their work.

Overview

The CPS needs to have a complete picture of the individual and the alleged offence in order to provide charging advice. At present, CPS lawyers do not always receive the relevant information from the police at the right time, leading to a situation that is more akin to a

jigsaw puzzle with missing pieces. In only quarter of the cases we reviewed did the police provide the relevant material to the CPS.

We found that the quality of information provided by the police to the CPS was variable and usually poor. The MG5 form, which the police use to summarise cases, does not make it sufficiently clear if an individual has mental health issues. Custody records, which can show referrals to L&D services, are not always provided with the file for charging advice. Additionally, we found that, contrary to provisions in the *Police and Criminal Evidence Act 1984*, the police are not routinely providing defence lawyers with full custody records at the police station. This means that lawyers may only become aware of an individual's mental health issues very late in the day.

The CPS does not have a flag on its case management system to highlight cases involving individuals with mental health issues. The main challenge for the CPS and the other agencies remains the lack of a nationally acceptable definition for these cases. This continues to make it difficult to identify such cases, quality assure work and collect data. We were told that, as part of the development of the common platform, HMCTS and the CPS are considering the introduction of a mental health flag. For this to be effective, it will need to be supported by a national definition of mental ill-health and clear criteria for how, when and why the flag is applied.

We were pleased to find that every CPS area has at least one single point of contact (SPOC) for mental health, who is also a member of the national SPOC Network. Discussions are underway with the NPCC to roll out a mental health checklist that can be used nationally by the police when seeking charging advice for individuals who have mental health issues. The CPS is also planning to roll out training in the form of podcasts to support its revised guidance on mental health conditions and disorders.

In 2009, we found that there were a few Memoranda of Understanding in place for information-sharing between the police, NHS and CPS in cases of assault against healthcare professionals. The situation is not much better 12 years later in that few of the six areas inspected have informal arrangements in place to cover these assaults. Where such arrangements were in place, the quality of the information provided was much better than in respect of the majority of other cases involving individuals with mental health issues. It is clear from what we have been told that misunderstandings about GDPR restrictions have hindered effective communication. This has had a negative impact on information-sharing between agencies and must be reviewed and resolved to support the administration of justice.

Mental health services at court are variable. The judges we spoke to expressed frustration that there are so many individuals with mental health issues in the CJS who they felt should not be there. Judges also expressed concern about the mental health of defendants remanded into custody, particularly given the long periods spent in prison cells due to the Covid-19 pandemic, and the uncertainty about their ability to access meaningful treatment. Every judge we spoke to who did not already have access to services would welcome the opportunity to get an early assessment/diagnosis and thereby reduce the number of defendants remanded into custody while they wait for more information about them and their mental ill-health.

Although sentencers, in particular judges, were generally satisfied with most aspects of the pre-sentence reports they received, we found their quality to be insufficient. While the information to support sentencing was good in a small majority of inspected reports, too many reports still lacked details about risk management, safeguarding and domestic abuse checks. Report writers do not liaise consistently with others who have also prepared reports about the individual, such as L&D services. This meant the analysis of mental health was

often weaker and treatment requirements were often not fully understood. Sentencers had little confidence that a Rehabilitation Activity Requirement condition would make any difference, although there was greater confidence in Mental Health Treatment Requirement orders.

The number of unrepresented defendants who have mental ill-health is a growing concern. The impact on individuals, particularly in the Crown Court, is significant. Cases take longer to resolve, and defendants are more likely to be remanded in custody because the court does not have enough information about them or their mental health.

Through our fieldwork interviews and case file analysis, the following strengths and areas for improvement were identified:

Strengths

- Every CPS area has at least one single point of contact (SPOC) for mental health who is also a member of the national SPOC Network.
- CPS lawyers that we spoke to were familiar with the CPS Guidance on mental health conditions and disorders (October 2019) and the Code for Crown Prosecutors (October 2018), which are both available on its Infonet. The guidance is supported by an aide-memoire that highlights the key points.
- In almost all the cases where pre-sentence reports were requested, report writers had access to both the CPS documents and any previous conviction history of the individual. This system worked well.
- Sentencers, in particular judges, were generally satisfied with the pre-sentence reports they received.

Areas for improvement

- CPS files do not have a mental health flag. Those interviewed acknowledge that this means that there is no opportunity to carry out dip-sampling or other quality assurance work, or to collect data.
- There is no specific document for the police to use to alert the CPS or judges to the mental health needs of a suspect. They must search through the file for relevant 'clues'. As noted earlier in the report, the quality of mental health related information provided by the police to the CPS is variable and usually poor.
- Defence lawyers do not always pick up mental ill-health and this may have been compounded during the pandemic, as lawyers are not always meeting clients in person.
- None of the six areas visited in this inspection had a Memorandum of Understanding for information-sharing between the police, NHS trust and the CPS – though this was recommended in 2009.
- Incorrect interpretation of data protection regulations means that important information is not exchanged, including the provision of L&D assessments to the CPS, defence lawyers and sentencers.
- Mental health services at court are variable. Where there is a service, this is likely to be in the magistrates' court. Very few Crown Courts have access to them.
- Judges expressed frustration and concern that defendants with mental ill-health had to be remanded in prison to await an assessment or receive other support due to a lack of appropriate alternatives.

- There is a growing concern in the courts about the number of unrepresented defendants who have mental ill-health.
- Judges report that applications for intermediaries or other special measures in court for defendants with a mental illness are often not supported by evidence. Defence lawyers told us that they are rarely granted for a whole trial.
- L&D staffing in court settings was inconsistent and this was compounded by the pandemic.
- There are significant delays in obtaining psychiatric reports in court caused by funding applications and identifying a psychiatrist.
- Overall, the quality of pre-sentence reports prepared by probation court teams was insufficient. In half of the pre-sentence reports reviewed, diversity factors were not addressed.

What needs to happen next – our recommendations

Ministry of Justice and Home Office should work with the Department of Health and Social Care and Welsh Government to:

4. develop a multi-agency Memorandum of Understanding on information-sharing in order to promote better joint working and better outcomes for people with mental health problems.

Her Majesty's Courts and Tribunals Service should:

9. improve the arrangements for the commissioning and monitoring of psychiatric reports in order to ensure that delays in sentencing are minimised, especially when the individual is held in custody.

The probation service should:

20. improve the quality of pre-sentence reports to ensure that they contain a comprehensive analysis of trauma, mental health needs and, where indicated, proposals for appropriate treatment.

[Further detailed findings on prosecution and courts.](#)

6. Probation – Key findings

Introduction

This section covers the work of probation services. At the time of the inspection, probation services were delivered by a National Probation Service (NPS) and 21 Community Rehabilitation Companies (CRCs). On 26 June 2021, probation services were unified into a single service which manages all people on probation.

Individuals coming before the court can be dealt with in a variety of ways, ranging from court fines to imprisonment. In the community, the probation service supervises people who have been given community sentences for their crimes or have been released from prison on licence. The role of probation practitioners is to work with people to manage the risk of harm they present, reduce the risk of further offending and deliver interventions which will enable them to make better choices and fulfil their potential. A number of tools are available to probation practitioners to help them get a better understanding of an individual's behaviour. While probation practitioners are not mental health experts, they nevertheless have to contribute to managing the mental health needs of the individuals under their supervision. Through pre-sentence reports and initial assessments, they have opportunities to identify mental health needs and to link people with the relevant support they need.

During this inspection HM Inspectorate of Probation inspectors visited six areas, reviewed 60 probation cases and interviewed approximately 170 staff, including strategic mental health leads, learning and development managers, performance and quality managers, probation practitioners, staff delivering mental health programmes and psychologists.

Based on our fieldwork interviews and case file analysis of probation work in six areas, we have identified the following key findings in relation to strengths and areas for improvement:

Overview

At a strategic level, the NPS identified national commitments and priorities for improving work with people on probation with mental health issues. However, despite the positive intent, this did not always translate into effective local policies. The inspected CRCs lacked a specific strategic focus on work with people with mental health needs.

In terms of practice, both practitioners and managers struggled to supervise people on probation with mental health issues effectively. Practitioners had significant knowledge gaps and need to be better equipped to talk to individuals about their mental health needs. Practitioners reported a lack of access to learning resources – most of the available courses were not mandatory and were deemed too basic. Some practitioners found it difficult to locate guidance and relied on colleagues for support. We found examples of practitioners conducting their own research online, which is not standard practice. Mental health training for new staff varied widely and there was a haphazard approach to sharing learning with colleagues. Management oversight was missing or poor in far too many of the inspected cases (nearly two-thirds). Managers must address their own knowledge gaps and hold more robust conversations with practitioners, so there is a clearer understanding of effective and ineffective practice.

There is a shortage of high-quality services for people on probation with mental health needs. This was further exacerbated by the Covid-19 pandemic. Relationships between probation services and providers also varied widely. Service provision is good for individuals who have been diagnosed under the Mental Health Act, but referrals through other routes

did not always receive an intervention. Probation services should also do more to ensure that directories of services are updated regularly and that practitioners are aware of what is on offer and how to access these services on behalf of people on probation.

Our inspection of individual cases found a mixed picture. There was good evidence of practitioners taking into account the personal circumstances of individuals and their motivation and readiness to engage with supervision. However, a comprehensive analysis of mental health needs was found in only just under half of the inspected cases. Practitioners accepted self-reporting by the individual too readily and did not consider information from the wide range of available resources such as CPS documents, court reports and historical case records. Planning and risk of harm work were also variable.

The unification of probation services presents an opportunity for senior leaders to review national strategies and policies, and to ensure they translate into effective practice across the whole service. We would like to see greater consistency of approach, more training for practitioners and managers, and closer working with service providers to meet the range and complexity of individuals' needs.

Strengths

- Exceptional delivery models that had been designed during the pandemic had appropriately considered the wellbeing of staff and individuals.
- We found some good examples of clinical supervision being provided by psychologists.
- Offender Personality Disorder pathways were well established, and the training package provided is good.
- The recent introduction of the enhanced Intensive Intervention and Risk Management Service in some regions, offering casework by a psychologist, is a welcome addition.
- Each NPS division was supported well by a forensic psychologist who provided specialist advice to probation practitioners.
- Since October 2017, the roll-out of a number of Community Sentence Treatment Requirement sites has led to an encouraging increase in the number of Mental Health Treatment Requirement orders. This increase has been driven by the development of new services providing individualised psychologically led interventions for those who present with lower level mental health issues but also include a range of vulnerabilities including for example, dual diagnoses, histories of trauma/abuse and self-harm/neurodiversity. Initial outcomes are demonstrating positive outcomes.
- Practice guidance instructions on mental health are produced regularly. We found some good examples across both the CRCs and NPS.
- Management information systems are embedded in probation services and considerable data is generated across a range of business areas.

Areas for improvement

- We found significant gaps in the knowledge and understanding of mental health work among probation practitioners and managers. Management oversight was insufficient.
- Practitioners told us that they are frequently allocated cases with mental health concerns for which they do not feel qualified.

- The identification of mental health needs and disorders is confused. There was a wide range in the proportion of cases flagged in our fieldwork areas, from 1.8 per cent to 25 per cent of cases.
- There is a shortage of comprehensive and high-quality services to meet the spectrum of mental health needs of individuals on probation supervision and this has worsened during the Covid-19 pandemic.
- Mental health services for ethnic minority people are limited, with very little evidence to suggest that probation leaders were reaching out to source or access specialist services.
- Sentencers, in particular Crown Court judges, had very little confidence in Rehabilitation Activity Requirement conditions to meet the emotional needs of individuals.
- Inaccurate assumptions about GDPR requirements have contributed to probation staff being unable to access information from community mental health service providers.
- Little information is available about the effectiveness of interventions for individuals.
- Assessments and intervention plans needed significant improvement. Individuals were not always given the opportunity to contribute and their diversity needs were often overlooked. Many staff lacked the confidence to talk about diversity issues with individuals.
- The management of cases within Multi-Agency Public Protection Arrangements was disappointing. We were advised that mental health providers often failed to attend meetings and it was difficult to obtain up-to-date information.
- Work to review risk of harm was poor. Information from statutory partners was often not sought, neither were problems escalated.

What needs to happen next – our recommendations

The probation service should:

19. review its mental health flagging guidance to help probation practitioners to identify and accurately record a person's mental health needs (within six months)
21. work with the Welsh Government, NHS Wales, NHS England and Improvement and HMCTS to increase the use of Mental Health Treatment Requirements across England and Wales.

[Further detailed findings on probation.](#)

7. Prisons and resettlement – Key Findings

Introduction

For some individuals, their progress through the CJS results in a period of imprisonment. Some will enter prison with existing mental ill-health, while others may develop mental health issues during their sentence. On entering prison, initial screenings are undertaken to assess an individual's vulnerability and the risk they may pose to themselves. Referrals to mental health services should follow where needed. This can include group work or individual treatment. During the Covid-19 pandemic, people have been detained in their prison cells for lengthy periods of time, up to 23 hours a day. There have been long waiting lists for treatment and interventions in prison. Most people in prison do have access to in-cell telephones, which they can use to call the Samaritans. Mental health practitioners also use this facility to provide a degree of remote wellbeing support. Peer mentors and chaplaincy staff are also available to provide help and advice.

Most prisoners will be released back into the community and resettlement services play a key role at this point. Resettlement services work with the individual to prepare them for release and liaise with providers in the community. Effective information-sharing is essential if the continuity of care is to be maintained. Sometimes, individuals will be released with treatment conditions on their licences to keep them safe.

During this inspection HM Inspectorate of Prisons inspectors visited six prisons, reviewed 31 prisoner files and interviewed approximately 95 staff, including prison governors, prison custody officers, mental health nurses, psychiatrists and psychologists.

Overview

We found some positive work in prisons. Mental health assessments were undertaken with new and transferring prisoners in line with national standards. In the vast majority of cases where an individual disclosed mental health issues, a prompt referral was made to mental health services. Our inspection found good-quality clinical notes and all clinical staff reported that they received regular supervision and training.

However, there are several areas for improvement. As with other parts of the CJS, information-sharing was inconsistent. An individual with mental health needs will have been assessed by several criminal justice and medical agencies before arriving at the prison gate; yet we found staff relied on telephone calls, voicemails and emails between L&D and prison mental health staff. Crucial information about an individual's mental health is likely to be missed if staff focus on parts, rather than the entirety, of someone's mental health history.

We were also concerned to see that prisons continue to be used as a place of safety. This is especially true for women, who make up a relatively small proportion of total prisoners but who self-report much higher rates of mental ill-health, including depression and suicidal feelings. The scale of the issue was unclear, as data was not collected and incidents were not reported centrally. Senior managers at one women's prison counted 24 such incidents in the previous 12 months; these cases involved extremely vulnerable women being remanded in prison as a last resort, as suitable alternatives could not be accessed. We believe that prisons should not be used as a place of safety – it is inappropriate and inhumane. The government must do more to find or fund beds elsewhere.

The Covid-19 pandemic had a major, negative impact on mental health services in prison. Mental health services were reduced to focus on acute and urgent cases only, leaving long waiting lists for routine assessments, psychological treatment and counselling in most

prisons. Face-to-face appointments ceased and were replaced with in-cell telephones; where available, these can be a valuable substitute in the absence of face-to-face contact.

We found fragmented and inconsistent work to support prisoners as they prepared for release and resettlement in the community. Ensuring continuity of support beyond the prison gates was often difficult, for example because prisoners were released to approved premises hundreds of miles away or because of the lack of availability of services in different regions. Many prisoners continue to be released homeless, creating a further barrier as community services often require an individual to have an address and a GP before appointments can be made. In one inspected area, there was typically a 24-month wait for a community mental health team appointment. Any positive progress made in prison risks being eroded if timely support is not available in the community.

Through our fieldwork interviews and case file analysis, the following strengths and areas for improvement were identified:

Strengths

- Nationally approved initial assessment screening tools are appropriately used by healthcare practitioners to identify and assess the mental health needs of prisoners.
- Mental health services in all the prisons visited in this thematic review were firmly embedded within prison structures.
- Mental health teams in prisons had expanded and now included disciplines such as speech and language therapists, social workers, learning disability nurses and occupational therapists. This was meeting needs and improving outcomes for patients.
- The delivery of psychologically informed treatment interventions, when provided, is strong.
- Relationships with providers of mental health and substance misuse services is good and this provides a base from which to address comorbidity issues.
- RECONNECT Care after Custody is a positive initiative and needs to be nationally embedded.

Areas for improvement

- Prisons continue to be used inappropriately as a place of safety, especially for women while they wait for trial.
- Information-sharing processes across departments are inconsistent and GDPR requirements are not properly understood.
- Far too many people are released homeless or with unsuitable accommodation.
- Continuous professional development mental health training is needed for prison officers.
- Extremely unwell prisoners who need urgent transfer to a secure mental health inpatient hospital for treatment continue to experience unacceptable waiting times.
- Clinical psychologists were not always part of mental health services. This resulted in some prisoners not being able to access treatments, such as therapy for complex trauma disorder.
- Resettlement planning is fragmented, with work undertaken in custody not continuing into the community.

- Too often resettlement work is 'to the gate' and not through the gate.
- Far too many vulnerable people are being released without the appropriate pathways to help plan ongoing care.
- The continuity of mental health care from custody into the community is generally poor.
- Waiting lists for services in the community are long, leaving vulnerable people having to cope without the help that they need. They often reoffend and return to prison not long after release.

What needs to happen next – our recommendations

The Ministry of Justice should work with NHS England and Improvement and Welsh Government to:

5. immediately ensure that acutely unwell prisoners who require secure mental health inpatient hospital treatment are transferred within 28 days, in line with NHS guidelines
6. end the inappropriate use of prison as a place of safety, and ensure that alternatives to prison are available for sentencers in line with the Mental Health Act white paper.

Her Majesty's prison service should work with NHS England and Improvement and Welsh Government to:

22. tackle the long waiting lists caused by the Covid-19 pandemic including for mental health assessments, psychological treatment, counselling and therapeutic group work.

[Further detailed findings on prisons and resettlement.](#)

Additional Information

3. Policing

3.1. National Strategic leadership

We found national leadership of mental health within policing to be appropriate, comprehensive, and well-coordinated.

There is a nominated National Police Chiefs' Council (NPCC) chief officer lead for mental health. They are supported by a national mental health coordinator, who, innovatively, performs the same role for the NPCC and the College of Policing (CoP). A mental health representative also sits on relevant cross-cutting NPCC coordination committees, such as for local policing, workforce and criminal justice.

The NPCC lead chairs a quarterly national mental health forum that includes senior leads from policing, the Home Office, the CPS, the government, Health, and Justice. There are also other strategic forums in which police leadership meets with health, justice and the government in relation to mental health (such as the Crisis Care Senior Operational Group).

The two prominent national sources of mental health guidance for forces are CoP approved professional practice, and the more recent NPCC national strategy for policing and mental health.

The mental health approved professional practice has subsections for 'crime and criminal justice' and 'suspects with mental ill health and vulnerabilities'. Officers are also referred to relevant material within other products, such as the detention and custody approved professional practice.

The mental health approved professional practice and NPCC strategy are consistent in recognising the complexity of the relationship between mental health and offending. Examples of guidance from the NPCC strategy include:

- it is both possible and necessary to prosecute some suspects for offences committed whilst mentally ill – this remains true where a person is so unwell that they are detained under the Act.
- whether someone should be prosecuted is a different matter – all cases should be assessed on their individual merits.
- in weighing up whether or not criminal charges are required in a given circumstance, generally the more serious the alleged offence, the less relevant someone's mental health problems to the police or CPS decision to prosecute but decisions should reflect the full set of evidential and public interest test requirements in the Code for Crown Prosecutors.

It is clear from the national guidance and from our interviews that there is a greater focus on recognising and responding to the mental health needs of victims than of offenders. The exception to this may be management of mental health within the custody environment but, otherwise, we were informed that the issue is not one that commonly generates particular risks or issues. National leaders feel that this focus and attention are commensurate with the risk and therefore proportionate.

3.2. Local senior leadership and strategic partnerships

a) Governance and management

Force management of suspects and offenders with mental health conditions is a complex area, cutting across many departments and portfolios. Leadership of the subject generally involves a combination of department heads and portfolio leads.

We found that primacy for leading the subject of this inspection sat with a mental health portfolio lead in each force, although the criminal justice and custody leads also played prominent roles.

The structures and processes for managing the interoperability between portfolios and departments are necessarily complex. We found similar structures in most forces, with mental health portfolio leads linking into relevant departmental heads and portfolio leads through meeting and governance structures, with some variation in how well defined these were. We found two forces that had adopted different approaches. In Devon & Cornwall vulnerability management was promoted and had been put at the heart of the policing model through the instigation of a specific Vulnerability Command. The command had a number of strands, including mental health, and within the command was a Safeguarding Improvement Hub which drove vulnerability elements of other departmental business.

Conversely, Durham adopted an approach of departmental and individual responsibility. They assigned an additional portfolio responsibility to a single senior officer as a mental health coordinator. Each department was expected to understand how mental health impacted on its work and individual officers were expected to assess risk and make informed and appropriate decisions.

Both of these approaches had strengths and weaknesses but were overall equally effective.

We found strategic partnerships tended to be arranged either along 'health' or 'criminal justice' lines. Whilst mental health is an area of focus for health partnerships, and suspects and offenders for criminal justice partnerships, we did not find that either partnership had any particular focus on the mental health of suspects and offenders. Some forces could identify meetings where both sets of partners are represented. The best example we saw was the Mental Health and Learning Difficulties Criminal Justice group in Gwent.

b) Strategy and policy

The primary source of strategic focus for a police force is normally its Police and Crime Plan, which originates with the PCC (or equivalent) for that area. In most forces we inspected we found elements of the Police and Crime Plan that, while not targeted at the narrow subject of suspects with mental health issues, could reasonably be expected to drive activity relevant to this inspection. Examples include Greater Manchester Police, where strategic objective two of three reads:

'To reduce harm and offending – preventing anti-social and criminal behaviour by intervening earlier and rehabilitating offenders'.

In many cases, forces had accompanying or overlapping strategic priorities, which often provided a similar, if not explicit, strategic impetus.

Such plans were at various stages of their lifecycle within the forces that we inspected. We found some evidence that progress against the relevant strategic objective was being tracked through PCC/police leadership meetings, but limited evidence of data, analysis or evaluation to support this.

We found that forces have a range of further subject-specific policies, the most relevant being the force mental health policy. All forces except one had such a policy as suggested

by CoP approved professional practice. In most cases the policy was comprehensive and included specific, albeit limited, content about suspects, investigations, and case disposal.

Where such content did exist, we found that it mirrored the approved professional practice and NPCC guidance. In no force did we find that diversion content of mental health policy extended beyond consideration of diversion from prosecution via L&D services. There was little content about mental health in the wider context of offender management.

All forces had additional specific policies or guidance documents, including joint protocols with partner agencies relating to mental health crisis cases where detention under the Mental Health Act was required, or offences within healthcare settings or against healthcare staff. Both examples display joint working principles where there is a clear imperative for both healthcare and policing to engage. Forces generally reported that partnerships were good, although there were some suggestions that health partners were 'reluctant to engage', leaving police to drive the criminal justice health agenda.

c) Force guidance

We found that force guidance closely aligned with mental health policy documents. In the Metropolitan Police there is an extensive (85-page) mental health toolkit which constitutes both policy and guidance. As with the guidance of all forces we inspected, it is available via the force intranet.

We also explored who staff might consider as points of contact for mental health guidance. Many staff recognised the enhanced training and knowledge of custody staff and stated that they would seek advice from them. Other staff highlighted qualified triage practitioners, particularly in the forces with the most comprehensive schemes, such as in Gwent, where staff were highly complementary of their role, accessibility and expertise.

All forces had L&D practitioners based in custody and we were surprised how few officers considered these to be an available source of advice in relation to their cases. They were primarily viewed as a custody service in most forces that we inspected.

Most forces had accessible mental health leads either at force level, at local level, or both (depending on the size of the force).

d) Commissioning and partnership services

In every force, clinical commissioning groups (CCGs) had commissioned criminal justice health services. Policing was not directly represented in CCGs but could articulate demand for services indirectly.

In all forces, services included L&D based within police custody. Triage based in either the street or the control room (where mental health professionals work alongside police to consider cases coming in) was common, although not universal. Both schemes vary in their coverage and availability and also in the extent of the service provided.

We found that police forces collected little performance data on these services. The services themselves did produce data for the commissioning groups, although this was predominantly statistics about the service user and their circumstances rather than the effectiveness of any intervention.

The NPCC mental health strategy document acknowledges this:

'In recent years, the two main partnership initiatives through which progress has been forged are Street Triage and Liaison and Diversion in police custody. At this time, evaluation of both has been partial and this reflects the understanding the service has of mental health related demands.'

e) Force training

We found a variable picture in relation to mental health training. Most forces could cite either e-learning packages or training day presentations on the subject of mental health. However, we found that few officers and staff could recall mental health training in general terms and recollections of inputs relating to suspects/investigation/prosecution were very rare. An exception was Gwent, which in 2017 had completed a round of staff professional development days, including a module on criminal justice and mental health.

Training for specialists was better and more targeted to their needs. Custody training was found to be extensive and this is supported by findings from the rolling custody inspection programme. Similarly, we found subject-specific training relating to mental health in advanced suspect interview courses for example.

We found that for many 'generalist' officers such training may be too narrow or too impractical to schedule for widespread dissemination. Forces recognise this and rely on guidance and advice. West Midlands Police were in the process of rolling out mental health tactical advisers within control rooms, response teams and custody suites. The training for these staff included a focus on offenders and offences. We consider that those in full-time investigative roles should have more training in this area.

An area of training where officers reported mental health to be prominent was officer safety training, where restraint of those in crisis, and the associated risks, is a focus.

f) Availability and use of data

We found limitations in data relating to mental health within policing and this included the sophistication and consistency of mental health markers on systems. We found that many (although not all) systems had facilities to flag an individual or case as having a mental health factor. But they did not universally allow for subcategories, specific conditions or qualifying information, and we found that this could decrease the quality and relevance of any data collected. Some forces queried the relevance and proportionality of producing data in this area.

Where we did discover regularly produced data, it tended to reflect the areas of greater risk and prioritisation, such as crisis care, or areas that could directly reduce demand on resources.

The best example of mental health data we encountered was in the Metropolitan Police. Their mental health dashboard produces a range of ongoing data sets relating to mental health. These focus on mental health key performance indicators (KPIs) that are not specific to offenders and suspects. The dashboard does include data on mental health flagging in custody and, uniquely among the forces we inspected, prevalence of mental health in 'use of force' cases, which at the time of the inspection was shown to be 16 per cent of cases.

During the inspection we were provided with some performance data produced by partners in relation to the services they provide. This was often produced for commissioners or for internal use by the partner agency, but too often was not shared with police.

3.3. Local processes and behaviours

For police, dealing with offences where the suspect has mental health issues or is in crisis can be extremely challenging. This case study illustrates a range of those challenges:

Case study

Police were called to a 21-year-old woman who had assaulted her mother and then tried to jump from an upstairs window. She had a number of diagnosed mental health issues and had been sectioned under the Mental Health Act on a number of occasions. She was extremely agitated at the scene and was arrested for assault. She was restrained with handcuffs and leg restraints, during which she further assaulted two police officers.

While being conveyed to police custody, she continually hit her head in the van. On arrival at the custody suite, she was carried straight to a cell kicking and screaming. As a result of her self-inflicted injury, she was conveyed to hospital for assessment, and a request for a full mental health assessment was made. However, she was returned to custody without this having been done, due to her violent behaviour towards hospital staff. On the return journey, she again deliberately hit her head on the side of the van resulting in a lump to her head. An ambulance was called, and paramedics tried to treat her, but she refused treatment. During her time in detention, she was placed on constant observation and kept in restraints.

The mental health team assessed her in custody as having no serious mental health conditions. In total during her arrest and stay in custody she assaulted six police officers for which she was remanded for court where she received a suspended custodial sentence.

a) Diversion before arrest

Forces have arrangements for patrol officers to access 'at scene' advice via street triage vehicles*³³ or remote advice via control room triage. In both scenarios, professionals are available to advise officers and to facilitate required activity. One of the strongest examples was in Gwent, where the force had employed mental health professionals and social workers to provide almost 24/7 support to officers based in the force control room.

These initiatives drive informed and improved decision-making about arrest versus Mental Health Act detention.

When a person is detained under section 136 of the Mental Health Act, they should be taken to a 'place of safety'. Changes to legislation and guidance since the Act was introduced mean that police facilities should now only be used as a place of safety in exceptional circumstances (and never for children). We found this to be reflected in our inspection with very rare occurrences that were fully and properly justified.

In preference to police facilities, someone in crisis should ideally be taken to a mental health facility. Lack of availability of these facilities has been a longstanding issue. We found that in most forces the availability of 'place of safety beds' had improved or was improving, with

³³ * Where we found actual deployable triage vehicles or mental health ambulances, these were commonly under review, were being withdrawn or had been recently been withdrawn.

surprisingly few officers reporting any consistent lack of availability or significant delay. We did find one rural force where the situation was at odds with all others and where space was extremely limited and often a great distance from the incident in question. In that force we found that a perverse incentive had developed where identification of any substantive offence, including minor and victimless offences, resulted in the person being taken to custody which was 'the best place from which to commence an assessment and access services'.

A factor in decision-making is whether a person's behaviour may be caused by mental health and/or drug or alcohol consumption. Officers are aware that mental health professionals are unable to properly assess someone who is under the influence of drugs or alcohol, and as such know that seeking an assessment can be futile. In these instances, the options are to take the person to A&E for medical care or, where offences are apparent, to take them to a custody facility.

Any advice about or decision on whether to detain the person under the Mental Health Act is often inextricably linked to progression of a criminal investigation. We found that officers have a good understanding that minor crime, particularly crime caused by the mental health crisis itself, could be swiftly discontinued in favour of a health care approach. They also recognised that more serious investigations could progress in parallel with mental health treatment or could be put on hold pending such treatment. In cases where officers did not think there were grounds for mental health detention at the scene, they recognised that further expert advice and assessment could be sought and obtained within custody. We rarely found that this understanding was rooted in knowledge of policy or approved professional practice but instead came from wider experience and an understanding of proportionality, discretion, and decision-making models such as the national decision model.

b) Custody processes

As part of the custody 'booking in' process, persons arrested are subject to a risk assessment. We found a risk assessment pro-forma in every force. These varied slightly in content, but all contained direct questions regarding health, mental health, learning difficulties and medication used or required. Screening and managing detainee risk are very much at the forefront of police custody work. They feature heavily in custody staff training and in custody management systems and we found that staff take them very seriously

Data from analysis of our case file assessments shows that a risk assessment was completed in 202 out of 203 custody cases.

Our case files all related to individuals who at some point had been flagged, usually on the police national computer, as having some form of mental health issue. As a test of the effectiveness of the risk assessment processes, we measured how many of this sample group (not representative of the general population) were properly identified as having a mental health condition. We found that 90 per cent were so recognised.

It is very difficult to compare cases for consistency. Our best method of doing so is to compare two instances where the same suspect was detained or interviewed. We found 108 custody cases where an earlier instance was available for review.

Of these 108 cases, 11 per cent were not identified with mental health conditions during the primary case, while 23 per cent were not identified during the earlier instance. Of the 95 cases where mental health conditions were identified in the primary case, 21 were not identified earlier. Out of the 12 cases where mental health conditions were not identified in the primary case, seven were identified in the earlier instance.

Despite the levels of commitment, we did find a number of examples where, through human error, forces had missed available information about a suspect's mental health, not fully recorded it or not acted upon it with an HCP or L&D referral.

More generally, we found that, in most forces, recording of pertinent information in custody records was inconsistent. Our rolling custody inspection programme (conducted with HM Inspectorate of Prisons) reaches the same conclusion. Inspectors cite examples of detainees with mental ill-health where it was difficult to track the course of events, such as when requests for mental health assessments were made, when they were carried out and the decisions reached.

We found that many detainees would attract a mental health flag on force systems. Officers in all forces report that police recording of mental health adds value; however, the limitations of this must be recognised, because:

- The range of potential mental health conditions is significant, and mental health will be recorded for all potentially applicable conditions including for example, mild anxiety.
- Many conditions are transitory, and records may quickly become out of date – with some forces having no reliable weeding facilities.
- Officers are inclined to proactively record factors even when the provenance is weak, this will include self-diagnosis from suspects, which many officers believe offenders use in the belief that it will influence how they are treated.

In July 2018, the Police and Criminal Evidence Act codes of practice altered the definition of a vulnerable adult who would require the support of an appropriate adult (AA) during an investigation. The revised definition provided a more subjective test for officers that requires an assessment of understanding, comprehension, reliability, and susceptibility.

We were surprised to find that the majority of risk assessment screening tools within IT systems had not been adapted to directly reflect the changed tests. Greater Manchester Police was an exception, where the risk assessment pro-forma included an additional 'officer assessment' question: Does the person appear to be vulnerable as defined under the Police and Criminal Evidence Act?

Whether AA provision is sufficiently comprehensive is a longstanding question. A common argument from those who think AA provision is insufficient would be that only a small proportion of those recognised as having a mental health condition are provided with an appropriate adult. Analysis of the case file reviews conducted for this inspection show the balance of referenced conditions as follows:

Schizophrenia Suicidal
 Self-harm Personality disorders
 Psychosis PTSD
 Dyspraxia
 Depression Paranoia
 ADHD Bipolar
 Autism Alcohol dependant Anxiety
 Memory loss Asperger's

A clinically trained interviewee highlighted statistics that, while not directly relating to vulnerability, emphasise the prevalence of lower-level, less severe illness. We were told that the population of the police area was approximately three million, of whom 550,000 would have a mental health condition, of whom only 36,500 (6.6 per cent) were being treated for such a condition via their GP. They added that, even where a person's condition is more serious, if it is diagnosed and medicated, they could be entirely capable of functioning without an AA.

Overall, we found that processes for identifying mental health vulnerability and AA need in custody are good. We consider there to be some vulnerabilities from the cumulative effect of: workforce inconsistency in relation to missing some available pertinent information, missed opportunities for healthcare assessments, the inaccuracy of some mental health flagging, and from the absence of specific vulnerability prompts within risk assessments.

Our inspection found some variability in the availability of AAs for vulnerable adults, although officers reported a generally positive situation. We found that provision could vary within a force area along local authority lines. The rolling custody inspection programme has also found that obtaining AAs promptly is an area that requires improvement in many forces and highlights that there is no statutory requirement for local authorities to provide AAs for vulnerable adults, as there is for children.

Our case file review analysis of the 203 custody cases found that, of the 90 per cent of cases where mental health issues were identified, on average 26 per cent of these were assessed to need the support of an AA. This varied between forces, from one out of 10 cases to five out of 10 cases, and the inconsistency is concerning.

Of the 108 custody cases where an earlier instance was available for review, we found that 30 of the primary cases had required an appropriate adult; of these 30 cases, 11 had not been judged to need an AA for the earlier instance.

We found that most forces have extensive healthcare coverage on all sites (although, in one, HCPs had to travel between multiple smaller custody suites). Practitioners can be a

mixture of nurses, paramedics and doctors. Healthcare staff, sometimes in conjunction with L&D staff, can assess fitness to detain, fitness to interview, the need for an AA, and the need for specialist mental health assessment.

No force required that all indications of mental health issues must result in an HCP referral. Staff understood their responsibility to decide whether this was required based on the information they gathered through the booking-in and risk assessment process. We did discover some inconsistency in decision-making, both within and between forces. We also found some cases where we were surprised, based on the information recorded, that an HCP had not been engaged.

Our case file review analysis found that, of the 90 per cent of cases where mental health issues were identified, 64 per cent of these were assessed as requiring an HCP referral. There was some variability between police forces, ranging from four out of 10 cases to seven out of 10 cases.

As a result of the risk assessment and healthcare process, custody staff took necessary steps to safeguard the detainee and others. These steps may include more thorough searching, removal of some clothing items where necessary, and increased visits or observations while the detainee is in a cell.

We found that enhanced and strip searching was in all forces well evidenced and properly recorded. However, in one force we did find high instances (31 per cent) of strip search within a pool of 55 cases involving people with police mental health markers. In none of these cases was anything found, and inspectors inferred that an inappropriate connection between potential for self-harm and the likelihood of concealed items was being made.

We inspected processes for managing risk at the end of a period of custody. Our rolling custody inspection programme also inspects this area, and both inspections found a good recognition of the risks at this stage, provision within policy and guidance to address these risks, and templated risk assessments at the point of release. We found that staff generally complied with policy and completed assessments well, although we did encounter areas of inconsistency both within and between forces. As in other areas of custody work, we sometimes found that written records did not always fully reflect what has been considered and done.

Case study

A 46-year-old man was arrested on suspicion of criminal damage, where it was alleged that he had thrown paint over a property and smashed its windows. During the risk assessment, he disclosed that he suffered from depression, anxiety and split personality disorder (medicated) but that he was feeling ok at that moment. Despite this extensive history of (declared) mental health issues, there was no evidence of either an L&D or HCP referral. After 13 hours in custody, he was bailed with conditions. The pre-release risk assessment upon leaving custody failed to record the risks identified at the time detention was authorised, including mental ill-health, alcohol dependency, domestic violence and self-harm.

We found that most forces had referral leaflets for support agencies, including those relating to mental health. We also found that, in most forces, the risk assessment process on release was enhanced for sexual and child abuse type offences. A strong example of post-release support was seen in Durham, where a 'little blue book' of contacts, services, organisations and support networks was provided.

Managing risks when they are identified is a challenging area for policing. In a proportion of cases the release from custody is at the point of charge and therefore officers do have the option to remand in custody for court. The grounds for remanding in custody would include that the detainee presented a risk to others or to themselves. While mental health is therefore not a reason for detention, officers reported that it can influence the risk that a detainee can pose. Where the risk is to others, a decision to remand might be straightforward; however, where the risk is one of self-harm then this is more complex.

We found that officers in many forces would consider a remand application where self-harm was a risk. Doing so was in part to limit the risk and exposure for the police force in releasing the person into an uncontrolled environment. Officers in many forces reported that the CPS would argue that remand did not address the risk of self-harm (and could even increase it) so would not support such applications.

In a larger proportion of cases the release from custody is not after charge and so further detention is not an option.

Officers and healthcare staff reported that it can be common for a detainee to indicate an intention to self-harm without being in need of assessment or detention under the Mental Health Act. One L&D practitioner explained this as follows:

“There is a difference between someone with a severe and enduring mental health condition vs someone e.g. with emotionally unstable personality disorder, who is responding badly to crisis. In some scenarios, e.g. [child sexual exploitation] offences, the consideration of self-harm can be a crisis response that doesn’t indicate or rely upon any mental health condition whatsoever.”

In examples like this, the police must release the person. The person may be indicating an intention, or otherwise be judged likely, to self-harm. The police have no powers to compel the person to access help, and support from other agencies may not be immediately available. All police can do is to try and mitigate risks.

If a suspect is remanded, then the police have a responsibility to pass on relevant information to the escort service and the court. They do this by completing a prisoner escort record. When these were available to our inspectors, we found them to be completed to a high standard.

c) Voluntary attendance

Many of the considerations and risks relating to custody are applicable and heightened when considered against processes for managing voluntary attendance (VA). Voluntary attendance (or interview) is the process whereby a suspect is interviewed about an offence when not under arrest. The suspect attends a location, most commonly within a police building, to be interviewed under caution. We found that, in most forces, there was a risk assessment template for VA, which was generated and completed within the crime or custody IT system. In some cases, the content of the VA risk assessment closely mirrored or was identical to the custody risk assessment. We question this, as obtaining personal medical information may not be necessary.

VA interviews take place predominantly in police buildings. In all forces, we found that custody interview rooms were used through necessity, and in some forces, this was the most common setting. Regardless of location, the responsibility for completing the VA risk assessment lies with the interviewing officer. Since these officers have less experience and training, there is a greater risk that vulnerability indicators will be missed.

Some forces have recognised this risk, and enhanced VA assessment processes by adding multiple stages. In West Midlands Police, we found that a supervisor was required to conduct the risk assessment. In Gwent, a VA suspect must be 'booked in' by a custody officer, even the interview takes place away from custody.

In those forces that did not place additional safeguards around the process, we found no evidence of subsequent supervision or oversight of the risk assessments conducted for VA. We did find many good examples of effective risk assessment for VA but also cases of concerns or those where a record of the risk assessment could not be found.

We found that post-interview 'release' risk assessments also existed for VA and that, other than for specialist officers dealing with sexual or child abuse cases, completion standards were variable. We also found that occasions when officers facilitating a VA interview considered or used an HCP or L&D were rare.

There are other elements of policing processes where VA similarly creates or enhances risk, such as through the service of postal charge (known as PCR). We did not inspect this area in great detail, although we did encounter good examples where officers had recognised a suspect's vulnerability. Where this happened, officers sought to deliver a 'postal' charge other than through the post. This was to ensure that the suspect understood what was required and was not unduly distressed. We are not confident that this routinely happens.

Our case file review analysis looked at 44 VA cases and found some stark differences in outcomes compared with custody cases.

A risk assessment was recorded in 29 out of 44 VA cases (199 out of 203 custody cases). Within the 44 voluntary attendance cases, there are disparities between forces: three forces recorded a risk assessment in all cases reviewed; two forces did not record a risk assessment in any of the cases reviewed or it was not known if one was recorded; and one force recorded a risk assessment in some cases (including the 'paper' based force where records weren't visible to inspection staff).

Mental health was identified as an issue in 26 out of 44 VA cases, compared to 183 out of 203 custody cases. HCP advice was sought in three out of 44 VA cases (and in 126 out of 203 custody cases, but this was not directly comparable).

Out of the 26 VA cases where mental health issues were identified, there was a referral to L&D in one case, compared with 83 out of 183 custody cases.

An AA was used in nine out of 26 of the VA cases where a mental health issue was identified, compared with 48 out of 183 custody cases.

d) Investigative, case progression, and prosecution decision-making.

As described above, officers often encounter offending when dealing with people in varying degrees of crisis. Where an initial decision is to detain someone under section 136 of the Mental Health Act, this does not prevent an offence being progressed at a later stage, although where evidence needs to be gathered immediately through forensic capture or searches, this becomes more complicated. Where cases did result in arrest, we were told that on rare occasions custody staff may consider arrest to have not been appropriate and to divert the detainee towards healthcare locations.

Case study

A 25-year-old female had been arrested for being drunk and disorderly she was spotted moving between traffic along a busy road. The police found her to be intoxicated and erratic, being abusive to officers and attempting to run into the path of oncoming traffic.

She was arrested under the Police and Criminal Evidence Act (there was no mention of section 136 of the Mental Health Act on the detention log). During her custody risk assessment, she expressed concerns about her mental health and was found to have a recent history of multiple suicide attempts.

She was referred for L&D intervention, during which she refused mental health intervention but accepted other post-release support (for example, housing). However, an HCP assessed her and also consulted the woman's housemate. This identified significant concerns about her behaviour, current state of mind, and likely compliance upon release from custody. It was recommended that the woman should either be referred for a section two mental health assessment or placed under section 136 restrictions. The latter was pursued, and the custody sergeant immediately closed the original offence as requiring no further action, before the woman was transported to a local mental health unit.

Our inspection found that there was an acceptance at all levels, and from both police and partners, that a CJS approach is often both appropriate and necessary. We also found a recognition that mental health could be a mitigating factor and may influence any decision to discontinue a case or adopt a non-judicial solution such as an out-of-court disposal.

We found some national guidance on progressing cases with mental health issues through approved professional practice and NPPC strategy, but this could only set broad parameters for decision-making.

We were told by officers that it is not uncommon for a suspect in custody to be assessed, detained and transferred under the Mental Health Act. In such cases, we found that there was a consensus that the progress of the criminal investigation would be decided on the merits of the case, and that this would depend on a wide range of factors. We found that officers made these decisions in consultation with supervisors and that they were generally confident in their decision-making. We found examples where this approach did result in the investigation being closed with no further action being taken. Such cases were generally lower-level offences, or those where the victim understood the crisis element and did not wish to proceed. We also found cases where the investigation was paused during mental health treatment but re-commenced, and also cases that were progressed in parallel with mental health treatment.

Case study

Police witnessed a man causing criminal damage to a window. Officers arrested him when he became violent towards them, resisting arrest, and a lock-knife fell from his pocket. Use of force was used, including CS spray. Once handcuffed, the man was taken into custody. Psychosis was identified during the man's initial risk assessment. He was referred to the HCP and then for an assessment by L&D staff for the mental health concerns. A full Mental Health Act assessment was conducted, and he was detained under section 2. Police charged the man with assaulting police and possession of bladed article, before taking him to hospital. The submitted case papers properly reference mental health issues within the relevant sections. The man was arrested for a further offensive weapon offence a few weeks later.

Similar considerations applied in cases that did not result in detention under the Mental Health Act but where mental health was nonetheless a factor. In some forces, these

decisions simply sit with the investigating officers and their supervisor. It was rare for us to be told that L&D staff would contribute to these deliberations. Variability in officer interpretation added to the range of offences and conditions. There is an inevitable risk of inconsistency both within and between forces.

We found some force initiatives that provided additional structure or process to such decision-making. Greater Manchester Police had set up Mentally Vulnerable Offender Panels, where cases would be submitted for disposal advice from a panel that included partners from health and justice services. In both Devon & Cornwall and Durham we found deferred charge and deferred caution processes that go beyond just progressing the case and consider how to divert the offender from the CJS as well.

Officers highlighted that the CPS can have a role in deciding the outcome of a case. Officers can either submit a request to the CPS for early investigative advice (which we found to be quite rare) or submit a request for charging advice. Officers recognised that the CPS has an appetite for more detail when mental health issues are highlighted within case documentation. They stated that sometimes the CPS's advice might be an alternative to charge and prosecution.

Case study

A man was arrested after attending the address of his ex-partner despite having previous warnings for harassment.

During the custody risk assessment process, the man disclosed mental health issues, including depression and suicidal thoughts.

The man was referred to the HCP on a number of occasions during his time in custody and repeatedly stated that he was going to kill himself once released from custody. The man was conveyed to hospital for a full mental health assessment and sectioned under the Mental Health Act.

Police submitted a charging advice request to the CPS, detailing the relationship history and the outcome of the mental health assessment.

The CPS's charging advice was to withdraw proceedings.

Where it is decided that a case warrants no further action, the crime record must be finalised with an outcome code. This is an administrative process based on the rationale from the investigating officer and supervisor. The relevant outcome codes for cases involving mental health considerations might be OC9 – CPS decision that not in public interest to proceed, OC10 – Police decision that not in public interest to proceed, OC12 – Named suspect is too ill to prosecute.

We did encounter some limited oversight of case outcomes. In some forces, there was an independent panel who dip-sampled out-of-court disposals; in others, outcome codes were scrutinised either through ongoing or bespoke workstreams. We did not find that the outcome codes 10 or 12 were scrutinised or otherwise overseen in any force.

Our inspection reviewed some OC12 cases and found a mixed picture in relation to the apparent threshold. We were told in some forces that a mental health factor could be used as an 'excuse' to clear a crime and manage workloads.

Where cases do progress to charge or charging advice, we inspected how mental health information is passed from the police to the CPS. We found that there was a distinction between cases where a mental health crisis may have been directly relevant to the offence

or been raised by the suspect as a defence and those cases where the suspect simply has mental health issues. In cases with a direct link, the information inevitably features in the case papers and forms part of the case narrative. In those cases where the mental health condition is simply background information that may inform decision-making, we found it rare for it to be included.

Case study

A male suspect was arrested for a domestic abuse assault on a former partner. A previous incident was disclosed by the victim, which included taking a knife to the victim's throat and threatening to kill her.

When the suspect was in custody, his mental health conditions were recorded as split personality, ADHD and depression, with the suspect taking prescribed medication. Self-harm was identified from two weeks before this period of detention and self-harm markers were recorded on police systems. The male was seen by an HCP and also declared alcohol-dependent.

The case was deemed suitable for an emergency police decision, which was subsequently ratified by CPS. However, no reference to any mental health concern was made by the custody officer when recording the decision to charge and remand. The male was charged and remanded until his trial. There were no references to any mental health concerns on the case file documents (MG4/5/6/7) submitted to the CPS.

He subsequently received a 17-week custodial sentence suspended for 12 months

Guidance from the Director of Public Prosecutions (current version DG6) sets out that the information required for a charging decision should include ***'Any indication that the suspect has a mental health issue that may impact on the decision-making or handling of the case'***.

Required information should be available via a custody record, although prosecutors are prompted to consider whether to make a 'request for further information' in relation to the mental health issue.

There is no specific section within the case papers that would prompt officers to consider including this information, nor any specific space within the papers to do so. Officers are not at all clear on the extent of the requirement, the information to be included, where they would obtain this from, or what can legitimately be disclosed. We did not encounter any national or force guidance that sets these expectations out from a police perspective or clarified the disclosure status of HCP and L&D records where the suspect doesn't consent.

We found the issue of information-sharing to be a complex one. For custody cases, L&D or healthcare services may have accessed information about a detainee's mental health and treatment history. This information will be shared with custody staff and may be written in the custody record. Most L&D practitioners consider the purposes of this to be minimising risk and ensuring the appropriate treatment of the detainee in custody and beyond.

Officers compiling case papers could reasonably access mental health information contained in custody records, but we did not find that they routinely asked L&D services for further detail to inform the next stages of the criminal justice process. We found that the majority of L&D services did not consider this to be part of their role or information-sharing protocols. We are told that CPS colleagues are often frustrated by references in custody records that indicate mental health issues but do not provide sufficient information.

Of 183 cases where mental health issues were identified through risk assessment, 85 required a written request for charging advice. Of these 85 cases, 21 made reference to the mental health condition in the charging advice documentation.

Of the 183 cases, 103 resulted in a set of case papers and the mental health condition was referenced in 21 of these case papers. In 12 of these cases, mental health was recognised as a factor in the offending and in all 12 of these cases this was referenced in the case papers.

e) Diversion and offender management

We inspected force-led offender management schemes, diversion schemes, and the pathways that forces had developed in conjunction with partners.

In all forces, we discovered a custody-based L&D service which provided greater focus on certain groups, including women offenders and service veterans, based on additional risks or potential success factors.

We found two forces where a deferred charge and caution scheme included a detailed needs assessment and a tailored intervention plan with statutory partners, third-sector providers and scheme staff. In Devon & Cornwall, the success of the scheme can be measured through offender self-assessment, with 55 per cent of participants reporting a significant improvement in their mental health and wellbeing at the end of their contract

In all forces, there are established adult safeguarding processes where any officer can raise concerns about a subject's wellbeing by submitting a form that is then assessed by a central team before being prioritised for onward referral. Such referrals are less common for suspects and offenders. Neighbourhood Policing Teams operate a problem-solving approach and we found that referrals were part of their toolkit for dealing with individuals committing crime or displaying anti-social behaviour. Officers and partners told us that referrals for mental health services can outweigh capacity, particularly from health partners, and that referrals are prioritised based on clinical need, which means that either no referral is made, or no treatment is accessed in a proportion of cases.

In every force we inspected we found that an Integrated Offender Management (IOM) service is provided with probation service partners. The primary cohort of offenders for IOM are persistent and serious acquisitive criminals but, in many cases, this had expanded into other areas of offending. All IOM schemes would have access to mental health pathways and could demonstrate that these pathways were utilised where appropriate for offenders.

Multi-Agency Public Protection Arrangements (MAPPA) are in place to manage the highest risk violent and sexual offenders and this is done in part through Management of Sexual or Violent Offenders (MOSOVO) teams and officers. Multi-agency risk assessment conferences (MARAC) address the highest risk domestic abuse offenders. In all these processes mental health services are either directly involved or are used as a critical pathway when applicable to the offender being considered.

We found that some forces had extended domestic abuse offender management arrangements to intervene more directly with medium-risk offenders. In Durham, a multi-agency tasking and co-ordination (MATAC) process would identify those who could be worked with to address the causes of their offending, including through referrals related to mental health. Greater Manchester Police and Devon & Cornwall had similar schemes.

Finally, in a number of high demand forces, Violent Crime Reduction Units have been set up. These partnership units include referrals into critical pathways such as mental health services.

There are some limitations to diversion schemes, capacity being one. Also, schemes must generally rely on consent, which leaves a significant cohort of offenders who will not consent and therefore will not benefit from these schemes.

The most joined-up approach to offender management was seen in Durham. L&D services extended to assisting with pathways for MARAC cases, where IOM and the checkpoint diversion scheme are closely aligned, and where towards the end of a deferred charge contract a case can be handed to the Familiar Face or community mentor scheme for ongoing support.

Case study

In Durham we were told of a female resident with alcohol and mental health issues who, when under the influence of alcohol, would frequently and persistently call police. She was referred to the force's 'Familiar Face' scheme, which not only engaged with her needs, but also provided support to the force through guidance to the control room on how to deal with her calls. Although there were periods when her behaviour improved, the problematic calls continued or re-commenced. The force then deferred a prosecution using the 'Checkpoint' scheme. The woman engaged with the scheme, but had a few lapses, which were viewed sympathetically. She was able to complete the contract and avoid prosecution. The calls began again, and the woman was then prosecuted. It was this approach that finally broke the pattern of behaviour. The woman is now a 'lived experience' mentor for others on the force's community mentor scheme.

More generally, across the country, offender management in its broadest sense is not particularly well coordinated. There is little national guidance and within forces the various schemes are often contained within disparate portfolios with little visible coordination. We did not find frequently produced or comprehensive data on diversion schemes.

4. Liaison and diversion services (England) and criminal justice liaison services (Wales)

NHS spending on L&D services in England in 2019/2020 was around £66.2 million. It is estimated that the scheme received 84,742 adult referrals from the police and courts during this period. In 2020/2021, adult referrals had increased to around 110,768.

NHS England commissions L&D services across most areas of England. However, the funding in each area and the model commissioned vary, with numerous providers delivering different elements of services.

NHS trusts were the main providers in the five English areas we visited. Arrangements were slightly different in Greater Manchester, where the trust provides the service but it is subcontracted by Mitie, which retains overall responsibility. Third-sector organisations often deliver outreach/peer mentor services. In Croydon, for example, they deliver court L&D services jointly alongside the trust. Not all areas have providers contracted to be on site in courts – Exeter L&D are not required to be on site but did do so as they felt it worked. This was, however, withdrawn during the pandemic and has not been reinstated due to staffing levels. In Wales, as part of the NHS Wales Together for Mental Health Strategy,³⁴ Criminal Justice Liaison Services in police custody suites and courts have been funded to identify those in mental distress and facilitate access to care and treatment.

4.1. Leadership

Although national strategies for L&D services in police custody were in place in England and Wales, the application of this provision at a local level varied significantly. The commissioning arrangements differed depending on funding and we saw different arrangements for provision in both custody suites and court settings. In all areas we visited, both L&D providers and custody staff felt that there were not enough resources to meet the needs of those with mental ill-health in police custody and court settings. Either more staff or more hours on site were required to meet demand. In part, some areas felt this was due to the increased acuity and complexity of patients being seen during the pandemic, which led to longer assessments and therefore fewer patients able to be seen. Under the new L&D national specification arrangements in England, practitioners are not just seeing patients with mental health needs, they are seeing patients with all vulnerabilities, which further stretches the resource.

We found that strong local leadership promoted high-quality personalised care. Staff were passionate about supporting patients in custody, and we saw proactive work to identify anyone who may need support who had not already been referred to services.

Systems and processes did not always support the delivery of effective care. Each area had multiple providers for L&D, healthcare, peer mentoring and outreach work. Each provider used their own system for electronic records, and, despite some areas implementing a further system to link several different ones together, overall this issue meant that information could not always be accessed or shared in a timely manner. This could then impact on the care an individual received, or on the criminal justice outcome for them.

³⁴ Welsh Government. (2012). *Together for mental health: a strategy for mental health and wellbeing in Wales*. <https://gov.wales/together-mental-health-our-mental-health-strategy>

Partnership arrangements were mostly positive. However, their effectiveness was hampered by the challenge in agreeing information-sharing protocols and system access across multiple providers.

Commissioners held providers to account and regular contract review meetings gave providers the opportunity to raise and discuss any concerns or issues.

4.2. Staffing and training

The Covid-19 pandemic had impacted on the identification of individuals with mental health needs and disorders. L&D teams had worked remotely during periods of lockdown, which meant they relied on partner agencies identifying a concern and referring an individual to them for a phone assessment.

We found a rich mix of skills across L&D teams, which was significant progress since the last inspection. All L&D teams included mental health nurses, and social workers and assistant psychologists were regularly seen. Learning disability nurses were also employed in some areas, which provided much-needed pathway support for those in custody with a learning disability. The different experience and knowledge within the teams expanded the options for individuals accessing the L&D service. In Birmingham, we found an L&D team delivering services in a culturally sensitive way, accessing specialist services and making good use of the diversity data they were collecting.

Good practice example L&D

- All individuals are screened; ethnicity data is collected, and information is evaluated to determine any trends in order to improve service delivery.
- Translation services are available and accessible to staff.
- Cultural awareness training is provided to ensure that the greatest sensitivity is shown to those with religious needs, for example around Ramadan and prayer times.
- Faith/culture-based charities, such as Salma Food Bank and Himaya Haven, which specifically support ethnic minority people, are regularly used.
- An 'inclusivity champion' is being allocated to the team.

Access to training for L&D teams was good and, in some areas, had improved during the pandemic as more remote learning resources were provided. Staff told us that they were able to access online training as well as sharing learning among their teams. Daily meetings were often in place to allow colleagues to keep in touch and share feedback or seek advice where needed. L&D teams often provided training for newly recruited custody staff to inform them of the service they can offer; however, this had inevitably been on hold during the pandemic.

Management oversight was strong, with good governance systems to ensure a high-quality service was delivered. We saw audit programmes and incident reporting frameworks, as well as regular team meetings to share learning and innovation. Generally, staff told us they felt well supported and could access supervision. However, in England, staff commonly felt removed from the wider trust they were employed within and that there was a lack of understanding of what L&D services did within the trusts.

All L&D service providers had robust systems for mental health learning and development. Most of the training had been moved to online platforms because of the pandemic. We found that IT issues in some custody suites meant that staff could not easily access their

own case systems to complete online learning or patient records. This was frustrating for staff and was often exacerbated by the numerous different systems they needed to access, alongside poor Wi-Fi signals in some areas.

Staff told us they felt empowered to make their own decisions and had someone they could call for advice or to escalate a concern. However, this could be hampered by the challenges they faced in accessing patient information from different systems, by Police and Criminal Evidence Act time limits in custody or by pre-sentence report deadlines in court.

4.3. Services

Every force inspected had a commissioned L&D service.

The aims of the commissioned L&D services were consistent with national expectations, although we found that most provided a core or basic service level. This was focused within the custody environment and consisted of assessing detainee needs, advising on required interventions (in conjunction with HCP), providing some background information to custody staff, and referring detainees on to support agencies once released.

We found that, although 'in scope' for most services, interventions with voluntary attendees were rare.

Where we found data on L&D services, this was usually produced by the service and provided a detailed breakdown of the users (such as demographics and offending behaviour), their needs, and their referrals. We found little information on the effectiveness of schemes.

Information-sharing was often a barrier to effective service delivery. Investigating police officers had access to quite basic information about mental health in cases where the suspect has been in custody. Those interviewed were not sure how they could obtain more detail or the status of information-sharing protocols, where they existed.

Of the 108 custody cases where two instances of detention were available, 47 were referred to L&D in the primary case of who only 18 were referred for the earlier instance

We found that relationships with custody staff were generally good overall, with a fuller understanding of the work L&D teams do and better communication to support individuals with mental health issues. Individuals detained under the Mental Health Act (MHA) were not taken to police custody as a place of safety. Instead, they were taken to the local designated place of safety, which meant they received care in the appropriate environment.

Interventions delivered by the L&D teams in custody and courts are limited to assessment and referral pathways due to the nature of the role. Assessment templates on electronic patient records were based on national guidance and of a good quality. Providers had governance systems in place to monitor the quality of L&D interventions, including audit schedules and peer review sessions, which were overseen by local managers. Team meetings were well embedded and provided an opportunity to share learning from audits and complex cases.

In custody, assessments were completed to a good standard, and onward referral pathways were robust, including where an MHA assessment was requested. However, the ongoing support provided was not always timely. There were long waiting lists to access mental health support in the community, which had worsened significantly during the pandemic due to an increase in demand for services and reduced face-to-face contact with patients.

Poor practice example

Diversion services such as street triage (L&D teams on the street with police officers to support and advise on individuals in crisis) and control room support from L&D practitioners were inconsistent across areas, with some running pilots and others having no provision. Where these services were available, hours were limited significantly due to funding. Passionate and motivated staff were frustrated that they could not offer a broader service when this was so highly valued by police colleagues.

The level of engagement between L&D teams and local agencies differed depending on the services available in a particular area. For example, in Exeter, a hub in the community provided a 'one-stop shop' for a number of vulnerabilities, including substance misuse, housing and debt support. This service was advertised to individuals while they were in custody. Relationships with services were often maintained through recovery/outreach/peer workers, who provided a link between the individual and support services. In Durham, the L&D team maintained a caseload of people they supported post-custody, maintaining contact until the person had engaged with the service they were referred to.

In most areas, the same health board or trust provided L&D custody services and community mental health services, but their suitability and ability to meet individuals' needs varied. In some areas, staff shared their frustration at trying to refer or arrange appointments for individuals who may not meet the threshold for support due to the extremely high demand for services, which had increased during the pandemic.

The range of mental health services provided took account of diversity factors for individuals. Trusts and the health board had taken a proactive approach to engaging with community organisations that may support specific groups of people, for example a well-promoted and used women's pathway in Birmingham.

Providers continue to encounter challenges in accessing inpatient beds for individuals assessed for detention under the MHA. L&D practitioners felt confident in calling an MHA assessment and described positive relationships with advanced mental health practitioners. However, due to a lack of capacity, individuals requiring an MHA assessment were often held in custody overnight to await day-time teams to carry out assessments. In turn, individuals referred for an MHA assessment later in the day would often wait for the out-of-hours emergency duty team to be seen due to the high demand for assessments during the day. Some L&D teams felt this was due to the perception that an individual in custody was in a safer place than an individual awaiting an assessment in the community.

L&D teams were able to refer to recovery workers and peer mentors in the areas visited. We heard positive feedback from individuals regarding the support they received from peer mentors, who were able to offer time on a short-term basis to support individuals engaging with local agencies and to share advice and experience. This had often bridged the gap between referral and assessment for some services during the pandemic, such as community mental health team appointments.

4.4. Information and facilities

We found that providers of L&D services had the appropriate policies in place to govern services delivered, and local pathways were well established to support the different needs of individuals accessing the service. A role funded to support children in custody in Croydon was highly regarded. It offered specialised support to children brought into custody with mental health problems.

In England, the profile of services was reviewed and monitored by NHS England commissioners, and regular contract meetings took place between providers and commissioners.

There was confusion and misunderstanding about GDPR confidentiality rules and requirements. This led to key partners being denied access to assessment information and ultimately individuals suffered further. There were usually several different providers working in a particular area, each with a different electronic recording system, yet there was only a link between all systems to enable cross-provider access in one of the six areas we visited in England and Wales. Although some areas had commissioned a single use system for all health providers to access, this was yet to be embedded and did not provide any historical information.

We found that current processes give investigating police officers access to quite basic information about mental health vulnerability in cases where the suspect has been in custody. Overall, neither police nor L&D staff were clear about the status of existing information-sharing protocols or how police officers could obtain more detail, such as a history of referrals.

Poor practice example

In one area we visited in England, court practitioners were employed by two different providers, one being a mental health trust and the other a third-sector organisation. In this area, there was no link between each provider's systems; therefore, not all practitioners would be able to access past mental health records. This meant that reports of varying depth and quality were submitted to the court, through no fault of the practitioner. While information could be requested by email or phone, this was not timely and there was often a lack of understanding from community teams regarding the time constraints of information-sharing within custody and court settings.

We saw good examples of information-sharing in Birmingham, where the trust provided both L&D and community mental health services, and records were held on the same system. However, even this was overshadowed by connectivity to trust systems within the custody suites. On some days, staff had had to reduce the number of hours they spent in custody seeing patients in order to access systems and record notes, which reduced the number of service users they could see.

We did not visit any physical sites in Wales. Premises we visited in England varied significantly from area to area, but also within each county/borough. Police custody is not deemed an appropriate environment for someone who is mentally unwell, and it was pleasing to see that those individuals requiring detention under the MHA were no longer brought into this environment.

Good practice example

One custody suite we visited in Exeter had been purpose-built and designed with L&D services in mind. There were excellent facilities to promote joint working. Healthcare and L&D teams were based in adjoining rooms, and there were separate rooms to allow for privacy during assessments and interventions. Office space was designed for L&D practitioners to observe the booking-in process and work closely with custody staff to support any patients requiring interventions.

In other areas, facilities were often lacking. There was limited space for L&D practitioners to be based, and this was often further away from custody, which limited contact between custody and L&D staff. There were also difficulties accessing room space in some areas; this was a particular issue in courts, where practitioners would often need to queue for rooms alongside lawyers.

The Covid-19 pandemic had significantly impacted on the environment in which L&D practitioners work. It was no longer possible to see patients face to face in private rooms in most areas, due to social distancing guidelines and trust safety measures. This meant that L&D practitioners were required to assess an individual's mental health at a cell door with a detention officer close by, and often with the individual in a CCTV recorded cell. This environment was not conducive to discussing mental health issues. L&D teams felt that this had reduced the level of engagement and quality of the service they had been able to provide.

Where we found data on L&D services, this was usually produced by the service and provided detailed information on the users (for example, demographics and offending behaviour), their needs, and their referrals. We found little information on the effectiveness of schemes. Statistics provided by L&D services showed that mental health was one of the referrals most frequently made by L&D professionals. In Gwent, mental health was second only to foodbank referrals. Data from the West Midlands (February 2021) showed that mental health (not including learning difficulties) was the most common referral type, at 27 per cent.

While providers had processes in place to obtain feedback from patients using their service, this was not always easy due to the environment in which it was sought. In some areas, the providers had acknowledged that they could gain more useful feedback from people after they had left custody and had implemented alternative ways for feedback to be provided. We saw positive patient feedback for peer mentoring services, which highlighted the significance of peer support.

4.5. Quality of service delivery

Assessments carried out by L&D teams were holistic and personalised, and there was clear evidence in electronic records that individuals were involved in their assessments. While not all referrals to the L&D team for mental health support were appropriate, the quality of referrals from custody staff had improved overall since the last thematic inspection. Custody staff had a better understanding of L&D referral and service provision.

The timeliness of assessments was an issue across all areas we visited in England. This was for a variety of reasons, all of which were outside the providers' control. There had been an increase in acuity of individuals' needs over the last 12 months. This meant that L&D practitioners spent longer periods of time with individuals and therefore saw fewer people overall in any given day. There had also been an increase in demand for services over the last six months and lockdown restrictions had eased. Again, there were not always enough staff or hours in the working day to be able to see every person referred, as well as complete all records and follow up actions such as onward referrals.

Services were limited by coverage, access and ambition. In all police forces, the presence of L&D practitioners was limited by days and hours of coverage. Examples ranged from Monday to Friday, 9am to 5pm, to Monday to Sunday, 8am to 8pm. In some force areas, the service might be located within a 'main' suite and delivered remotely to satellite locations. Having explored provision with practitioners and custody staff, we felt that the service provided to individuals who were not in custody when the service providers were present was less certain and not equitable with those seen in person.

We found little direct interaction between investigating officers and L&D services who can theoretically advise on case progression but were not found to do so. We found that, even when the individual was still in custody, the officer in charge would obtain information indirectly via the custody staff or custody record. Once the initial detention had ended, investigating officers gave little consideration to L&D as a source of advice or information relating to their suspect. We also found that, although 'in scope' for most services, interventions with voluntary attendees were rare.

There continued to be delays in accessing MHA assessments for individuals in both custody and court settings. Despite good working relationships and communication with Approved Mental Health Professional (AMHP) teams, there were not enough doctors available to meet the demand for assessments, either during the day or within emergency duty teams' out of hours provision. This meant that some patients may have been released from custody without receiving an assessment and referred to the community mental health crisis team. We also saw evidence of patients being remanded to prison as a place of safety when a patient in court was assessed to be detained under the MHA, but no inpatient beds were available.

The L&D services we visited in England were focused on supporting patients, and we observed passionate and dedicated staff teams who showed care for the people they supported in custody and courts. Since the role of L&D teams is assessment and referral only, individuals would not have a care coordinator. However, we found that, where individuals were known to local mental health services, there was good communication with care coordinators to share risk information.

The support for patients with dual diagnosis needs continued to be an issue. L&D services were commissioned to support 'all vulnerabilities' and practitioners could refer to community substance misuse teams. It was rare for substance misuse staff to be present within custody suites. Nonetheless, healthcare nurses and doctors working alongside L&D teams were now able to provide some symptomatic relief for drug or alcohol withdrawal in some areas, which was positive. L&D practitioners described challenges in referring individuals to mental health teams if they were using substances. They said that referrals were rejected until those issues had been addressed. This often left individuals lacking the support they required to address substance misuse and mental health issues simultaneously.

5. Prosecution and court

5.1. CPS oversight and training

Every CPS area has at least one single point of contact (SPOC) for mental health, who is also a member of the national SPOC Network. The network meets monthly but is moving to six-weekly because of the pressures of the pandemic on day-to-day business. Members come to meetings with a range of issues and are all interested in trying to achieve better information-sharing between the police and CPS. Some SPOCs have their own mental health checklists, which the NHS and police forces in their areas are asked to use in assault cases on staff in secure accommodation/hospitals.

The CPS is trying to raise awareness about the quality of information it needs and why. It is holding discussions with the NPCC about the roll-out of a mental health checklist that will be used nationally. This will bring together what is already being used in some form in a few areas. There is an aspiration to have reached an agreement by the time this thematic report is published.

The CPS's *Guidance on mental health conditions and disorders* (October 2019) and the *Code for Crown Prosecutors* (October 2018) are both available on its Infonet. The guidance is supported by an aide-memoire that highlights the key points from the guidance. Lawyers that we spoke to were familiar with the guidance. They refer to it when dealing with cases where mental health is raised by the police or the defence. The general view is that, although the guidance is clear, having some specific training, particularly in the practical aspects of identifying and dealing with these cases, would be helpful.

The CPS had planned to hold face-to-face training on the revised guidance, but the pandemic has prevented this. It is now producing a training podcast for staff. One SPOC is planning to make it the focus of one of their team meetings, where it can be followed by discussion and shared learning. The podcast is being developed for release later in the year.

During the pandemic lawyers spoken to have talked of regular meetings over Microsoft Teams where they can discuss cases that cause concern and share experiences. They are familiar with resources and have a collegiate approach to decision-making. Additionally, they can confer through their line management or SPOCs in the event of any uncertainty.

The CPS conduct IQAs (Individual Quality Assessments) and dip-sampling of decision-making but cannot do so specifically in relation to mental health cases, as these cases are not flagged or identifiable in any other way.

5.2. Quality of information provided to the CPS

We found that the quality of information provided by the police about defendants with mental ill-health is variable and usually poor. Further, there is a lack of understanding of the impact that poor-quality information has on the CPS's ability to provide timely advice on charging.

There is no specific document for the police to use to alert the CPS to the mental health needs of a suspect. The MG5 form used by the police may record that the suspect had an appropriate adult in interview, but it does not record the reason why. The lack of a simple identification in the file means that prosecution lawyers must search through the file to find out if the appropriate adult was there because of a mental health issue or a learning disorder or other vulnerability. Where there is a mental health condition or disorder, the police may note it on the MG3, MG5 or MG6 forms, but as our findings show, it was

recorded in less than a quarter of the cases we examined and, in all of those cases, inspectors had to search to find any details.

The quality of police information has also been picked up by a number of judges, who refer to the MG5 in the first instance for a case summary. They have found that the quality of information on the defendant's mental ill-health is variable and again is not consistently contained in a specific police document. Some prosecutors were able to see the value of having a distinct box or section on the MG3, in the same way they have for domestic abuse cases, persistent and prolific offenders and hate crimes, or recording it in the case outline/review section completed by the officer in charge.

Our case examination also highlighted that the police do not consistently provide the custody record with the file for charging advice. The custody record should contain a note of whether the suspect has been seen by L&D or another clinician. Where the custody record is provided or requested by the CPS, prosecutors report that reference to any mental ill-health is minimal. That said, it provides a basis for further enquiry about the suspect's mental ill-health.

Decisions are made in accordance with the Code for Crown Prosecutors (October 2018) on a case-by-case basis. Sometimes it is in the public interest to prosecute, despite the nature of the defendant's mental illness.

On diversion, we found that decisions are usually made before the individual is charged. Therefore, by the time the case reaches the CPS, it is for a charging decision. Prosecutors are rarely involved in diversion at that stage, but report that they are mindful of diversion when reviewing cases for charge. Defence lawyers are not provided with enough information to make representations.

5.3. Quality of information provided to defence lawyers

Defence lawyers do not always pick up mental ill-health and this may have been compounded during the pandemic, as lawyers are not always meeting clients in person.

Defence lawyers also raised concerns about police understanding of mental ill-health. They told us that 'it feels as if' they are trying to get people out of the custody suites as quickly as possible. This echoes the concerns expressed by a number of district judges that the police are charging suspects and placing them before the court, believing that L&D at court will address any issues of mental ill-health. Judges report that the police fail to understand mental health issues.

This thematic review has highlighted that there are concerns with the provision of custody records to defence lawyers. They are entitled under Code C of PACE (the *Police and Criminal Evidence Act 1984*) to see/inspect them if they ask at the police station, or to be provided with a copy when their client is out of police custody. One defence lawyer reported that this is now a problem because of the rise in 'super' custody suites and custody officers feeling under pressure. If defence lawyers see the custody record at the police station, it may only be the page relating to arrest. Any visit by L&D or other clinician will be recorded on the custody record, which could alert them to any potential issues early on and so could inform any representations that they may wish to make to the police about diversion or to the prosecutor or court at the first hearing.

The situation here is compounded because the police are not providing this information when defence lawyers ask for it. When the case reaches court, custody records are not served with the case but are treated as 'unused material'. This means that defence representatives may not see a copy until quite late in the proceedings, sometimes on the day of the trial.

When an individual is especially unwell, defence lawyers may be invited to multi-agency case discussions to consider how best to manage the case. However, this is the exception and defence lawyers would like to see much better multi-agency involvement, early in the process.

5.4. Information-sharing

Our CJI inspection in 2009 found that a few areas had a Memorandum of Understanding (MoU) for information-sharing between the police, NHS trust and the CPS. None of the six areas visited this time has such a protocol. Four of the six areas have a checklist for use by police and clinicians for cases of assaults on NHS staff. It is designed to ensure that the charging lawyers receive the relevant information to inform the public interest test.

Some areas have an MoU in relation to the rapid transfer of individuals from police custody under the Mental Health Act, when this is appropriate and necessary. In these instances, as in 2009, the mental health issue is already diagnosed or clear. CPS West Midlands and CPS South West have such an MoU. The parties to the MoU are the CPS, the police, HMCTS and the NHS. It is expected that the agreement will only relate to a small number of cases of serious offences such as murder or attempted murder. It also applies where the severity of the mental illness gives rise to grave concerns about the suspect or another if they were remanded in custody for even a short period. There is no agreement in place in relation to the remaining majority of cases where mental ill-health is perhaps obvious but not diagnosed, or where it is self-diagnosed.

This inspection has highlighted an acute problem with the provision of L&D assessments by the police to the CPS and to defence lawyers. In interview we heard that police officers' understanding of confidentiality and GDPR (General Data Protection Regulation) causes a reluctance to share L&D assessments. This illustrates a lack of understanding of not only the data protection principles but also the impact this lack of information has on other CJS partners and the criminal justice process. The *Data Protection Act 2018* was never intended to be used to interfere with the work of the CJS. One of the exceptions to the restrictions on information-sharing is in relation to the administration of justice.³⁵ Access to any L&D assessments and other available medical reports is crucial for a number of reasons:

- Defence lawyers could make representations early on in the process to divert their client out of the system. They can use them to inform representations on bail and inform representations for an early assessment or diagnosis. Furthermore, lawyers may know about their client's mental health history.
- Prosecutors need the information to make better-informed decisions on charging. Examples include: advising on diversion, or whether it is in the public interest to prosecute; informing decisions on bail; representations on venue; deciding whether to accept particular pleas; and assisting the court in the exercise of its sentencing powers.
- The judiciary also needs this information about the defendant to inform decisions on matters such as bail, appropriateness of pleas, and management and progression of the case.

If an L&D assessment is prepared at court, the court is usually given a copy, at which point the prosecutor may also be made aware of the assessment.

³⁵ HMCTS367_court_list_arrangements_May_2020.pdf (publishing.service.gov.uk)

5.5. Identification of mental health

CPS files do not have a mental health flag. Those interviewed acknowledge that this means that there is no opportunity to carry out dip-sampling or other quality assurance work, or to collect data. The CPS hopes to have a mental health flag on Common Platform (a new case management system to be used in Crown and magistrates' courts), although it is not known when this will be rolled out. That said, the main challenge to having a distinct mental health flag is the lack of a nationally acceptable definition for these cases. If there is a flag, there would need to be clear criteria on how, when and why it applies.

The majority of lawyers spoken to felt that a distinct flag would make no difference to their day-to-day operations because they would be aware of any mental ill-health when examining the file and would highlight it in the MG3³⁶ for the prosecutor at court. That said, some thought it could be of practical help to prosecutors. For example, they could call up other cases to see how various issues have been dealt with previously. They all felt that it would be useful for quality assurance purposes and management information data.

One of the lawyers spoken to suggested that a more effective way of capturing these cases might be to have a particular case finalisation code where the defendant's mental ill-health was still relevant at the conclusion of the case.

There is no distinct flag on any of HMCTS's five case management systems. It may be possible to manually interrogate them to identify cases where the court has made an order, but the additional challenge is that information is not consistently recorded.

It is clear that there needs to be some method of identifying these cases, not only for the purposes of internal auditing but also as a means of sharing data and learning with CJS partners.

5.6. Service delivery at court

Mental health services at court are variable. Where there is a service, this is likely to be in the magistrates' court. Very few Crown Courts have access to mental health services. All judges spoken to would welcome these services. They believe these would provide early assessment/diagnosis and reduce the numbers of defendants remanded into custody, given that the court does not have relevant information about their mental ill-health. Judges express concern about the fragility of these defendants' mental state and the detrimental impact a period in custody may have, particularly where, due to Covid-19 restrictions, they are detained in their cells for 23 hours a day.

One resident judge felt that their court may not qualify for a dedicated presence. However, having remote access to a practitioner would assist in decision-making, especially where defence lawyers were raising concerns about a defendant's fitness to plea.

Judges are frustrated that there are so many individuals in the CJS with mental health issues who should not be. They believe they should be receiving mental health support in the community to prevent them from entering the system. Judges report that there are very few resources that provide an alternative to a remand in custody. This is an acute problem in the CJS. Judges spoke of the difficulties in accessing local mental health services. This was

³⁶ MG3 – form used by the police when seeking a charging advice from the CPS. It should contain key information and evidence from the investigation.

corroborated by defence lawyers, who confirmed the need for more resources and more bed space in the community.

Good practice example

One resident judge gave an example of a defendant who was unwell and would not accept any assistance. The judge wrote to the prison governor and to the lead psychiatrist at the prison asking them to transfer the defendant to a hospital because the court could not move the case forward until they knew if the defendant was fit to plead or not. The defendant had been remanded in custody for about six to seven months before the judge was able to persuade the prison psychiatrist to transfer the defendant, where it was found that he was unfit to plead.

One resident judge asked for judges to be allowed to make findings of fact when a defendant is unfit to plead. It is time-consuming to empanel a jury, then to call a witness to give evidence that the defendant cannot contest because they are unfit. It is a strain on court time and resources, especially given the tensions created by the pandemic.

5.7. Intermediaries and special measure applications

Defence representatives can apply to the court for an intermediary or other special measure for the defendant. The statutory provisions are not yet in force, but the court has an inherent power to appoint an intermediary and some special measures to assist a defendant to prepare for the trial in advance of the hearing and during the trial so that they can participate effectively in the trial process. Sometimes there may also be merit in an application to appoint a support worker or other companion who can provide assistance when it has not been necessary to appoint an intermediary, as a defendant may still benefit from other assistance to understand proceedings.

Judges report that some applications have merit because they are comprehensively considered. They would expect to be provided with supporting medical, psychiatric or psychological evidence but say that it is common to find that applications are not supported by evidence. Some judges believe that there is too much 'cut and paste' in reports. At times they do not set out the test and evidence on which their recommendations are made. Defence representatives suggest that judges rarely grant these applications for the whole trial. They believe that judges' views are that any issues can be addressed by making adjustments in the trial, for example a ground rules hearing.

5.8. Unrepresented defendants

There is a growing concern in the courts about the number of unrepresented defendants who have mental ill-health. They can be unrepresented for a number of reasons. They might have dismissed their lawyer, believing that they are in the right. There may be issues around funding. On occasions, despite an assessment, they may be unable to afford the monthly payments for legal aid, and sometimes it may be a lack of trust in the system.

The impact on the court is significant. Where defendants are unwilling to accept advice, the judiciary have to take time to try and explain some complex issues of process. In the meantime, the defendant will already be anxious about being in court. Often, the prosecutor may be unclear who to send legal documents to, or where. All of this contributes to cases taking longer to resolve, as these defendants are more likely to be remanded in custody because the court does not have enough information about them or their mental health.

5.9. Liaison and diversion reports

The police are the first to encounter individuals in their criminal justice journey. The CPS requires the police to provide information about the suspect's mental ill-health, as do defence lawyers and the courts. Where there are issues, they expect to see any assessment or report available to the police. Prosecutors report that, based on GDPR concerns, the police are unable to share assessments completed in police custody.

L&D staffing in court settings was inconsistent. In some areas, staff cover courts remotely on an 'on-call' basis, and in some areas court coverage was remote due to staffing levels. In areas where L&D would usually have had a physical presence in courts, this had been withdrawn during the pandemic because of the move to virtual courts, and the environment often not allowing for social distancing. With L&D teams covering courts remotely, they relied on court staff advertising their service and making referrals. As a result, there had been a decrease in the number of referrals to L&D from court.

In light of the above, pre-sentence information did not always address the mental health needs of individuals in court. There is no framework with partners such as the probation service to enable them to share information routinely. L&D practitioners were generally reactive to requests they received for this information, rather than proactive. The fact that practitioners were not always based in court meant that the relationships and dialogue with probation colleagues were reduced, and sometimes opportunities were missed to share information that may have been valuable during the sentencing process.

5.10. Psychiatric reports

Applications for psychiatric reports are usually made by the defence where there are concerns about the defendant's fitness to plead or culpability, or to assist in mitigating on the defendant's behalf at the point of sentencing. Very occasionally, the prosecution instructs a psychiatrist where culpability or fitness to plead is an issue.

Applications are usually in relation to fitness to plead and are ordinarily made at the Crown Court. The defence may not raise the issue of fitness to plead until the Plea and Trial Preparation Hearing (PTPH), when there is an application for an adjournment to seek legal aid and establish a psychiatrist to assess the defendant.

The judiciary and prosecutors are satisfied that for the most part the defence is appropriately identifying a defendant's mental ill-health. However, it is not always highlighted as an issue in the case on the Better Case Management (BCM) form. In most magistrates' courts, the BCM form is completed by the legal adviser. It is the view of a number of judges and prosecutors that magistrates' legal advisers need to be more robust and challenge defence representatives to set out the issues for the Crown Court. During this review, we found one Crown Court that completes a triage of cases coming into court and prioritises the listing of cases where there are vulnerabilities, whether defence or prosecution, in the hope of expediting them through the system.

A frustration for some judges is that, even when the defence highlights the defendant's mental ill-health, usually in terms of their fitness to plead, they do very little to progress the case in the four to six weeks it takes a case to reach the PTPH stage, especially when the defendant may be in custody. Some judges are very robust and will challenge the defence about what they have done in the four to six weeks since raising the issue on the BCM form.

Judges are trying to minimise delay and reduce blockages in the process by setting the stages to a trial date. Most often, if the report states that the defendant is fit to plead, it is

invariably followed by a guilty plea. If the report confirms that the defendant is unfit to plead, the trial date can be used as an 'actus reus' hearing.³⁷

Defence lawyers do not always find that psychiatric reports assist them with mitigation, and judges suggest that they do not always assist with options for disposal. Delays in obtaining psychiatric reports raise challenges. These include:

- Once the issue of mental ill health is raised, defence lawyers must apply for the funding that they need to commission a psychiatric report. They must then find a psychiatrist who is willing to assess the defendant. Depending on their schedule, it can take time to obtain a comprehensive diagnosis and report. Defence lawyers say that there are fewer psychiatrists who are willing to prepare a report for legal aid costs.
- Covid-19 has added to delays. Although some psychiatrists will carry out a video interview, the problem relates to gaining access to the defendant because of a shortage of resources and a lack of video conferencing facilities at prisons.

5.11. Probation pre-sentence reports

Inspectors from HM Inspectorate of Probation reviewed 60 pre-sentence reports prepared by NPS court staff in the inspected areas; 48 reports were on men and 12 were on women. The vast majority (83 per cent, 50/60) of the reports reviewed were short format reports completed without a full OASys assessment. The mental health conditions identified were assessed as having a considerable impact on day-to-day functioning in just over half of the reports reviewed. Almost a quarter of reports were prepared on the same day as the plea or finding of guilt.

In almost all the cases where pre-sentence reports were requested, report writers had access to both the Crown Prosecution Service documents and any previous conviction history of the individual. This system worked well and meant that report writers could use details about the individual's offending behaviour, combined with accounts from witnesses, in their discussions with individuals.

Overall, the quality of reports was insufficient.

In around 60 per cent (35/59) of the reports, information to support sentencing was good. However, there were far too many reports where much more detail was needed. Just over half of the reports were submitted without safeguarding and domestic abuse checks. Better arrangements are needed to improve access to this important information to protect and safeguard the individual and to help keep others safe.

Report writers had fully identified the risk to self posed by an individual in only 47 per cent (27/58) of the reports that were reviewed. In 45 per cent (26/58) of the reports, risk to self had only been partially recognised, as shown in the following example.

³⁷ An actus reus hearing is a hearing to determine whether the defendant did the actions required to commit the offence. Their state of mind at the time is not a consideration'.

Poor practice example

Jordan, a young man with a history of trauma, including being placed in care and sustaining injuries from serious assaults committed by peers, was before the court for sentence. Jordan disclosed that he had been diagnosed with PTSD/ADHD/mood disorder and learning difficulties. He identified the medication that he was taking. The report author did not verify Jordan's account, the risk he posed to himself or the involvement of mental health professionals.

The author recommended an Intensive Community Order with Drug Rehabilitation Requirement and Rehabilitation Activity Requirement days. The proposal did not identify any work to address his mental ill-health. At court, Jordan was made subject to an immediate term of custody.

Some report writers told inspectors that they had to prepare reports at pace and many individuals they interviewed, in particular men, did not want to talk about their mental health.

Where other reports had been prepared, for example L&D and psychiatric reports, the report writers had not consistently liaised with the authors of these reports. This meant that analysis of mental health was often weaker and treatment requirements were often not fully understood. The below example shows how this can be done well:

Poor practice example

In interviewing Rani, a woman convicted for assault following trial, it became clear to the report writer that it was not going to be possible for her to complete the report on the same day, given the disclosures about self-harm. Rani was receiving mental health treatment at the time. An adjournment led to the preparation of a psychiatric report. The psychiatrist identified mixed anxiety and depressive disorder, with traits of emotionally unstable personality disorder. Due to Rani's history of self-harm, and the additional impact on her mental health while awaiting sentence, the report writer arranged to speak with the author of the psychiatric report. This contributed to a better appreciation of the impact of a custodial sentence and the need to alert any receiving establishment. The psychiatric report concluded that, despite a diagnosis of complex mental health issues, this did not constitute a mental health disorder warranting either a hospital order or a Mental Health Treatment Requirement to be imposed. Therefore, in consultation with the psychiatrist, a programme of intervention was agreed. The process followed by the report writer contributed to a proposal that was supported by another professional and one that was likely to have the best outcome to support desistance and improve mental health.

It is important that probation practitioners assess an individual's motivation to address their emotional and wellbeing needs. This had been done well enough in only 34 out of 60 reports. More development work is needed to equip report writers to assess motivation at an early stage so that it can be factored into case supervision.

The coverage of diversity, for example experiences of racism and sexual identity, where relevant, was not robust. Ethnic minority individuals often had to seek out their own support as articulated by one individual:

“I was struggling and didn’t know why. I thought there was no support for me and after having a conversation with my Imam he went and scheduled an appointment with a mental health nurse”. (Asad)

In half of the reports reviewed, diversity factors were overlooked and/or not addressed. This is a practice weakness and needs to change so that appropriate interventions and treatments are identified through comprehensive diversity assessments. An additional area for development is the examination of the impact of trauma on individuals. Inspectors found that report writers talked confidently about trauma-informed practice, but evidence of this work was rarely included in pre-sentence reports (PSRs).

Sentencers, in particular judges, were generally satisfied with most aspects of the reports they received. However, some reported that the sentencing proposals were often too vague, and it was not clear how the recommendation would be implemented. Furthermore, there was little confidence that a Rehabilitation Activity Requirement condition would make any difference. Where Mental Health Treatment Requirement orders were proposed, judges were far more confident that a meaningful intervention would be delivered. In these circumstances, it was clear to them there that there was an intervention that would be beneficial. They would like to have greater access to this sentencing option and were pleased to hear that Community Sentence Treatment Requirement sites were expanding across England and Wales.

Between 2010 and 2018, there was a reduction in the use of PSRs and, where reports were used, there was a shift in report type. In 2010, 211,494³⁸ reports were prepared and in 2018 this had fallen to 113,228, amounting to a 47 per cent decrease. In the same period, the percentage of PSRs delivered orally had risen from 11 per cent in 2010 to 60 per cent in 2018.

In the summer of 2020, the NPS started consulting with the judiciary, defence lawyers, CPS, HMCTS and other key stakeholders to address concerns about PSRs. In response to this, the NPS rolled out a PSR pilot across 15 magistrates’ courts in England and Wales between March and May 2021. This pilot is testing an alternative delivery model which is designed to increase the delivery of high-quality and timely PSRs for service users. The alternative delivery model comprises three elements: a before plea protocol for PSRs to be requested before the sentencing hearing for eligible service users, a comprehensive learning and development programme, and the targeting of short format written reports for priority cohorts. Priority cohorts in this pilot are women, 18 to 24-year-olds and those at risk of custody. It is hoped that these short format written reports will support the sentencing process and enable report writers to build and consolidate their work with staff from L&D teams as well as other stakeholders. For individuals with mental health needs, early identification may lead to more suitable sentencing and diversion. This remains conjecture, but it is an initiative that has potential to improve early identification and treatment of mental ill-health. We were pleased to find that an impressive learning and development programme is being delivered alongside the pilots, covering topics such as trauma and risk assessment.

³⁸ Source, Implementation Unit, Ministry of Justice/psrpilot@justice.gov.uk.

6. Probation

6.1. Leadership

In June 2019, the NPS launched its Health and Social Care Strategy,³⁹ which covers both England and Wales. It said that the document is not intended to be 'prescriptive' but instead aims to guide and inform NPS operational practice to improve health outcomes. It identifies three core commitments:

- improve the health and wellbeing of people under probation supervision, and contribute to reducing health inequalities within the CJS
- reduce re-offending by addressing health and social care related drivers of offending behaviour to reduce victims of crime
- support the development of robust pathways into services for people under probation supervision, including improving continuity of care between the custodial and community setting.

In relation to mental health and wellbeing, three priorities have been identified:

- increase training provisions for staff to support them to feel more confident when managing individuals under NPS supervision with mental health problems
- support timely and appropriate sentencing that adequately considers the mental health and wellbeing needs of individuals entering the CJS, including supporting the use of Mental Health Treatment Requirements attached to a community sentence
- strengthen partnerships at all levels to improve pathways into mental health treatment and services, particularly aiming to inform local commissioning processes for appropriate services that adequately cater to the needs of this complex cohort.

We found that senior leaders in the NPS were familiar with the overarching national strategy and priorities. In our opinion, however, this knowledge and intent was not actively driving local policy. All expressed a determination to achieve better mental health outcomes and admitted there was much more work to do across all three priorities. We did not find the equitable strategies in the Community Rehabilitation Companies (CRCs) that we inspected. Here, mental health was located within wider policies, priorities and strategic intentions. This meant that it was often marginalised.

Covid-19 has presented enormous challenges for probation leaders. We were pleased to find that the exceptional delivery models that had been designed during the pandemic had appropriately considered the wellbeing of staff and individuals.

Probation senior leaders were well represented at cross-agency partnership boards, such as community safety and health and wellbeing. However, their influence was limited. This left some feeling frustrated in a very complex commissioning environment for services to meet the mental health needs of people under probation supervision. Several leaders had invested heavily in building effective relationships with providers. We found that, in Greater Manchester, where governance was devolved, access to secondary mental health care services for those subject to community orders and custodial licences was better. London

³⁹ NPS and HM Prison and Probation Service. (2019). *National Probation Service Health and Social Care Strategy 2019-2022*.

CRC had been able to commission specialist mental health provision through the St Andrews Trust. This investment had provided considerable support to probation practitioners working with people who had a dual diagnosis.

6.2. Skills of probation practitioners

Probation practitioners are not mental health experts, but they do need transferrable skills that they can use to help individuals turn their lives around. We found that there were significant gaps in the knowledge and understanding of mental health work among probation practitioners and managers. In our survey, 70 per cent (38/54) of practitioners interviewed reported that they did not have access to effective mental health learning. Many in our focus groups spoke about the 'weight of responsibility' they felt while working with the complex mental health needs of those whom they were supervising. Some had used the internet to develop their learning but were afraid to do or say the wrong thing. A particular weakness was in understanding and applying motivational interviewing skills.

Experienced managers who had a background in mental health work could provide effective advice to practitioners, but this was the exception. From our case reviews, we concluded that management oversight was either absent or ineffective in 64 per cent (34/59) of the inspected cases. This was caused by their own limited understanding of how best to work with individuals and advise practitioners. Clinical supervision varied considerably, with many practitioners we interviewed reporting that the supervision they received did not comprehensively help them. In contrast, we found some good examples of clinical supervision being provided by psychologists supporting service delivery. One probation practitioner said, *"the insight the psychologist provided helped me to better understand why he [the individual being supervised] was behaving and responding the way he was. I have now changed the way I work with him, and it's working"*.

Managers in learning and development departments were surprised by our findings and signposted us to various training modules that staff could access through the NPS EQUIP, My Learning and CRC intranet platforms. Undoubtedly, there are a number of relevant courses available through these platforms, but most are not mandated, and practitioners consider the content to be too basic. The NPS expects operational staff to complete a substance misuse and mental health workbook when they join the service. Disappointingly, a significant number of NPS staff told us that they had not heard of this workbook.

We were pleased by the training package provided by the Offender Personality Disorder pathway teams. Up until very recently, this was only available to NPS practitioners. During the pandemic, more remote courses, covering topics around engagement, suicide prevention and self-harm, had been made available. These had been received well but were not always impacting on the way individuals with mental health needs were being supported and supervised.

In the past 15 months, during the pandemic, new operational staff have joined probation services. These have included PQiP and other practitioner-level staff. We were worried to learn that access to mental health learning for these groups varied considerably. PQiP learners undertook an academic module on mentally disordered offenders, and other new staff attended what they described as basic introductions to a range of work areas. These staff felt vulnerable in working with individuals who had mental health needs. Therefore, it will be vital to ensure that the training needs of these staff are robustly met, and that their learning experience has an impact. Otherwise, there is potential for practitioners to be managing cases for which they are not fully competent and experienced. Practitioners told us that they are frequently allocated cases for which they do not feel qualified. Some reported that they felt unable to return cases for re-allocation, fearing that they would be seen as not being capable.

In Durham NPS, we found some excellent work taking place in how newly qualified probation officers were being supported to develop their practice. Action learning was being used to broaden and widen the learning experience across a range of topics, including mental health. Here, learners regularly met remotely with quality development officers to explore, in a reflective way, how to improve their work with individuals. We believe there is scope to use this method more frequently to enhance and consolidate practitioners' skills in delivering mental health interventions.

The identification of mental health needs and disorders through flagging and at each stage of the supervisory process is muddled. Probation services mainly use the alert and safeguarding functions in nDelius to identify a mental health issue or need. The self-harm/suicide flag is supposed to be used when there is an active self-harm concern and an alert is used where there is any form or degree of mental health concern. The selected caseload information provided to us by the inspected areas showed variations ranging from 1.8 per cent to 25 per cent of cases being flagged. As the individual progressed through their supervision, where flags had been identified, the registration reviews were poor. Too often the reviews were copies of legacy entries. We found that most middle managers we interviewed did not know where they could find guidance about flagging; most said they had never seen it. This is very concerning and perhaps goes some way to support our judgement on the variable quality of management oversight. An urgent review is required.

6.3. Services

Relationships with providers and other agencies at a strategic and operational level vary according to the commissioning structures and availability of mental health services. Probation practitioners reported that they do not always have effective relationships with providers. Some are confused about what mental health service providers can offer and what criteria needs to be met before a service can be accessed. Probation practitioners need to involve mental health service providers much more in the management of cases to achieve better joint working. This will help them to be clearer about what can be delivered and enable them to better coordinate services.

There is a shortage of comprehensive and high-quality services to meet the spectrum of mental health needs of individuals on probation supervision. A recent HM Inspectorate of Probation Research and Analysis Bulletin on the availability and delivery of interventions provided a breakdown of findings from our core inspection programme (HM Inspectorate of Probation, 2019). It reported that emotional wellbeing was identified by inspectors as a priority need in 82 per cent of probation cases, but that appropriate interventions were delivered in only 48 per cent of applicable cases. In addition, contracted providers were found to have done enough in only 52 per cent of cases.

This has been exacerbated by Covid-19, the reduction in providers and changes in prioritising those most in need. For the minority who have a mental health diagnosis under the MHA, service provision is good. For others, while individuals can be referred to the Improving Access to Psychological Therapies service by their general practitioner, can self-refer to the Crisis team, or can be referred to a mental health service by a probation practitioner, these routes do not always lead to individuals receiving an intervention. Given the complexity of need, dual diagnosis and chaotic lifestyles, individuals often fail to keep appointments and their cases are too readily closed. This leads to additional anxiety and often contributes to a worsening of wellbeing. In our selected sample for this inspection, just under 60 per cent (35/60) of individuals had comorbidity needs, where mental health problems exist alongside other needs such as substance misuse and learning difficulties.

Probation services generally keep directories of services, but these are not regularly maintained and updated. Furthermore, these services, where present, are far too generic.

For example, mental health services for ethnic minority people are limited. The Race Equality Foundation⁴⁰ has identified some limited services that are available specifically to address the mental health needs of ethnic minority people. However, we found very little evidence to suggest that probation leaders were reaching out to source or access specialist services. Additionally, practitioners were not making use of the advice and guidance available through the Association of Mental Health Providers.⁴¹ Mental health services for women were better, both in custody and in the community. For men, the services received in custody were stronger but the continuity of mental health care from prison to the community was generally poor. This was often exacerbated by different commissioned providers in the community to the ones in custody.

Offender Personality Disorder pathway

The Offender Personality Disorder (OPD) pathway programme is a jointly commissioned initiative that aims to provide a pathway of psychologically informed services for a highly complex and challenging offender group who are likely to have a severe personality disorder and who pose a high risk of harm to others, or a high risk of reoffending in a harmful way.

OPD pathways are well established in the NPS but not always used as intended or required. The only way that CRC practitioners could access this resource for the individuals they were supervising was to escalate the case to the NPS. Probation practitioners reported mixed views about the case consultations and case formulations they received through this service. Some felt that the formulations were summaries of assessments and offered very little in terms of how to work with an individual. Others were grateful for the assurance that the formulations provided. The recent introduction of the enhanced Intensive Intervention and Risk Management Service in some regions has been welcomed, as it offers casework by a psychologist.

Intensive Intervention and Risk Management

As part of the national OPD pathway, Intensive Intervention and Risk Management Services work with individuals leaving prison or forensic mental health care to support successful transitions to community living. The services provide a range of support depending on service users' needs.

This can include psychological support to improve mental health and psychological well-being; risk assessment and risk management; social and living skills to help make and maintain good relationships; substance misuse support; housing advice and signposting to other services and advocacy.

In Exeter, the NHS Devon Partnership⁴² is able to provide a limited amount of intervention through psychologists for NPS individuals on probation supervision. This has been welcomed

⁴⁰ www.raceequalityfoundation.org.uk

⁴¹ www.amhp.org.uk

⁴² www.dpt.nhs.uk

by probation practitioners but there is a concern that the service level agreement will not provide enough coverage to all who would benefit from this service. Each NPS division was supported by a forensic psychologist who provides specialist advice to probation practitioners working with the most serious and vulnerable individuals. This service is welcomed as it combines reflective supervision with effective risk management advice and guidance.

We found some examples of Rehabilitation Activity Requirement interventions (such as healthy minds and emotional management) that had been developed in-house by CRCs and made available to the NPS through the rate card. However, these interventions were not robustly informed by research or evaluated fully. In the CRC in Bolton, we were made aware of an intervention called 'managing my emotions'. This was evidence-led and informed by desistance principles. The OPD pathway service and the Intensive Intervention and Risk Management Service provision included quality assurance and evaluation.

Sentencers, in particular Crown Court judges, reported that they had very little confidence in Rehabilitation Activity Requirement conditions to meet the mental health needs of individuals. The sentencing proposals presented to them were described as often 'lacking substance'.

Community Sentence Treatment Requirement roll-out

The Community Sentence Treatment Requirement programme is jointly overseen by NHS England and Improvement, Public Health England, the Department of Health and Social Care, Her Majesty's Prison and Probation Service, and the Ministry of Justice. The programme aims to reduce reoffending and divert people from short-term custodial sentences by addressing the mental health, substance and alcohol misuse issues of the person in contact with the CJS through treatment requirements that are undertaken in the community.

The Mental Health Treatment Requirement (MHTR), as part of a community sentence, was introduced in 2005 specifically to support individuals with complex mental health needs. However, due to historical difficulties in securing psychological services, this provision was not used fully and very few MHTR orders were made. Since October 2017, a number of Community Sentence Treatment Requirement sites have been established. For this review, two of the six areas we inspected were designated Community Sentence Treatment Requirement sites (Bolton and Croydon). Where sites had been embedded (currently 14), the number of MHTR orders made (between 01 July 2020 and May 2021) had increased from 80 to 443. MHTR combined orders (which include drug and alcohol treatment) had increased from 0 to 61 (38 MHTR/ATR, 23 MHTR/DRR). The programme of work delivered through MHTR orders is evidence-based and covers diverse needs well. There is a robust evaluation process to measure impact.

The impact of Covid-19 has meant that, where services have continued, these have largely been delivered remotely. This has had a negative impact on those needing more face-to-face contact.

6.4. Information and facilities

Probation providers have a range of systems and processes in place to support the delivery of mental health services. London CRC effectively used its 'One Referral' process to access relevant interventions. Screening tools such as Kessler 6 are used to determine whether or not an individual is likely to have a mental health problem. There are, however, obstacles in

accessing information from some external providers. Assumptions made about GDPR requirements have contributed to probation staff being unable to access information from community mental health service providers. This has been a constant and long-standing barrier to supporting individuals with complex needs.

Probation practitioners are able to access information about mental health services through their intranet. We were advised, however, that not all guidance is easily accessible. Many practitioners relied on other colleagues to show them where the information was located. If they could not find the information that they needed to support an individual they were supervising, some turned to the Google search engine for help. There is no guarantee that this will provide suitable advice. Practice guidance instructions are produced regularly. We found some good examples across both the CRCs and NPS of where practice development events had been used well to disseminate information.

Management information systems are embedded in probation services and considerable data is generated across a range of business areas. None of the inspected bodies were able to provide us with internal management reports that specifically gave a comprehensive analysis of mental health. It is possible to segment cases by mental health flags, risk and need, and self-harm/suicide, but this is not routinely taking place in practice. The potential for management information systems to inform service delivery has not been maximised or fully realised. Little information is available about outcomes of interventions for individuals, or how this has informed any strategic needs analysis. This is disappointing and is hindering practitioners' ability to robustly track the progress individuals may or may not be making. Reviewing of progress and adjusting of plans within case work is not always done well. Therefore, a strategic approach is needed to drive change.

The dissemination of learning about mental health was limited. On an individual level, practitioners were sharing what had worked for them with the people they were supervising but there was no strategic approach to passing on learning. Very few quality and performance audits of mental health work have taken place during the past 12 months given the challenges of Covid-19. Now that staff in performance and quality management teams have returned from pandemic-related deployments, it is anticipated that this area will now rightly receive greater attention, given the impact of mental health on wellbeing. Cases are discussed with managers in supervision, but the discussions tend to be general in nature rather than examining the quality of the mental health work delivered. Therefore, practitioners do not always know whether they are doing the right things, and this can lead to failings being repeated.

During the pandemic, a significant amount of supervision with individuals has been completed remotely. There have been face-to-face contacts, either through attending probation offices or doorstep visits. We did not visit any offices, but staff told us that their premises provided a safe environment for interactions to take place. Most individuals residing in approved premises had no or very little contact with relatives and friends during the early stages of lockdown. We were pleased to find that staff had invested a lot of time in creating a safe place to best support the actual and emerging mental health needs of individuals.

Before the first lockdown imposed due to Covid-19, CRCs had good systems in place for gathering the views of individuals on probation supervision. Service user councils and regular gathering of information from individuals had become the norm. This was informing service development. The NPS, on the other hand, did not have any comprehensive mechanisms in place to collect information. Given the impact of the pandemic on service provision, there has been little activity to systematically gather the views of stakeholders and those on probation supervision across both organisations. The unified probation service

will need to make sure that the voice of the individual is heard and used to inform mental health services.

6.5. Casework

Assessments

Robust, analytical assessments are critical in supporting positive mental health outcomes for individuals. Probation practitioners have access to a range of information from CPS documents, court reports and historical case records, where available. These, combined with screening and assessment tools, enable them to gain a comprehensive understanding of why the individual has offended. We found, however, that probation practitioners too readily accepted self-reporting by the individual and did not consistently consider information from other sources. This applied to 23 of the 60 inspected cases. A notable weakness in around 40 per cent (21/52) of applicable cases was that staff did not access information from statutory agencies working with the individual.

Poor practice example

Tony is a young man subject to a community order for an offence of assault. His initial assessment prepared by the probation practitioner provides some analysis of offending-related factors. It also indicates that Tony had previously been referred to mental health services. There is information about an ADHD diagnosis and a previous attempt at taking his own life following the death of his mother in a motor vehicle accident. However, there is very little analysis of Tony's experiences of trauma, and any previous engagement with mental health services. The probation practitioner has not contacted any of the other agencies who are working with him to gain additional information about his mental health needs.

We were pleased to find that conversations about an individual's motivation and readiness to engage with supervision were done well in 49 out of the 60 cases (82 per cent). In all these cases, self-assessment questionnaires had been completed and information used to generate dialogue. This engagement helped to build confidence and a willingness to disclose personal information.

Attention to personal circumstances, such as accommodation and employment, was strong in 87 per cent of the cases (52/60). However, attention to diversity needs was much weaker; these were not addressed well in 46 per cent of cases (26/57), because practitioners did not sufficiently explore the individual's lived experience. This was disappointing.

We found that just under half of the cases reviewed did not contain a comprehensive analysis of mental health needs. Practitioners need to be better equipped to talk to individuals about their mental health problems and understand their specific needs.

The most significant protective factor identified by individuals in this thematic review was a healthy relationship with immediate or extended family members. Where these positive relationships existed, we were disappointed to learn that, in almost half of the cases reviewed, there had been very little engagement with family members. This was a missed opportunity, because conversations with significant family members can provide vital information to support emotional wellbeing. We were, however, pleased to find from our interviews with individuals that they were grateful for the humanity with which they were treated, given their mental health struggles. This was particularly true during the pandemic, as demonstrated by one individual in this quote:

“There are days when I am overcome with fear to leave the house and my probation [officer] is aware of this and caters to my needs to help me with my supervision”.

Risk of harm assessment work was variable. This related to keeping both the individual and others safe from harm. In 38 per cent (21/39) of applicable cases, assessments did not clearly identify all relevant factors related to risk of harm to others. Furthermore, in 28 per cent (15/53) of the cases reviewed, risk of harm to self was not robustly identified.

Planning

Effective planning sets out a road map to help individuals to address their assessed mental health and associated risks and needs. It is essential that probation plans are aligned with treatment plans held by other agencies in order to maximise positive outcomes. Therefore, good partnership working, and communication are needed across providers.

The cases reviewed showed that intervention plans needed significant improvement. Individuals were not always given the opportunity to contribute and their diversity needs were often overlooked. This applied to just over half of the cases inspected. Probation practitioners often lacked an understanding of how diversity needs affect mental health. Many staff lacked the confidence to talk about diversity issues with individuals, fearing that they might say something wrong or unintentionally offensive. This view was also echoed in our recent thematic report, *Race equality in probation (2021)*.⁴³ More boldness is needed to appreciate the experiences of ethnic minority people that have contributed to their poor mental health.

We were not satisfied that enough time had been spent with individuals to help them to fully understand the requirements of their licences or community orders. In just under a third of the cases reviewed, individuals had only a partial understanding of what was expected of them. Given the complexity of their needs, including comorbidity, this often had a negative impact on their mental health when warnings were given about missed appointments.

Planning activity did not fully address the mental health needs of individuals in 58 per cent (34/59) of the inspected cases. In particular, practitioners did not always understand how they could make referrals to adult safeguarding services in cases where vulnerability had increased. This frequently led to a worsening of mental health. A notable concern was the deficits in planning where an individual had a dual diagnosis or a comorbidity condition. We found that much of the planning in these cases was disjointed, confused and not informed by a robust analysis of need and risk.

We were pleased to find that, while the quality of plans varied, they had been completed in most cases. One in four plans did not include how identified mental health needs would be specifically addressed and this meant that signs of a deterioration in mental health were not being recognised. We did, however, find some examples of plans that contained clear objectives, irrespective of the level of need. Here is one such case.

Good practice example

Naseem is subject to a suspended sentence order for arson. There is a detailed plan to address factors linked to re-offending, with noted pathways into areas such as housing, drugs intervention, training and finance, using the MAPPA process as a contingency if

⁴³ HM Inspectorate of Probation. (2021). *Race equality in probation*. www.justiceinspectorates.gov.uk/hmiprobation/inspections/race-equality-in-probation.

required. When assessing mental health needs, the practitioner concluded that this need was at the lower end. The medication prescribed by Naseem's doctor to manage stress and anxiety was enough at this stage. However, the plan also mentions the need 'to provide support in a timely manner to include referral to mental health for counselling where appropriate, with the service user's consent', coupled with a plan to activate this support if emotional wellbeing concerns developed.

The frequency and type of contact with Naseem were agreed. This was entirely appropriate. The plan provided a good package of work to support desistance and reduce reoffending.

Planning which set out the necessary restrictive and constructive measures to manage the risk of harm to others and self was better, which was encouraging. This applied to 72 per cent (39/54) of the cases and offered protection to the individual and actual and potential victims. Regrettably, planning did not make suitable links with other agencies working with the individual in 36 per cent (18/50) of the cases reviewed. This meant that critical information was often not accessed. This contributed to a weaker plan and led to less effective case management.

Implementation and delivery of services

The past 15 months have been extremely difficult for both staff and individuals, given the impact that Covid-19 has had on society. Staff and individuals being supervised by probation practitioners have had to adjust very quickly to the new norm. For those with complex mental health needs, this has been a particularly challenging time, as service provision has either reduced, paused and/or is being delivered in a different way.

During this thematic inspection, we heard a number of stories from practitioners about how their own experiences during the pandemic had enabled them to gain greater empathy with the people they were supervising. From the information we received from interviews carried out by Penal Reform Solutions consultants, it was clear that compassion had been exercised in many cases. This had brought people together, and when done well was making a difference in achieving better mental health. John and Les respectively said:

"My Probation Officer is my rock ... her honesty and respect lifted me".

"My Probation Officer is a super star, he worked hard for me to carry on living a normal life. I wanted to move back in with my family and the police blocked the move, however, my Probation Officer got the decision overturned so I could be a proper father and husband once again".

We were pleased to find that court orders and work on prison licence started promptly in the majority of cases reviewed. This is essential because individuals are most likely to be motivated at the beginning of the supervisory process. The level of contact set helped establish meaningful relationships. In a large number of cases, meetings, whether remote or in person, were being followed up in a timely manner.

There were, however, several weaker areas in the delivery of work to support positive emotional wellbeing. In 36 per cent (16/45) of applicable cases, services delivered did not build on the individual's strengths and protective factors, as found in this case example.

Poor practice example

Connor is a care leaver. He is well engaged with a leaving care worker and this has been identified as a protective factor. However, no joint meetings took place to support transition. Furthermore, Connor had told his supervising officer how he had used art to communicate his feelings when he was in care. The practitioner did not use this disclosure to engage Connor further, and Connor continued to be very quiet in meetings. There was clear evidence in case records, and from the probation practitioner when she was interviewed, about Connor being the victim of child sexual exploitation. He had experienced considerable trauma and there were opportunities to build on his strengths. This did not happen.

In 51 per cent (25/49) of the cases, the coordination of services, such as referrals and follow-ups, was poor. In 48 per cent (19/40) of the cases, practitioners had made very little effort to engage with significant people in the life of the individual. The latter would have given them access to real-time information to evaluate the impact of interventions. Almost half of the inspected cases had been supervised by two or more probation practitioners during the sentence period. It was not always clear why this had taken place, but individuals, as reported by Penal Reform Solutions, struggled with these changes as they had to re-tell their stories of trauma. Jakob articulated his feelings like this:

“I have been moved from probation officer to probation officer and I sit there wondering if the system has given up on me. I have no belief in the system or believe there is genuine care there for me or my mental health”.

Where available, mental health services were not used well. Too much time was spent managing crisis and this did not lead to good mental health outcomes. The management of assessed risk of harm to self and others was not consistent. In particular, the management of cases within MAPPa was disappointing. We were advised that mental health providers often failed to attend meetings and it was difficult to obtain up-to-date information. This created a heavy burden for probation practitioners. We found that not enough action had been taken to escalate concerns. This meant that risks associated with harm to others and self were not adequately managed. Where we did see some effective practice in this area, it was largely driven by the tenacity and persistence of individual practitioners.

Reviewing the impact of casework

Reviewing of casework, carried out well, can greatly enhance service delivery and lead to improved mental health outcomes. Risk is dynamic and probation practitioners need to be proactive in their responses when the circumstances of an individual they are supervising change. Circumstances for those with complex needs change frequently, as we found in the majority of cases we reviewed. Reviewing must not be seen as simply a task that needs to be completed but as an important tool to effect lasting change. The active involvement of individuals in the reviewing process is critical. This enables them, for example, to better understand what progress has been made, why progress has not been made and what more they need to do to turn their lives around.

Overall, we found that the quality of reviews was at best variable. On far too many occasions, reviewing was completed as an administrative exercise, as illustrated by the figure of 84 per cent (41/49) of formal reviews being prepared in a timely manner. Adjustments to plans, following significant changes in circumstances, were not considered in

just under half of the inspected cases, and 31 per cent (16/51) of plans did not contain a comprehensive review of mental health needs, as shown in this practice example.

Poor practice example

Julian is a young man on a suspended sentence order for assault. He reported that he had recently confided in his partner about being sexually assaulted while in custody. As a result, he had been encouraged to tell his probation officer. Julian struggled to speak about this event but found the courage to say what had happened to him. Initially, the probation officer showed genuine care, but this did not lead to agreeing on an intervention that would support Julian's mental health. The plan of work remained the same.

In contrast, the below example demonstrates how good case reviews can make a difference:

Good practice example

Ian is subject to a community order for fraud. The formal review explored changes in mental health and identified clearly what needed to be done differently. As his personal circumstances changed, for example forming a new relationship, the record was updated, and Ian encouraged to discuss the impact of living with his new partner. Following careful consideration, Ian agreed to a referral to the community mental health team. There was a great deal of focus on Ian's thinking and behaviour, coupled with his mental health treatment and how the new medication was affecting his wellbeing.

There were some obstacles to information-gathering due to patient confidentiality, but we found that information from statutory partners was often not sought, and neither were problems escalated. This often meant that practitioners based their reviews solely on self-reporting. This approach runs the risk of missing critical information that may support wellbeing and public protection. Work to review risk of harm was particularly poor. We found that, in just over half the cases reviewed where there had been notable changes in the risk of harm to others, reviewing did not identify these concerns. This meant that changes to plans were not made, which placed both the individual and others in potential danger. The most worrying aspect of practice related to service users not being invited to talk about their own vulnerabilities and reflect on the risks to themselves. This applied to just over three-quarters of cases. Furthermore, probation practitioners failed to make contact with people significant in the life of the individual to verify progress or lack of it.

7. Prisons and resettlement

7.1. Identification and assessment

Many people arrive at a prison with pre-existing or emerging mental health conditions and some will have had contact with community mental health teams, inpatient mental health facilities and L&D services in police or court custody, before their arrival. Crucial information about an individual's mental health is recorded during these assessments. It is vitally important that when these assessments have been undertaken this information is shared with prison mental health staff. In practice, we found inconsistent methods for sharing this clinical information. Staff relied on telephone calls, voicemails and emails between L&D and prison mental health staff. Although each prisoner arrived with an individual escort record which disclosed immediate risk, this was not a suitable platform for sharing medical information and appropriately was not used as such.

Good practice example

At HMP Durham, mental health staff had access to the same electronic platform for clinical records as L&D staff, making contemporaneous mental health records viewable to all staff involved in an individual's care and treatment. This was important in the process of identifying and managing key risks for people entering prison.

Services at HMP Birmingham were part of local arrangements, where neighbouring mental health trusts had information-sharing protocols firmly established. This meant that prison mental health staff could access mental health clinical information for prisoners arriving from neighbouring counties as well as the Birmingham area. Staff we spoke to told us this was a valuable resource, especially out of hours.

Health providers in prison are expected to undertake an initial and secondary health screening process for all prisoners newly arriving or on inter-prison transfer. This screening, undertaken by a competent health professional, includes a mental health assessment as well as physical health, substance misuse and social care assessments. In all the prisons we visited, healthcare screening was being undertaken using the national quality standard template we would expect and within expected timescales. Interrogation of clinical records showed that, in the vast majority of cases, individuals who disclosed they had mental health issues or were deemed to require further assessment were promptly referred to mental health services.

Despite the significant risks they posed to vulnerable individuals, prisons continued to be used as a place of safety from court. The scale of the issue was unclear as data was not collected and incidents were not reported centrally. However, during our inspection, we were made aware of one women's prison where the problem was so frequent that the prison's senior managers had recorded 24 incidents of their prison being used as a place of safety in the previous 12 months. Attached to each case was a very concerning narrative that documented extremely vulnerable women being remanded to prison as a last resort, as alternatives could not be accessed. Mental health service providers told us that this practice was due to the lack of mental health inpatient beds nationally and the courts having no other options but to use prison. The use of prison as a place of safety appears to be more common in women's prisons and, given the far fewer numbers of women in prison, somewhat disproportionate.

7.2. Service delivery

Services were arranged to respond to urgent and non-urgent referrals within agreed timescales. Mental health staff were rostered in all the prisons to respond to urgent referrals and provide immediate advice and guidance. All other referrals were managed through weekly integrated multi-disciplinary referral meetings and this continued throughout the pandemic.

From March 2020, mental health services in prison were significantly curtailed due to the restrictions imposed because of the Covid-19 pandemic. This meant that prisoners were held in their cell for most of the day and access to face-to-face care and routine appointments ceased. In-cell telephones were used extensively by mental health services to provide support during the restrictions; however, not all prisoners had access to an in-cell telephone. Prison mental health providers that had this service reported that it can be a valuable substitute in the absence of face-to-face contact. Prisoners we spoke to agreed with this. Having an in-cell telephone allowed prisoners in crisis to contact mental health services and organisations such as the Samaritans out of hours.

Good practice example

Prisoners at risk of suicide were managed under the ACCT (Assessment, Care in Custody and Teamwork) process, which provided a multi-disciplinary approach to risk management. In all prisons we visited, mental health staff attended all initial ACCT reviews to assist with formulating care plans. They attended all subsequent reviews of those prisoners who were on the mental health team's caseload until the prisoners were no longer deemed an immediate risk to themselves.

We found mental health services in all the prisons in this thematic review to be firmly embedded within the prison structures and professional relationships were strong. Mental health leaders and staff were actively involved in key prison partnership meetings such as safer custody and complex/enhanced case reviews, and routinely assessed prisoners' suitability to be segregated.

7.3. Prisoner views

A survey of prisoners is conducted as part of all full HM Inspectorate of Prisons inspections of prisons. These provide valuable information on the experiences of detainees. Prisoners are asked questions about mental health problems on arrival at prison, whether they have mental health problems, their views on any support received, and finally whether they will need health or mental health support on release. In surveys conducted for prison inspection reports, completed by 8,831 prisoners across 50 prisons, published between 01 April 2019 and 30 June 2020, the following was found:

- 36 per cent of prisoners in men's prisons and 54 per cent in women's prisons reported feeling depressed on arrival
- 12 per cent of prisoners in men's prisons and 26 per cent in women's prisons reported feeling suicidal on arrival
- 24 per cent of prisoners in men's prisons and 40 per cent in women's prisons reported having other mental health problems on arrival
- 48 per cent of prisoners in men's prisons and 70 per cent in women's prisons reported having mental health problems

- of those who reported having a mental health problem, 42 per cent in men’s prisons and 54 per cent in women’s prisons reported that they had been helped with their mental health problem in their current prison.

7.4. Training and development

Prison officers require a good understanding of mental health problems so that they can support prisoners experiencing anxiety and mental ill health. As one individual detained in custody said:

“Just having a trained officer to chat to for five minutes to ask how you are doing and to talk to, really does make a big difference. It doesn’t have to be someone from the mental health team even”.

In addition, prison officers need to know who to refer on to for further mental health assessments. All new officers received mental health awareness training during their induction; however, prison officers’ ongoing mental health training was found to be variable. Updates and ongoing training relied on bespoke provision from local mental health services, which had been further curtailed by the pandemic restrictions. This position appeared counter-intuitive, given the incidence of poor mental health in prisons and the officers’ daily interface with prisoners. However, it was positive to see that prison officers working in mental health inpatient units at HMP Durham and HMP Birmingham received a good level of training and awareness.

All mental health clinical staff we spoke to told us they received regular supervision and training. Staff who asked to upskill in areas such as non-medical prescribing and advanced practice were supported to do so. We found that mental health teams in prisons had expanded and now employed disciplines such as speech and language therapists, social workers, learning disability nurses and occupational therapists, which was meeting need and improving outcomes for patients.

7.5. Treatment

All services we visited used the stepped-care model to organise the provision of mental health care and to employ the most effective evidence-based interventions. Steps one to three range from assessment and identification through to individuals with moderate mental health needs, typically managed by the prison GP and/or primary mental health staff. Steps four to five are interventions for individuals with severe and enduring mental health needs and are typically managed by secondary mental health staff and/or the psychiatrist.

Poor practice example

Staffing resources delivering interventions using the stepped-care model varied considerably and we were concerned that not all prisoners could access the evidence-based therapeutic intervention most suited to their needs. We found clinical psychologists were not consistently part of mental health services, resulting in some prisoners not being able to access the appropriate treatments, such as therapy for complex trauma disorder.

Assistant psychologists and suitably trained nurses and healthcare staff were delivering individual psychologically informed treatment interventions for mild to moderate problems such as depression and anxiety across all the prisons. All clinical notes we looked at were

comprehensive and of a good quality. Prisoners in receipt of treatment we spoke to at all the prisons reported positively on their experience. One prisoner said:

“Once I was in prison, I managed to see a specialist for the first time and was diagnosed with bipolar. I was prescribed medication, and it was life changing”.

Clinical psychologists were not consistently part of mental health services, resulting in some prisoners not being able to access the appropriate treatments, such as therapy for complex trauma disorder.

We found the impact of Covid-19 restrictions in prisons had impacted negatively on access to mental health services. For most of 2020, mental health services were reduced to providing acute and urgent mental health care only, and this had resulted in long waiting lists for routine assessments, psychological treatment and counselling in most prisons. Groupwork for mental health conditions had to cease completely in all prisons because of the need for social distancing. This created ever-increasing waiting times for group therapies. At the time of our thematic review, groups had restarted at HMP Downview and we saw plans to recommence groups in all the other prisons.

Good practice example

Women’s mental health services at HMP Downview, where 50 per cent of the population was engaged with the team, delivered psychologically led treatments and therapies tailored to women’s specific needs. This was meeting the needs of the women and improving outcomes and had continued throughout the pandemic. There was a recognition that women would often present with comorbidity issues relating to substance misuse and physical health. Strong collaboration between health partners such as substance misuse workers and primary care was evident. A newly established perinatal mental health service had been commissioned, which was promising.

We found strong working relationships between substance misuse and mental health teams in all six prisons and clinical notes we looked at confirmed that prisoners with substance misuse and mental health needs were receiving integrated care from both services in conjunction with each other.

Prisoners with enduring mental health needs received care and treatment by registered mental health staff. Clinical notes we looked at in all areas confirmed they had a patient-focused care plan which was regularly reviewed. Those with enduring mental health needs could access a psychiatrist in a timely manner in all areas.

Prisoners receiving care under the Care Programme Approach (CPA) in England and Care and Treatment Plan in Wales were being managed appropriately and regular reviews of the care plan were taking place. Services at HMP Forest Bank had embraced digital technology and CPA reviews were held virtually over secure video conferencing, making reviews easier to access for community mental health providers and more efficient.

Poor practice example

Acutely unwell prisoners who required urgent transfer to a secure mental health inpatient hospital for treatment continued to experience long waits in prison. Delayed mental health transfers continue to be the reality for prisoners who are extremely vulnerable or a potential risk to themselves or others, or who require treatment for their condition that

cannot be provided in prison. For example, at one of the sites we visited, 17 prisoners had been transferred to hospital in the last 12 months and only one had met the national guideline of being transferred within 14 days. The longest took 375 days. At another, 23 prisoners had been transferred to hospital in the previous 12 months and only five had been transferred within 14 days. The longest took 91 days. This results in mentally unwell prisoners being held in conditions that are in no way therapeutic and in many cases clearly exacerbate their condition.

We found that a national lack of secure mental health beds was often the reason for delays and prison mental health providers were escalating cases appropriately, often to no avail. We were told there is a particular shortage of high security mental health beds nationally, which results in far longer waits for those with high secure needs.

However, at HMP Birmingham, 34 prisoners had been transferred to a secure hospital in the previous 12 months. Of those, only two had exceeded the 14-day guideline. Weekly, well-attended meetings took place between prison mental health services, NHS England and justice commissioners, NHS specialised commissioners and the local secure care providers collaborative, which was resulting in swift transfers taking place.

Resource pressures caused by the pandemic and a lack of access to face-to-face health interventions had caused annual physical health reviews of prisoners on mental health medications to cease at one site, which carried additional risks for some patients.

Dedicated mental health inpatient beds were operational at HMP Birmingham (Ward 2) and HMP Durham (Integrated Support Unit). Both acted as a resource for their respective regions and were staffed by mental health staff and prison officers solely dedicated to the unit. Patients on these units benefited from a recovery-based regime and access to individualised and group-based therapeutic interventions. Both units were providing a valuable alternative to acutely mentally unwell prisoners being held on standard wings or segregation units. In some cases, they were preventing prisoners being transferred out to a secure hospital following a period of recovery.

Prisoner peer workers were used at HMP Birmingham and HMP Dartmoor, providing support, guidance and mental health first aid to other prisoners on the wings. Peer workers were appropriately trained and supervised, and the peer workers we spoke to at HMP Dartmoor were enthusiastic and committed to their role. They gave good examples of prisoners they had been able to signpost to mental health services who were less likely to access services autonomously.

7.6. Resettlement

Resettlement planning was fragmented, with work undertaken in custody not always following through into the community. Often work was 'to the gate' rather than through the gate. This was compounded by service users being released to many different areas where the availability of services differed by mental health trust or commissioning arrangements. This lack of continuity impacted on engagement and outcomes.

There were examples of service users having to wait for many months to access mental health services in the community following release. This had a detrimental impact and exacerbated long-standing mental health issues.

About a third of the prison population in Wales is held in prisons in England, including all women. Women prisoners have high levels of mental health problems and of self-harming. Ensuring their safe and successful resettlement to their home areas in Wales is essential. Mental health services in Wales are therefore expected to work with healthcare teams in

English prisons to help plan for release. Welsh health boards, in turn, must ensure that they meet prisoners' rights to reassessment under *The Mental Health (Wales) Measure 2010*.

7.7. Release

Release arrangements for prisoners with mental health problems were inconsistent. Some prisoners with vulnerabilities were being released without the appropriate support arrangements in place, with no clear national pathways to help plan ongoing care when individuals leave prison. We did, however, find some encouraging work to support continuity of care arrangements, as shown in this example.

Good practice example

Karim was coming to the end of his custodial sentence. While in prison, his probation officer had maintained regular contact through video conferencing, letters and a face-to-face visit. The communication between the probation officer, resettlement and other custodial staff was regular and effective. Karim had struggled emotionally in prison due to the loss of his father while serving his sentence. This had resulted in him accessing support from a prison chaplain and the mental health team. It became apparent that Karim's mental health needs were far greater than had initially been identified and there was a risk of further offending and self-harm. Having been notified that Karim would be placed on a waiting list for counselling, his probation officer contacted the local mosque, at Karim's request, to secure some continuity in his mental health care. On release, Karim was met by a worshipper from the mosque and offered a hot meal. His probation officer joined the meeting to ensure that Karim was happy with the support that was being offered. In the meantime, Karim was provided with information about online mental health support. These two measures were used creatively to improve his mental health.

However, many prisoners continue to be released homeless. This creates a further barrier for individuals requiring mental health support, as community services often require an individual to have an address and a GP before appointments can be made. At one prison, prisoners were housed hundreds of miles out of area because of the lack of approved premises in the area. This resulted in the prisoners having to register with a new GP practice and disputes occurring around commissioning responsibilities.

7.8. Mental health services on release

There were gaps in community mental health provision, and this was resulting in prisoners with mental health needs leaving prison with merely a letter outlining the support and treatment they had received in prison, to be taken to their GP. In one area, we were told there was a 24-month wait for a community mental health team appointment. Resettlement workers reported that they often came across GDPR barriers when trying to obtain information about individuals preparing for release from custody to the community. Relationships and information exchange with community probation practitioners were generally good. This was the case both during the sentence and on release.

RECONNECT

RECONNECT is a navigator service provided by the NHS to prevent a return to ill health and reduce reoffending. Practitioners start working with people before they leave prison and help them to make the transition to community-based services that will provide the health and care support that they need.

RECONNECT Care after Custody services were available at HMP Durham and HMP Birmingham. They provided good support for prisoners who were released following short sentences. The Centre for Mental Health was commissioned by NHS England in 2020 to conduct an independent review into prison mental health care and called for the expansion of the RECONNECT service. The national evaluation from the RECONNECT pilot sites has been delayed due to the pandemic. However, from our own experience of this thematic inspection, we believe it is an effective service. Practitioners will work with the prisoner before release to help them make the transition to community-based services and for up to 12 weeks after release. They help with housing issues, health appointments and employment opportunities. Information from NHS England reports that this provision will be available nationally by 2024. This is good. RECONNECT practitioners were based in the release hub at HMP Birmingham, where prisoners, on their day of release, could access support with their transition into the community. The release hub could provide various financial and practical support and signposting to education, training and employment opportunities.

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Annexe 1: Glossary

Accredited programme	A programme of work delivered to offenders in groups or individually through a requirement in a community order or a suspended sentence order, or as part of a custodial sentence or a condition in a prison licence. Accredited programmes are accredited by the Correctional Services Accredited Panel as being effective in reducing the likelihood of reoffending
Actus reus	Guilty conduct by the defendant
Alcohol Treatment Requirement (ATR)	A requirement that a court may attach to a community order or a suspended sentence order aimed at tackling alcohol abuse
Allocation	The process by which a decision is made about whether an offender will be supervised by the NPS or a CRC
Appropriate adult	An appropriate adult is a parent, guardian or social worker or, if no such person is available, any responsible person over 18. The term was introduced as part of the policing reforms in the <i>Police and Criminal Evidence Act 1984</i> and applies in England and Wales
Child protection	Work to make sure that all reasonable action has been taken to keep to a minimum the risk of a child coming to harm
Community Rehabilitation Company (CRC)	A private company delivering probation services
Comorbidity	The co-existence of more than one vulnerability, for example mental ill-health and substance misuse
Drug Rehabilitation Requirement (DRR)	A requirement that a court may attach to a community order or a suspended sentence order aimed at tackling drugs misuse
General Data Protection Regulation (GDPR)	The GDPR is a legal framework that sets guidelines for the collection and processing of personal information from individuals who live in the European Union (EU)
Ground rules hearing	A ground rules hearing is to discuss and establish the ways in which a vulnerable person, such as defendant with mental health issues, can be supported to give their best evidence in court
Health care professional (HCP)	A person trained to provide professional health care
Her Majesty's Prison and Probation Service (HMPPS)	The single agency responsible for both prisons and probation services. See note below on NOMS

Improving Access to Psychological Therapies (IAPT)	Evidence-based psychological therapies to help people with anxiety disorders and depression.
Independent domestic violence advisers (IDVA)	Independent domestic violence advisers provide support to survivors of domestic abuse living in the community and assessed as being at high risk of further domestic abuse
Infonet	A knowledge and information management tool to which CPS staff have access. It can be used for document management, knowledge-sharing, and allowing access to information
Integrated Offender Management (IOM)	Integrated Offender Management brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together
Individual Quality Assessments (IQA)	The CPS's scheme to assess the performance of individuals and compliance with the CPS's Casework Quality Standards
Intensive Intervention and Risk Management Service (IIRMS)	Interventions provided by psychologists for individuals with mental health disorders
Liaison and diversion (L&D)	L&D services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects or defendants
Multi-Agency Public Protection Arrangements (MAPPA)	Multi-Agency Public Protection Arrangements are where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others. Level one is ordinary agency management, where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This compares with levels two and 3, which require active multi-agency management
Multi Agency Tasking and Coordination (MATAC)	A multi-agency process to engage perpetrators of domestic abuse
MG3	Form used by the police when seeking charging advice from the CPS. It should contain key information and evidence from the investigation
MG5	Form used by the police to give a summary of the case, including the facts and evidence, the defendant's interview, any visual or audio evidence, anticipated plea and any orders sought on conviction.

MG6	Form used by the police on which case file evidence and information is recorded. This contains a section for medical and psychiatric information
Ministry of Justice (MoJ)	The Ministry of Justice is a government department within the justice system. It works to protect and advance the principles of justice.
Management of Sexual or Violent Offenders (MOSOVO)	A management process designed to monitor those who have committed serious sexual or violent offences
National Delius (nDelius)	The approved case management system used by the NPS and CRCs in England and Wales
National Police Chiefs' Council (NPCC)	A national coordination body for law enforcement in the United Kingdom and the representative body for British police chief officers
National Probation Service (NPS)	A single national service which came into being in June 2014. Its role is to deliver services to courts and to manage specific groups of offenders, including those presenting a high or very high risk of serious harm and those subject to MAPPA
OASys	Offender assessment system currently used in England and Wales by the NPS and CRCs to measure the risks and needs of offenders under supervision
Partners	Partners include statutory and non-statutory organisations, working with the participant/offender through a partnership agreement with the NPS or CRC
Providers	Providers deliver a service or input commissioned by and provided under contract to the NPS or CRC. This includes the staff and services provided under the contract, even when they are integrated or located within the NPS or CRC
Pre-sentence report (PSR)	This refers to any report prepared for a court, whether delivered orally or in a written format
Probation officer (PO)	This is the term for a 'qualified' responsible officer who has undertaken a higher-education-based course for two years. The name of the qualification and content of the training vary depending on when it was undertaken. They manage more complex cases
Probation services officer (PSO)	This is the term for a responsible officer who was originally recruited with no qualification. They may access locally determined training to 'qualify' as a probation services officer or to build on this to qualify as a probation officer. They may manage all but the most complex cases, depending on their level of training and experience. Some PSOs work within the court setting, where their duties include writing pre-sentence reports

Rehabilitation Activity Requirement (RAR)	From February 2015, when the <i>Offender Rehabilitation Act</i> was implemented, courts can specify a number of RAR days within an order. It is for probation services to decide on the precise work to be done during the RAR days awarded
Section 136	A power under the Mental Health Act, given to a police officer, to take an individual to a place of safety so that a mental health assessment can take place
Single point of contact (SPOC)	An individual in an organisation who has been identified as the first point of contact for a particular subject
Unused material	Unused material is material gathered in a criminal investigation that is not being used as evidence against the defendant. Unused material is itemised on a schedule known as the MG6C, which is served on the defence, and there is separate schedule (MG6D) for sensitive information
Vicarious trauma	An occupational challenge faced by people working and volunteering in various professions, including criminal justice

Annexe 2: Methodology

The inspection sought to answer the following:

Is there effective leadership driving the delivery of a high-quality, personalised and responsive approach to delivering criminal justice and mental health services?

- Is there effective leadership at a national level with a well-defined vision and strategy in place?
- Does local leadership support and promote the delivery of a high-quality, personalised and responsive criminal justice and mental health service?
- Do systems and processes support the delivery of effective and personalised criminal justice and mental health services?
- Are there effective joint partnership arrangements in place at a strategic level to support the delivery of a joined-up service to support the needs of all service users?

Do the skills of staff support the arrangements and delivery of high-quality criminal justice and mental health services?

- Are individuals with a mental health problem being identified at each point of the system?
- Are cases allocated to staff who are appropriately qualified and/or experienced?
- Do staff have sufficient training to support service users with mental illness?
- Is management oversight effective?
- Are arrangements for mental health learning and development comprehensive and responsive?
- Are staff empowered to make timely and effective decisions at key points throughout the justice process?

Is there a comprehensive range of high-quality services in place to meet the mental health needs of service users?

- Are relationships with providers and other agencies established, maintained and used effectively to deliver high-quality mental health services to service users?
- Are suitable mental health services provided, either in-house or through other agencies, to meet the identified needs and risks?
- Do sentencers have a range of options to consider, including Mental Health Treatment Requirements?
- Are diversity factors sufficiently addressed in the range of mental health services provided?
- Are mental health interventions evidence-led and evaluated?
- Are sufficient and effective diversion services in place?

Is timely and relevant information available and appropriate facilities in place to support high-quality, personalised and responsive criminal justice and mental health services?

- Do the policies, guidance and information about services available enable staff to deliver a quality service, meeting the needs of all service users with mental health problems?
- Is there a sufficiently comprehensive and up-to-date analysis of the profile of service users, used by the organisations to deliver well-targeted mental health services?
- Are there clear and effective processes in place to ensure that cases and individual needs can be tracked and shared?
- Is there a sufficient understanding of the quality of work being undertaken with service users who have mental health needs?
- Do the premises provide a safe environment for service users with mental health needs?
- Are the views of service users and other stakeholders sought, analysed and used to review and improve the effectiveness of mental health services?
- Is learning communicated effectively?

Does work carried out by practitioners support both the criminal justice process and mental health needs of service users?

- Does pre-sentence information provided to the court sufficiently address the mental health needs of the service user to support the court's decision-making?
- Is assessment timely, well-informed, analytical and personalised, actively involving the service user?
- Is planning well-informed, holistic and personalised, actively involving the service user?
- Is the delivery of work well-focused, personalised and coordinated effectively, engaging the service user? For people with complex needs (e.g. dual diagnosis), is there a clear lead practitioner who coordinates their care?
- Is reviewing of progress well-informed, analytical and personalised, actively involving the service user?
- Is there evidence of positive early outcomes, with a clear strategy for sustaining and building on these outcomes?

Are Through the Gate services personalised and coordinated effectively, addressing the service user's mental health needs?

- Does resettlement planning focus sufficiently on the service user's mental health needs?
- Does resettlement activity focus sufficiently on supporting the service user's mental health needs?
- Is there effective coordination of mental health activity between custody and community?
- Are any challenges in access to mental health support in the community addressed and overcome?

Fieldwork

The fieldwork was completed between April and May 2021. The inspection was mostly carried out remotely using video conferencing platforms like MS Teams due to the Covid-19 pandemic. Telephone conferencing was also used and CQC/HIW and HM Inspectorate of Prisons held some face-to-face meetings. Cases from six local probation delivery units (NPS and CRC) were chosen for the inspection. Partner inspectorates inspected the linked police forces, CPS departments, courts and some prisons and commissioned L&D providers in the following areas:

- Durham
- Birmingham
- Exeter
- Gwent, Newport
- Greater Manchester, Bolton
- Croydon.

All inspectorates reviewed national policy documents relating to the organisations that they inspect.

CQC/HIW spoke with L&D service managers, social workers, custody, court and healthcare practitioners, governance leads, team leaders, outreach teams and peer support workers and health and justice leads.

HMICFRS reviewed national and local force documents; interviewed strategic leads; had meetings with staff, supervisors and manager groups and held meetings with partners. A significant time was spent in case review work. The investigation case reviews for this inspection numbered 274. Of these, 203 were custody-based crime cases and, within these, we found 108 custody cases where there was an earlier detention or investigation that could be reviewed. In total, 382 different detentions or investigative interviews were reviewed.

HM Inspectorate of Probation in each area (NPS and CRC) spoke to local delivery unit heads of function, learning and development senior managers, those supporting performance and quality development, senior leaders with a mental health lead, practitioners delivering mental health interventions, providers of mental health services, sentencers and psychologists. A total of 62 staff from these roles were interviewed. Focus groups with middle managers, probation practitioners and report writers and court staff totalled 89. HMCPSI interviewed judges, lawyers and mental health leads.

HM Inspectorate of Prisons met with prison governors, deputy prison governors, prison custody officers, NHS commissioners, directors, heads of healthcare, mental health team managers, mental health nurses, health assistants, occupational therapists, speech and language therapists, psychologists, support time and recovery workers and psychiatrists. Meetings with 16 prisoners also took place. In total, 79 interviews were conducted with a range of staff.

Joint inspection of cases

From caseloads held by probation services, we selected and inspected a total of 60 cases sentenced to a community order or suspended sentence order or released from custody on licence during the period June 2020 to August 2020. A number of cases were jointly reviewed as listed below:

- fifteen licence cases (short prison sentence) reviewed by all inspectorates

- fifteen licence cases (long prison sentence) reviewed by HM Inspectorate of Prisons, HM Inspectorate of Probation, and CQC/HIW only
- fifteen community cases reviewed by HMICFRS, HMCPSI, HM Inspectorate of Probation and CQC/HIW only
- fifteen community cases reviewed by HM Inspectorate of Probation only.

Characteristics of joint case sample

The tables below provide a breakdown of the characteristics of individuals inspected as part of the joint inspectorate case sample.

	Number in sample	Age range	Sentence length range	Offence range	Mental health needs
Female	12	22–52 years	Ranged from a 12-month community order to a 109-month custodial sentence	Ranged from a breach of restraining order to arson	4/12 had recorded suicide/self-harm issues. 2/12 were subject to a Mental Health Treatment Requirement
Male	33	20–67 years	Ranged from a 12-month community order to a life licence	Ranged from common assault to murder	7/33 had contact with the Offender Personality Disorder Pathway. 9/33 had recorded issues of self-harm/suicide

Race and ethnicity

White	35 cases
Mixed heritage: White and Black Caribbean	1
Asian or Asian British: Pakistani	3
Asian or Asian British: Other	1
Black or Black British: Caribbean	3
Black or Black British: African	1
Not recorded	1

The below table shows the joint sample mental health diagnosis/condition by type, where known. It should be noted that several cases presented with more than one condition; therefore, the categorisation is based on the primary diagnosis or key mental health feature.

Table showing the number of cases against types of primary mental health diagnoses/conditions

Primary mental health diagnosis/condition	Number of cases	Percentage
Anxiety/depression	8	18%
Suicide and self-harm	7	16%
OPD pathway	6	13%
Trauma	6	13%
Post-traumatic stress disorder	5	11%
Personality disorder	5	11%
Irrational behaviour	2	4%
Psychosis	2	4%
Other/unclear	2	4%
Paranoid schizophrenia	1	2%
Behavioural disorder	1	2%
TOTAL	45	

Substance misuse and neurodiversity needs in addition to mental health in cohort sample

Of the 45 cases in the cohort sample, 26 (58 per cent) were assessed as having a co-existing issue as well as mental ill health.

Co-existing need: substance misuse	21 of 26 cases	81%
Co-existing need: neurodiversity	2 of 26 cases	8%
Both substance misuse and neurodiversity needs	4 of 26 cases	15%

In addition, other cases outside of this sample were reviewed to gain an understanding of how processes and procedures were applied. The age, gender and ethnicity breakdown of all 60 cases reviewed was as follows:

Age	Number	%
18–25	11	18%
26–35	20	33%
36–55	25	42%
55+	4	7%

Gender	Number	%
Male	42	70%
Female	18	30%

Race and ethnic category	Number	%
White	44	75%
Black and minority ethnic	13	22%
Other groups	0	0%
Not clearly recorded	2	3%

In addition, HM Inspectorate of Probation reviewed 60 pre-sentence reports that were mostly completed in June 2020. Reports completed before this date were also included in the sample to take into account longer prison sentences. The age, gender and ethnicity breakdown of pre-sentence reports reviewed was as follows:

Age	Number	%
18–25	16	27%
26–35	20	33%
36–55	20	33%
55+	4	7%

Gender	Number	%
Male	48	80%
Female	12	20%

Race and ethnic category	Number	%
White	48	81%
Black and minority ethnic	9	15%
Other groups	0	0%
Not clearly recorded	2	3%

For each case in the joint sample, inspectors accessed their agency's case management systems to reach their judgements against a small number of key questions. HM Inspectorate of Probation interviewed 54 probation practitioners who were directly responsible for the supervision of these cases. These interviews were either carried out over the telephone or MS Teams.

Interviews and focus groups

In each area, inspectors interviewed a range of staff, including senior leaders, staff, commissioners, public health workers, police and crime commissioners, judiciary, prison resettlement staff, specialist practitioners, mental health service providers and national experts. They also considered the lived experience perspective from individuals in the CJS. Penal Reform Solutions, a research and consultancy collective, was commissioned to carry out the latter work and more detail about the specific methodology used is included in its report. Sixty-seven individuals were interviewed by Penal Reform Solutions.

Annex 3: Expert reference group

An expert reference group contributed to this report by advising on strategic, technical and operational issues associated with the subject and service under inspection, representing the views of key stakeholders in the areas under scrutiny, comment on emerging findings and final recommendations.

Group membership included:

The Rt Hon Lord Bradley

Author of the 2009 Bradley Report (Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system)

Prof. Charlie Brooker (Royal Holloway)

Honorary Professor, Centre for Sociology and Criminology, Royal Holloway, University of London

Greg (Gregor) McGill

Director of Legal Services, Crown Prosecution Service

Graham Durcan

Associate Director, Centre for Mental Health

Matthew Scott

Police and Crime Commissioner, Kent

Dr Coral Sirdifield (University of Lincoln)

Research Fellow, College of Social Science, University of Lincoln.

Mignon French

Programme Manager, Community Sentence Treatment Requirements, NHS England & Improvement

Jabeer Butt OBE

Chief Executive Officer, Race Equality Foundation

Dr Keith Reid

Consultant Forensic Psychiatrist & Associate Medical Director at Northumberland Tyne & Wear NHS.

Lady Emma Arbuthnot

Chief Magistrate

Steve Baker

Chief Inspector, national mental health co-ordinator at the College of Policing and National Police Chief's Council

Dr Iain Kooyman

Associate Medical Director, Consultant Forensic Psychiatrist, HMP Wandsworth, South London and Maudsley NHS Foundation Trust