FINAL REPORT

EVALUATION OF THE SOUTH WEST MENTAL HEALTH ASSESSMENT AND ADVICE PILOT

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EXECUTIVE SUMMARY

For defendants to be effectively screened when passing through court, cooperation between the criminal justice system (CJS) and mental health services (MHS) is required. One dimension of this is the transfer of information on the mental health of the defendant between services in the form of written reports. Reports follow the assessment of the defendant by the MHS usually at the request of the court or other party. This dimension of cross agency working has proved difficult in the past as might be expected of working between two public services so distinct in their expectations, priorities and working culture. In response to these difficulties, a partnership between the Criminal Justice System and The Mental Health Services was formed in a region of the SW of England and a pilot project was funded (South West Mental Health Assessment Pilot; 2007-2009) to implement a formal service Level agreement (SLA) between the MHS and CJS to optimise the provision of reports (Staddon, 2009).

The overall objective of the current study is to evaluate the effectiveness of this Service Level Agreement introduced into a range of magistrates and crown courts in the Hampshire and Bristol/Bath regions. The objectives of the evaluation were to explore specifically:

- The awareness of the liaison services
- the current demand for reports
- the demographics of defendants seen by the service
- the mental health issues and the level of risk they present
- the nature of the alleged offence
- the source of referral
- the number and timeliness of each type of reports being requested of the service
- the number of adjournments,
- the time to disposal and
- the nature of disposal
- the level to which members of each service perceive defendants to not be receiving adequate support in their trajectory through the criminal justice system
- the values held by the court and mental health services when working across agencies with defendants in contact with the criminal justice system
- The self efficacy of CJS and MHS personnel in dealing with defendants with mental health issues and their level of training in this area.
- Levels of satisfaction on various dimensions of the liaison services

To evaluate the impact of the SLA upon health and court services, a longitudinal design comprising of two data collection points was implemented:

- Pre SLA implementation (baseline audit),
- Post SLA implementation (final audit)

Each data collection point involved two phases:

- Phase 1: Monitoring of service demand. Data was collected through monitoring sheets and databases maintained by the CARS service
- Phase 2: A satisfaction survey of court and mental health service personnel

Data was collected from both the court and health services at both phases.

The analysis of data collected suggests that the SLA has lead to an increase in cases dealt with without adjournment, that the time from initial hearing to disposal has been reduced and that there is an increase in the number of defendants with mental health issues receiving community orders. The evaluation has also highlighted the limited and inconsistent record keeping systems in both the Criminal Justice System (CJS) and Mental Health Services (MHS) and has introduced a new pilot record keeping system into the Court Assessment and Referral Service (CARS) that has lead to an improvement in the consistency and utility of data collected by this liaison service. The evaluation has helped articulate key variables required within this database.

Both CJS and MHS personnel show positive attitudes towards defendants with mental health issues and both services recognise that defendants are often disposed of with insufficient advice being available on their mental health. There is a suggestion that, from the CJS perspective, the extent of this problem has improved post SLA. There is a higher awareness of liaison services post SLA especially in the Bristol/Bath region. Although respondents may be more aware of services available, some are still unclear of how to interact with these services. Respondents are as satisfied with the new screening reports as they have been with the health and social circumstances and psychiatric report provided pre SLA.

Qualitative evidence supports the numerical evidence that there has been an enhancement of practice in both the CJS and MHS, post SLA. Respondents from the CJS report improved timeliness in report delivery, more informed decision making and increased feelings of confidence when working with mentally ill defendants. MHS personnel recognise the decrease in inappropriate requests for reports.

For those CJS and MHS personnel that reported a less positive experience, they describe a continued lack of awareness of the service or know-how of how to engage with the service. For CJS workers there is a perceived need for the content of the report to reflect more closely the needs of the CJS.

Based on the findings of the evaluation it is recommended that:

- The new record keeping system introduced into the CARS service requires further development, specifically around the consistency with which data is entered into the database.
- The liaison service is a key gatekeeper that facilitates the movement of information on defendants with mental health issues between the CJS and MHS. In this role, they are essential in promoting effective interagency working ensuring that the outcomes of the two services are compatible. In this role, liaison workers should remember the commonalities between the services and focus on the values they share and their common recognition that the mental health needs of defendants need to be addressed.
- Further investment is required to provide formal training to individuals in both the MHS and CJS in order to develop their understanding of each other roles and responsibilities as well as organisational processes. Ideally this should be interprofessional where both services learn together with and from each other. Training should promote an awareness of how to actively engage with the liaison service effectively; as well as an awareness of the service itself.
- Further development of the liaison protocol is required to increase clarity regarding roles and responsibilities.
- Further projects could concentrate on the development of the report content itself, in addition to the timeliness of their provision which has been the focus of the current pilot project. The expectations of the CJS and MHS on what a report should contain need to be mapped to reach consensus on what will be both beneficial to both agencies. For the CJS, the report should contain information that promotes their decision making processes during court proceedings. For the MHS, the information they provide in the report must remain appropriate and within their remit. Formal feedback mechanism between the CJS and MHS also need to be established so the court can communicate their needs to the MHS and vive versa, opening up clear communication channels between the two agencies.
- Further investment is required to expand the current provision of liaison service through an increase in presence of mental health workers physically available in the courts and to include other courts in the region.
- Finally, all interventions need time to be well embedded for their impact to be evaluated effectively. It is recommended that the service be re evaluated when this has been allowed to occur.

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Chapter 1. INTRODUCTION

1.1. Rationale

The prevalence of mental health issues in the prison population (Joint Prison Service and National Health Service Executive, 1999; Reed, 2003; Department of Health, 2007) may partially be attributed to prisoners not being screened effectively for mental illness during earlier contact with the criminal justice system (CJS). For defendants to be effectively screened when passing through court, cooperation between the CJS and mental health services (MHS) is required. One dimension of this is the transfer of information on the mental health of the defendant between services in the form of written reports. Reports follow the assessment of the defendant by the MHS usually at the request of the court or other party. The report should enable the defendant to access the treatment they require and/or assist the sentencer in making an informed decision on an appropriate means of disposal. This dimension of cross agency working has proved difficult in the past as might be expected of working between two public services so distinct in their expectations, priorities and working culture. In response to these difficulties, a partnership between the Criminal Justice System (CJS) and The Mental Health Services (MHS) was formed in a region of the SW of England and a pilot project was funded (South West Mental Health Assessment Pilot; 2007-2009) to implement a formal service Level agreement (SLA) between the MHS and CJS to optimise the provision of reports (Staddon et al., 2009-Project report). This document reports the evaluation of this pilot over this period.

1.2. Aims

The overall objective of the study is to evaluate the effectiveness of a Service Level Agreement introduced into a range of magistrates and crown courts in the Hampshire and Bristol/Bath regions. Although part of the evaluation includes the Hampshire region, where a Court Liaison Service, has developed ways to provide a different and complimentary service from the Mentally Disordered Offender Service (MENDOS) there is a particular emphasis on the SLA as introduced into Bath magistrates, Bristol magistrates and Bristol crown courts through the Court Assessment and Referral Service (CARS) where the SLA was more embedded at the time of evaluation.

The objectives of the evaluation were to explore specifically:

- The awareness of the liaison services
- the current demand for reports
- the demographics of defendants seen by the service
- the mental health issues and the level of risk they present
- the nature of the alleged offence
- the source of referral

- the number and timeliness of each type of reports being requested of the service
- the number of adjournments,
- the time to disposal and
- the nature of disposal
- the level to which members of each service perceive defendants to not be receiving adequate support in their trajectory through the criminal justice system
- the values held by the court and mental health services when working across agencies with defendants in contact with the criminal justice system
- The self efficacy of CJS and MHS personnel in dealing with defendants with mental health issues and their level of training in this area.
- Levels of satisfaction on various dimensions of the liaison services

Although early days in the implementation of the SLA, where feasible, comparisons are made between pre SLA and post SLA data are drawn to evaluate the initial impact of the SLA and how it may be developed further.

1.3. Content of this Report

This report is divided into 7 chapters. This present chapter has presented the rational and key aims of the evaluation. Chapter 2 briefly outlines a theoretical framework that, developed through the evaluation, we feel has been useful in articulating the interagency working required when the mental health needs of defendants are addressed. Chapter 3 presents the design of the evaluation and methods used within it. Chapter 4 considers the outcomes of phase 1 of the evaluation in which monitoring sheets were administered to the mental health services and criminal justice system and that collected information on the individual requests for court reports. The chapter briefly reminds readers of the results of the pre SLA baseline data of phase 1 but focuses on phase 1 post SLA data. Chapter 5 describes the outcomes of a survey of a range of attitudes/opinions held by of court and health service personnel. The data presented in Chapters 4 and 5 are predominantly quantitative in nature. Chapter 6, looks at more free responses drawn from court and health personnel, reviewing their perceptions on the impact of the SLA and how it can be improved further. The final chapter summarises the key findings of the evaluation and recommendations for the future.

A central task in the evaluation has been to establish a consensus as to the evaluation outcomes and processes that are of central interest to all stakeholders. This has lead to a large amount of data being collected, some of central importance to the evaluation of the SLA but other more peripheral, albeit important data. However, we aim to present here a succinct final report picking out the key outcomes of the evaluation. Greater detail is provided in feedback on this two year evaluation that has delivered

in detailed presentations and interim reports through out the project. It is not our intention to repeat the discussion already captured in interim reports 1 and 2 (appendices 9.9 and 9.10), and we have therefore included both these reports as appendices to this final report. Interim report 1 in May 2008 reported on the outcomes of phase 1 of the Pre SLA implementation (baseline audit). Interim report 2 December (2008) reported on phase 2 of the baseline audit, focusing on specifically the satisfaction survey to the court.

Chapter 2. A THEORETICAL FRAMEWORK

2.1. Introduction

This chapter outlines a theoretical framework that developed through the evaluation that we feel has been useful in articulating the interagency working required when the mental health needs of defendants are addressed. It frames the SLA as an agreement that seeks to facilitate interagency working between the mental health services and criminal justice system.

2.2. A framework to visualise working across the mental health services and the criminal justice system

A host of agencies are involved in ensuring that defendants with mental health issues receive the support they require when passing through the court system, being diverted from the Criminal Justice system if necessary. The courts and the mental health services are two of these. Professionals in the Courts (e.g. lawyers, judges, and probation officers) work in partnership with those in the mental health services (e.g. psychiatrists, community psychiatric nurses, psychologists,)

Working across agencies/services/ organisations is complex and challenging. Models or frameworks clarify these systems for people working within these systems and help them understand these complexities and hence facilitates their practice. We present here a framework that has helped us visualise working across the MHS and CJS, a framework that has helped the evaluators, as outsiders, visualise the cross agency working that occurs when reports are requested by the CJS and delivered to them by the MHS.

Cross agency working of this kind can be separated into multi or inter agency working.

"Multi agency working implies more than one agency working with a client but not necessarily jointly. Multi agency working may be prompted by joint planning or simply be a form of replication, resulting from a lack of proper interagency co-ordination" (Warmington *et al.*, 2004, p14).

Interagency working, on the other hand, is where one or more agencies work together but where these working relationships are in a *" planned and formal way, rather than simply through informal networking* "(Warmington *et al.*, 2004) p14).

The SW Mental Health assessment Pilot is illustrative of how two services have moved from multiagency working to interagency working through the introduction of a service level agreement (SLA) in which formalized relationships between agencies were established to optimise the provision

of reports. Prior to the formalisation of the relationship between agencies, informal networking between agencies meant court outcomes were well below optimum with delays in report provision, inappropriate report content and high, unanticipated costs being some of the poor outcomes of previous multi agency interaction (Hean *et al.*, 2008). The Service level agreement between the criminal justice system and the mental health services means that formal arrangements now govern report provision and improved interagency working.

2.3. A framework to understand interagency working

Interagency working is complex and as such is difficult to manage and evaluate. A framework that has proved useful in making sense of this is that of the Activity System (Engestrom, 2001)

The activity system as framework is an evolution of socio cultural learning theory (Vygotsky, 1978). The basic tenet of the latter is that the meaning we make of an activity, or the learning that takes place during this activity, is a function not only of the individual's own cognition, ability or dedication. It is also mediated and influenced by factors external to the individual within the social world as well (Engestrom, 2001). Activity systems build on this individual level of analysis to take a more macro level approach (Hean et al., i*n press)*. Figures 1 and 2 (adapted from Hopwood & McAlpine, 2007) illustrate two activity systems that are present in scenario 1. Figure 1 represents a single activity that takes place within the activity system-the CJS. Figure 2 represents a single activity that occurs within a second agency – the mental health service

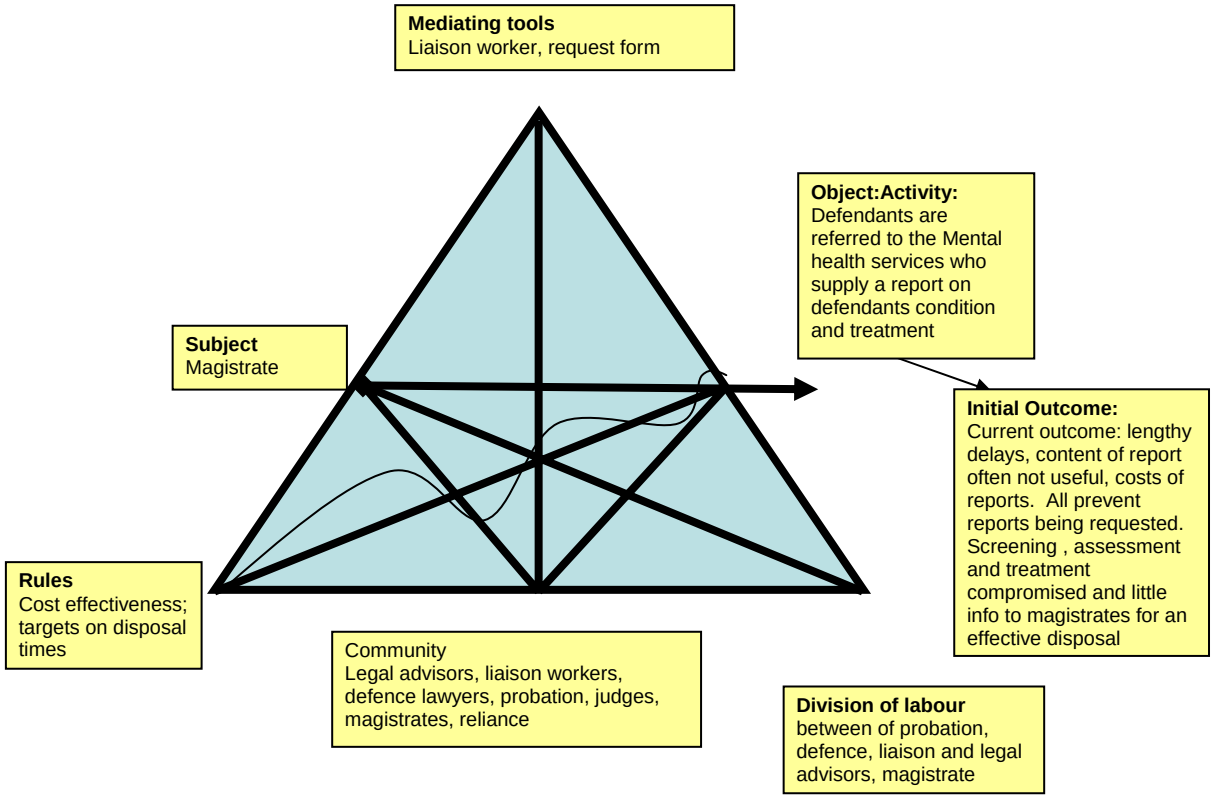

Figure 1: An activity system surrounding the requests for psychiatric reports made by the Criminal Justice system

In figure 1, the subject is the person within an agency undertaking a particular activity. The objective is the purpose of this activity. In the court activity system, the subject is illustrated by a magistrate dealing with a defendant identified as having potential mental health issue. In the interest of the defendant, and to inform sentencing (the object), the magistrate requests an assessment and report on the mental health of the defendant (the activity). In order to achieve this, the magistrate may complete a written assessment request or negotiate with legal advisors or liaison workers in court to make these requests. The latter are tools that mediate the activity. Surrounding this mediated activity are a range of other variables that may have influence. These include both the unwritten social norms and formal rules that govern the way in which the CJS function, e.g., government imposed targets that specify the times in which court cases need to be completed. Also surrounding the activity are members of the wider CJS community who include liaison workers, defence lawyers, probation officers, court ushers, other magistrates, and security personnel. Each of these members may fulfil a particular role within the CJS that will dictate how the activity under focus can be achieved (division of labour). The outcome of this activity is mediated by the complex structures that surround it. Prior to the implementation of the SLA, these outcomes were problematical caused by a range of contradictions within the activity system. For example, there is a contradiction in the activity system (figure 1) between the need to request a report (object) and governing rules that stipulate that court cases need to be completed in a set time frame. As reports are often delayed, this contradiction means that

magistrates were sometimes loathe to request reports as the delays the report introduces, compromises the government time targets they are trying to achieve.

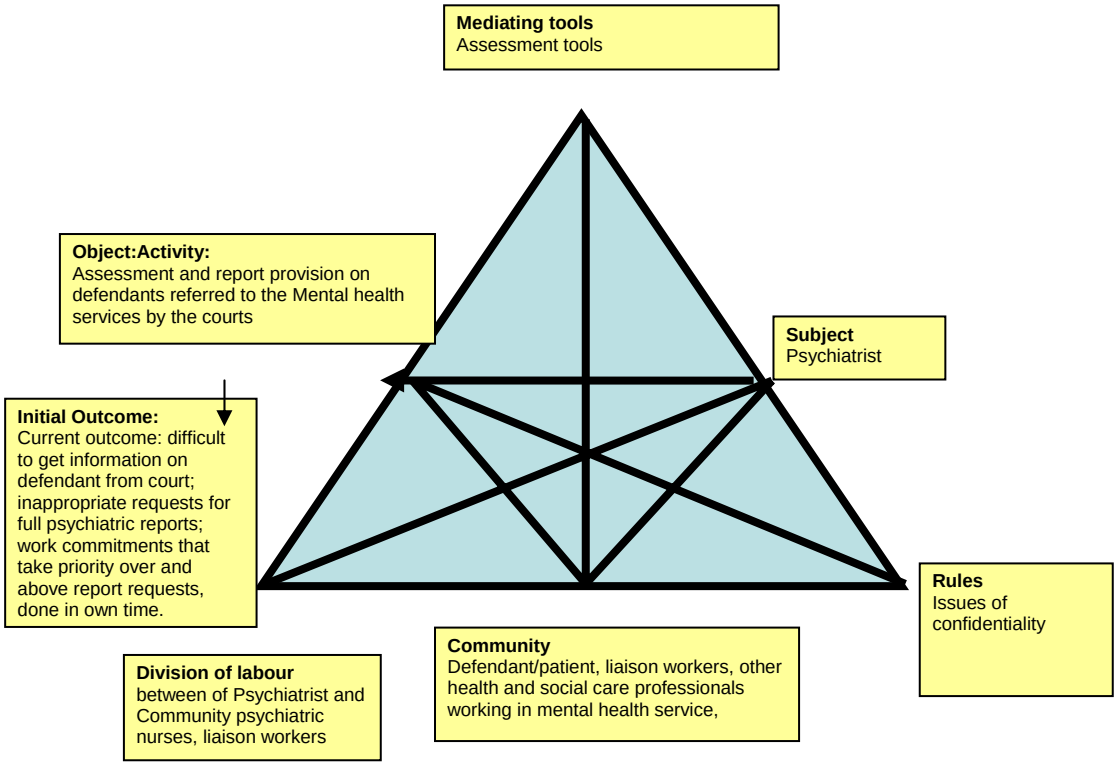

Figure 2: An activity system surrounding the provision of psychiatric reports by the Mental health services

In figure 2 the subject is a psychiatrist undertaking an assessment and making a report on a service user in contact with the CJS. The psychiatrist does this using the assessment tools available to her/him as part of their normal practice. The way in which the report is written may be underpinned by several norms and rules, e.g.:

- psychiatrists view that their first responsibility is to the defendant and his/her treatment (and not punishment)
- Patient confidentiality.
- Psychiatrists are expected to complete reports for the court on a private consultancy basis over and above their current work load.

The community, who surrounds the report writing activity undertaken, by the psychiatrist include other psychiatrists, community psychiatric nurses and social workers. A clear cut division of labour arises in report writing with psychiatrists being responsible for the full assessment and psychiatric reports required of the more seriously mentally ill or more serious offenders. Abbreviated health and social circumstance or screening reports are conducted by other health professionals. The outcomes of

this activity can be challenging in that information from the courts on a patient are not easily accessible and expectations of report content and timeframes are not clearly communicated (Hean *et al.*, 2008).

In considering inter agency working , we need to look beyond the two separate activity systems in isolation and review them in parallel, identifying how the objects of each activity are synchronous. We also need to articulate a new joint shared outcomes of these two agencies working together (figure 3). To optimize this joint outcome, the tensions or contradictions between the components of the each system need to be identified and resolved to achieve improved joint agency outcomes (see Figure 3). Resolutions are produced and piloted by both agencies in partnership and agencies learn together to develop ways in which to effectively work together (Engestrom, 2001). In scenario 1, the mental health services and the CJS formed a working partnership to achieve just this. Representatives from each agency came together in a project steering group. The objects of each system were identified (see figure 1 and 2). Through a range of meetings between agency representatives and an evaluation of interagency challenges (Hean *et al.*, 2008), the group identified that, although they are involved in different activities, in terms of interagency working, they share a common overarching object -the transfer of information about a defendant with mental health issue between the two agencies. Initial joint outcomes were below optimum, the evaluation showing that there was no shared expectation of agreed time scales and that too many psychiatric reports being requested inappropriately (Figure 3).

Facilitated by a project manager, contradictions within each system were identified, and a resolution put in place and tested. The jointly engineered solution was the introduction of a service level agreement in which the mental health service are commissioned to provide 'brief screening reports' on all defendants referred to them or already known to them. These were to be done on the day or within one working day of the referral. If further information was required a Health and Social Circumstances Report or a psychiatric report will be provided to agreed timescales.

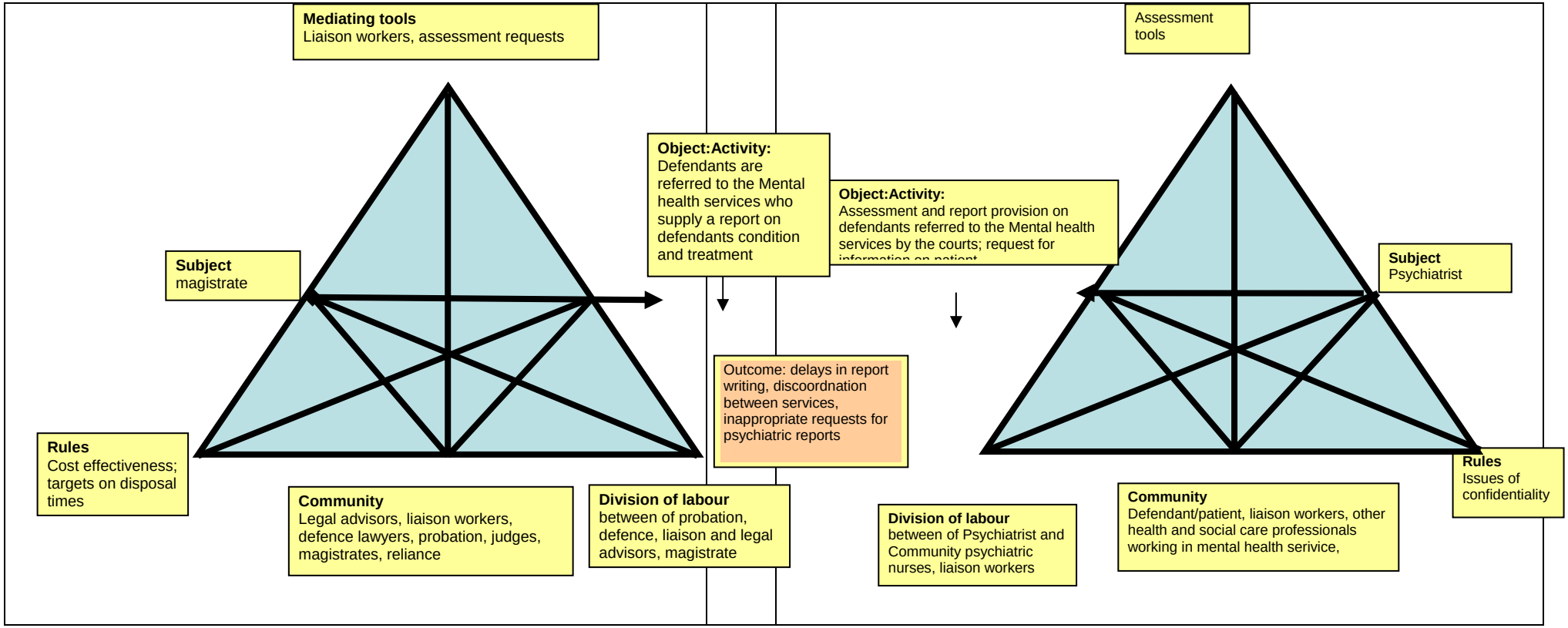

Figure 3: Interaction of the Activity systems of the criminal Justice system and mental health services respectively

Chapter 3. METHODOLOGY

This chapter presents the design of the evaluation and the methods used. The design of the evaluation, key variables of interest and methods used to measure these variables were established through consultation with the pilot steering group and close working with the Pilot Project manager.

3.1. Evaluation design

To evaluate the impact of the SLA upon health and court services, a longitudinal design comprising of two data collection points was implemented:

- Pre SLA implementation (baseline audit),
- Post SLA implementation (final audit)

Each data collection point involved two phases:

- Phase 1: Monitoring of service demand
- Phase 2: A satisfaction survey of court and mental health service personnel

Data was collected from both the court and health services at both phases.

3.2. Phase 1 Pre SLA

A monitoring form (appendix 9.1) was distributed to key contacts in the *court services* participating in the project. The contact was requested to complete this form for every incidence in which a request for mental health assessment/report was made of mental health services and which was paid for directly by this court service. This precluded reports requested for and paid for by defence solicitors as well as reports paid for through legal aid. The data collection period was between 15 May 2007 and 31 December 2007. Forms were collected monthly from each contact. The form collected data on a range of variables including the

- Number and type of psychiatric reports, assessment and advice requested
- The health service from which psychiatric reports, assessment and advice are requested
- The timeliness in which reports, assessment and advice are received
- The usefulness of reports, assessment and advice received
- The number of case adjournments
- The status of defendants (Bail, remand)
- The demographic details, offence and means of disposal of the defendant

A similar and complementary monitoring form (see Appendix 9.2) was distributed to key contacts in *the mental health services* to collect monthly data on a range of variables including the

- Number and type of psychiatric reports, assessment and advice requested of the service by the courts
- The court service from which psychiatric reports, assessment and advice are requested
- Whether the defendant is known to the health service
- The time taken for reports, assessment and advice to be completed and reasons for any delays
- The appropriateness of the referral
- The type of mental health worker completing the report, assessment and advice.

Monitoring sheets recorded defendants case and health record numbers (the latter anonymised) in order that duplicate cases recorded by both court and mental health service could be identified.

Attempts were made to collect the monthly records being kept by either liaison workers or the CJS across the region. It became clear that in many instances record systems were not being kept. Where they were, data was recorded in an aggregate form which limited the analysis that could be performed on these data. In addition, there was no consistency in the type of data being collected across services or, if there was overlap, information was recorded in different ways.

3.3. Phase 1 Post SLA

A key recommendations of interim report 1 on baseline data from phase 1 reported in Hean et al., (2008) was to:

> *Encourage and/or develop interagency administrative processes at the interface of working between the courts and mental health services. This includes accurate and sustained recording of court requests for assessment. Detailed and shared databases should be established and maintained by both court and mental health services to achieve this.*

Acting upon this recommendation, a database was designed and implemented in the Bristol/Bath region to monitor the cases assessed by the Court Assessment and Referral Service (CARS). Variables were chosen based on those identified in the phase 1 baseline data monitoring sheet (as agreed by steering group), in line with the requirements of the new SLA implemented in April 2008 and in consultation with CARS workers and court contacts who would complete the database (see Appendix 9.3).

The database is jointly administered by staff in the CARS and Court services.

As with the phase 1 of the baseline audit, data was collected on each individual defendant case independently. The criterion for inclusion of a case into the data base was the defendant being assessed by the CARS liaison service with each month of data collection. Data was collected over a 5 month period from April to August 2008.

The database is stored by a CARS administrator and, for reasons of confidentiality, names are removed before being sent to the researcher.

This system is being piloted in the Hampshire region. This pilot is not included in the analysis presented here.

3.4. Phase 2: PreSLA

Data collection for the baseline data for phase 2 involved canvassing opinion of court and health service personnel on issues related to mental health assessment of defendants in contact with the criminal justice system. The collection of questionnaires from the CJS and MHS were completed between February and June 2008 (see Appendix 9.4 and Appendix 9.5)

3.4.1. Pre SLA court sample

The survey canvassed opinion of judges, legal advisors, probation officers and defence lawyers that serve Bristol magistrates, Bristol Crown, Bath Magistrates, Southampton Combined, Southampton Magistrates, IOW magistrates and IOW Crown Courts, Portsmouth Crown, and Portsmouth magistrates Courts.

3.4.2. Pre SLA health sample

The survey was sent to professionals likely to work with defendants: Psychiatrists, Nurses, Social Workers and Psychologist/Psychotherapists, mental health workers in the CARS

(Bristol/Bath) and MENDOS (Mentally Disordered Offenders Service, Hampshire) liaison services.

Two medium secure units from each geographic location were included in sample:

- Fromeside (Bristol/Bath)
- Ravenswood (Hampshire)
-

Twelve Community Mental Health teams in the Bristol/Bath region were accessed:

- Bath South Community Mental Health Team
- Bath North Community Mental Health Team
- Paulton Community Mental Health Team
- BANES Assertive Outreach Team
- Cabot Primary Care Liaison Team
- Bristol Central Assessment and Intervention Service
- Bristol South Assertive Outreach Team
- Bristol City Wide Home Intervention
- Adult Bristol Inpatient PICU Hazel Unit
- The Pines, Southmead Hospital
- Bristol North Inpatient Maston Ward
- The Central Outreach Team

Twelve Community Mental Health teams in the Hampshire region were accessed:

- Anchor House,
- Waterford House,
- Elizabeth Dibben Centre
- Hawthorn Lodge, Moorgreen Hospital
- Cannon House
- Hayling CMHT
- Petersfield CMHT
- Waterlooville CMHT
- Osborn Centre,
- Hewatt House
- Connought House
- Andover Adult CMHT

3.5. Phase 2: Post SLA

Data collection for the baseline data for Phase 2 post SLA involved canvassing opinion of court and health service personnel that had had exposure to the new SLA arrangements. The collection of questionnaires from the CJS and MHS were completed in April 2009 (see Appendix 9.6 and Appendix 9.7)

3.5.1. Post SLA court sample

The survey again canvassed opinion of judges, legal advisors, probation officers and defence lawyers. A reduced number of courts were accessed at Phase 2 as dictated to by where the new SLA had been implemented at the time of the survey. Bristol magistrates, Bristol Crown, Bath Magistrates, Southampton Combined, Southampton Magistrates, and Portsmouth Crown Courts were included in sample.

3.5.2. Post SLA health sample

The survey was sent to professionals likely to work with defendants with defendants: Psychiatrists, Nurses, Social Workers and Psychologist/Psychotherapists. Psychiatrists in two medium secure units from each geographic location were included in sample:

- Fromeside
- Ravenswood

Twelve Community Mental Health teams in the Bristol/Bath region, specifically Psychiatrists, Nurses, Social Workers and Psychologist/Psychotherapists were accessed:

- Bath South Community Mental Health Team
- Bath North Community Mental Health Team
- Paulton Community Mental Health Team
- BANES Assertive Outreach Team
- Cabot Primary Care Liaison Team
- Bristol Central Assessment and Intervention Service
- Bristol South Assertive Outreach Team
- Bristol City Wide Home Intervention
- Adult Bristol Inpatient PICU Hazel Unit
- The Pines, Southmead Hospital
- Bristol North Inpatient Maston Ward
- The Central Outreach Team

3.5.3. Instrument development

The monitoring forms and questionnaires used in phases 1 and 2 were designed and piloted in conjunction with the SLA project manager and the steering group of the project. These members represented members of both the health and court services. These members were used as a panel of judges felt to have the expertise and experience in both services to be able to comment on the content and construct validity of the questions employed.

3.5.4. Ethical considerations

The monitoring sheets, questionnaires and associated electronic databases were stored securely in the offices of Bournemouth University under the custodianship of the report authors. Raw data was only made available to the report authors and no one else. Information (other than court and mental health service name) that was provided to project leaders, the steering group has been anonymised in this report. Both of these will also be anonymised in any academic dissemination of the findings. Monitoring sheets and questionnaires will be stored for 5 years and then destroyed. Members of the court who provided completed monitoring sheets and questionnaires and the defendants associated with the record have the right to check the accuracy of data held about them and correct any errors.

Chapter 4. RESULTS OF PHASE 1

4.1. Introduction

This chapter briefly reminds readers of the results of the pre SLA baseline data of phase 1 reported in interim report 1. It then focuses on post SLA data, specifically

- the current demand for reports in the CARS service
- the demographics of defendants being seen by CARS,
- the mental health issues and the level of risk they present
- the nature of the alleged offence
- the source of referral
- the number and timeliness of each type of report being requested of the service

Where feasible, comparisons between pre SLA and post SLA data are drawn on

- the number of adjournments,
- the time to disposal and
- the nature of disposal

Caveats associated with these comparisons highlighted and overall recommendations for future practice discussed.

4.2. Demand and Timeliness Pre SLA

Monitoring sheets requested for each report request were collected from Mid May to December 2007 from the courts in both the Hampshire and Bath/Bristol region. Full descriptive data for the pre SLA may be found in interim report 1. Over the period, 69 reports were requested, 45 of which were psychiatric reports and 11 health and social circumstance reports. There was no reliable data as to how many people were seen over this period as a whole or on a monthly basis.

There was little consistency as to when full reports were returned from the MHS. These estimates varied depending whether the MHS or CJS were making these estimates. The CJS estimated reports being returned between 37 and 124 days (median 55.5 days). Health and social circumstance reports were returned between 2 and 18 days (median 10 days).

4.3. Post SLA

The demand for cases seen by CARS after the implementation of SLA and the creation of the new record keeping system, post SLA, are reported here. Post SLA data was collected from April to Sept 2008 and pre SLA data was collected from May to December 2007;

4.3.1. Demand

With improved record systems in place post SLA, we can more accurately estimate the demand for mental health services in the courts. On average (mean), 40 people are being seen a month (n=199) (over 5 month period) (Table 1).[1] The majority of cases come from the Bristol magistrates court (142; n=199; 71.4%), followed by Bath magistrates court (41; n=199; 20.6%) and Bristol Crown court (16; n=199; 8.0%).

Table 1: Distribution of cases over 5 month period

2008					Total
April	**May**	**June**	**July**	**August**	
39	37	47	43	33	199

4.3.2. Nature of client

The average age of offenders is 33.9 years but ranged from 17 to 76 years. The majority are male (157; n=199; 78.9% of sample) and white British (156; n=199; 78.4%). Defendants are in a range of accommodation types the most common being with family and friends (39; n=199; 28.1%), NFA (26; n=199; 13.1%) and council housing (22; n=199; 11.1%);

The mental health issue of each case varies (Table 2) with depression (45; n=199; 22.6%), psychoses (34; n=199; 17.1%) and dual diagnosis (24; n=199; 12.1%) being the most commonly diagnosed conditions. The majority are perceived as being of risk to themselves or others (125; n=199; 62.8%) and the vast majority have been involved with the health services previously or currently (150; n=199; 75.4%).

[1] we cannot compare this with the pre SLA data as we only have data on the number of reports requested and not the number of case seen overall

Table 2: Mental health issue recorded for case by CARS

	Frequency	**Percent**
Depression	45	22.6
Psychoses	34	17.1
Bipolar	6	3.0
Schizophrenia	5	2.5
Learning difficulties	12	6.0
Self harm and suicide	9	4.5
Dual diagnoses	24	12.1
Not known/no condition identified	16	8.0
substance misuse	12	6.0
personality disorder	16	8.0
OCD	1	.5
Anxiety	3	1.5
ADHD	3	1.5
eating disorder	1	.5
Total	187	94.0
Missing	12	6.0
Total	199	100.0

The most frequently recorded offence is assault (40; n=199; 20.1%) followed by theft (30; n=199; 15.1%) and criminal damage (16; n=199; 8.0%).

4.3.3. Source of referral

The majority of referrals were reported as originating form checks of the MHS providers' databases (65; 32.7%; n=199); probation (25; 12.6%; n=199) and legal advisors (27; 13.6%; n=199) (Table 3).

Table 3: Sources of referral to CARS

	Frequency	Percent
legal advisor	27	13.6
Self referral	8	4.0
outreach workers	3	1.5
reliance	11	5.5
probation	25	12.6
MHS check	65	32.7
crown court clerk	3	1.5
solicitor	22	11.1
court custody staff	11	5.5
CJIT	2	1.0
Weston ward	2	1.0
ASW	2	1.0
Care coordinator	4	2.0
magistrate	4	2.0
Streetwise	1	.5
Fromeside	1	.5
GLOC inreach	1	.5
Medacs	1	.5
DHI team	1	.5
FLCDT	1	.5
CAIT team	1	.5
CDAS	1	.5
Total	197	99.0
Missing	2	1.0
	199	100.0

4.3.4. Screening reports

The majority of 199 screening reports conducted through the 5 month data collection period 177 were completed on the day of referral (89.1%). Screening reports were all conducted by the CARS team. For the few that are not completed on the day, there are delays of 2 to 32 days. No apparent relationship was identified between the presence of a delay and the source of referral although referrals from probation showed a slightly higher level of delay.

The vast majority of screening reports lead to no recommendations being made (179; 93.2%; n=192); 10 reports (5.2%; n=192) lead to a HSC report and 3 reports (1.6 %; n=199) lead to a psychiatric report being recommended. In terms of the action taken to deal with the defendant's mental illness, 5% result in no further action. For a large proportion (56.3%), records indicate only that some form of liaison took place.

4.3.5. Psychiatric reports

Records indicated that of all defendants that were screened, CARS felt that 6.5% (13 reports in the 5 month period) required a psychiatric report. Of these only 4% (8 reports) were requested by CARS. Of these 8, information was recorded for 5 of the reports. Reports took between 30 and 84 days to complete with an average of 67 days.

4.3.6. HSC reports

11 HSC reports were done over the 5 month period. HSC reports were completed by 11 to 21 days to complete (median 19 days). Of the 6 for which a recommendation had been recorded, only 1 required a full psychiatric report.

4.4. Comparing pre and post SLA

Comparisons were drawn on the number of adjournments, the days from initial hearing to disposal of each case and the nature of disposal. A first comparison was drawn between all the data collected pre SLA (i.e. including data collected from Hampshire); a second and more accurate comparison was calculated with pre SLA data only from the Bristol, Bath courts; In both comparisons however, the comparison is not a strict comparison of like with like as in phase 1 data was collected through monitoring sheets and in phase 2 data was collected through the new record system kept by CARS. These caveats should be noted when drawing conclusions on the strength of the conclusion drawn from these comparisons.

4.4.1. Number of adjournments before and after SLA

There is an increase in the number of cases that receive no adjournments (see Table 4 and Table 5). In the Bristol/Bath comparison this is illustrated by an increase from 9.5% to 25.4% in cases were no adjournment was reported (Table 5). The number of three or more adjournment case has dropped from 46.4% to 35.5% (Table 5). Single and double adjournments have increased, however.

Table 4: A comparison of data on the number of adjournments in cases Pre SLA (Hants included) and post SLA

Number of adjournments	**Pre SLA N=37**	**Percentage**	**Post SLA N=169**	**Percentage**
0	5	16.67	43	21.6
1	17	56.67	34	17.1
2	4	13.33	32	16.1
3	3	10.00	15	7.5
4	0		13	6.5
5	1	3.33	13	6.5
6			6	3.0
7			5	2.5
8			1	.5
9			3	1.5
10			1	.5
11			1	.5
14			1	.5
18			1	.5

Table 5: A comparison of data of the number of adjournments in cases Pre SLA (Bath/Bristol comparison only) and post SLA

Number of adjournments	**Pre SLA (N=21)**	**Percentage**	**Post SLA**	**Percentage**
0	2	9.5	43	25.4
1	4	19.0	34	20.1
2	2	9.5	32	18.9
3	3	14.3	15	8.9
4	3	14.3	13	7.7
5	1	4.8	13	7.7
6	2	9.5	6	3.6
7	0	0.0	5	3.0
8	4	19.0	1	.6
9			3	1.8
10			1	.6
11			1	.6
14			1	.6
18			1	.6
Total	21		169	
3 and more adjournemnets	13	46.4	60	35.5

4.4.2. Days to disposal before and after SLA

Data suggests that in Bristol magistrates, Bath magistrates and Bristol Crown court (April to Sept 2009, post SLA), the median number of days to disposal is less (median =15 days in Bristol/Bath comparison)(Table 6) than was measured in the wider sample in May to December 2007 (83days in the Bristol/Bath comparison)(Table 7)

Table 6: A comparison of the time taken from initial hearing to disposal in cases Pre SLA (Hants included) and post SLA

	Pre SLA n=28		**Post SLA n=150**	
	Range	Median	Range	Median
	0-136days	54days	0-530days	15days

Table 7: A comparison of the time taken from initial hearing to disposal in cases Pre SLA (Bath/Bristol comparison) and post SLA

	Pre SLA N=19		**Post SLA N=150**	
	Range	Median	Range	Median
	32-136days	83days	0-530days	15days

4.4.3. Nature of disposal before and after SLA

Data (Table 8 and Table 9) suggests that in Bristol magistrates, Bath magistrates and Bristol Crown court (April to Sept 2009, post SLA), there are more community orders being issued post SLA (41.2% in the Bristol/Bath comparison) than were pre SLA in May to December 2007 (33.3% in the Bristol/Bath comparison)

Table 8: A comparison of the type of disposal in cases Pre SLA (Hants included) and post SLA

	PRE SLA		**POST SLA**	
	Frequency	Valid percent	Frequency	Valid Percent
community order	9	21.5	66	41.2
Custody	13	31.0	41	25.6
sent to crown court	3	7.1	15	9.4
adjourned sine die			2	1.3
hospital order	3	7.1	1	.6
conditional discharge/discharged	7	16.7	11	6.9
Deferred/suspended sentence	5	11.9	2	1.3
discontinued/dismissed/withdrawn			10	6.3
fine/compensation order	1	2.4	9	5.6
no order made			1	.6
non attendance bench warrant not backed for bail			1	.6
not guilty			1	.6
prosecution offered no evidence	1	2.4		
	42	100	160	100
Missing	5		39	

Total	47		199	

Table 9: A comparison of the type of disposal in cases Pre SLA (Bath/Bristol comparison only) and post SLA

	PRE SLA		**POST SLA**	
	Frequency	Valid percent	Frequency	Valid Percent
community order	9	33.3	66	41.2
Custody	8	29.6	41	25.6
sent to crown court	1	3.7	15	9.4
adjourned sine die			2	1.3
hospital order	1	3.7	1	.6
conditional discharge/discharged	4	14.8	11	6.9
Deferred/suspended sentence	3	11.1	2	1.3
discontinued/dismissed/withdrawn			10	6.3
fine/compensation order	1	3.7	9	5.6
no order made			1	.6
non attendance bench warrant not backed for bail			1	.6
not guilty			1	.6
Total	27	100.0	121	100
Missing	1		39	
Total	28		160	

4.4.4. Timeliness of reports

Pre SLA, psychiatric reports, collected over an 8 month period across the Hampshire and Bath/Bristol, areas were returned between 37 and 124 days (median 55.5 days). Psychiatric reports post SLA collected over a 5 month period and for the Bristol/Bath area alone, took between 30 and 84 days to complete with an average of 67 days.

Similarly, Pre SLA, health and social circumstance reports were returned between 2 and 18 days (median 10 days). Post SLA, this occurred between 11 and 21 days (median 19 days).

4.4.5. Caveats

The validity of the above comparisons pre and post SLA is limited.

It became obvious at baseline data collection that accurate and consistent record systems were not available in either the CJS or MHS. In addition, the monitoring sheets, implemented by the evaluation team to compensate for this lack of record keeping, were often not consistently or accurately completed. The lack of consistency means at baseline, we cannot be confident

that all cases being viewed by liaison workers are being recorded nor that all reports requested by the courts and completed by the mental health services have been recorded.

Evaluators worked alongside the project manager to develop more accurate record systems ready for post SLA data collection. This lead to a more accurate means of data collection, however, it compromises the validity of pre/post SLA comparisons as different data collection methods have been used at the two data collection points.

The progress of the pilot also lead to unforeseen changes n the pre and post SLA samples compositions. i.e. the. Pre SLA samples contain Hampshire courts and post SLA does not. Where possible we have conducted comparisons with and without the Hampshire component.

Furthermore, the new record system, although vastly improving the quality of data collection, remains flawed. Data related to timeliness variables are particularly limited, being inaccurately recorded by respondents at post as well as pre SLA data collection points.

4.5. Overall conclusion

Data suggests that the SLA has lead to improvements in three key variables, namely:

- the number of adjournments have reduced (an increase in cases dealt with without adjournment);
- the time from initial hearing to disposal have reduced
- the way in which defendants are disposed of appears to have changed to show an increase in the number receiving community orders.

No meaningful comparisons can be drawn between these timings pre and post SLA.

The new record keeping system introduced at the Post SLA stage of data collection has lead to an improvement in the consistency and utility of data collected by the liaison service.

4.6. Recommendations

There remains opportunity to develop the new record keeping system further. Development is required specifically around the consistency with which data is entered into the database. A clear consistent set of terminologies to describe common conditions, outcomes of treatment etc. are required. We would recommend that extra funds are put into the ongoing development

of this database and training is required for administrators/ practitioners to correctly input data into the records system in a reliable way. Improved databases will make comparisons across regions and time periods more accurate in ongoing evaluations of the system.

Chapter 5. RESULTS OF PHASE 2

5.1. Introduction

This chapter presents the outcomes of phase 2 of the study. It describes first:

- the nature of the Pre and Post SLA CJS sample in terms of professional role and court of origin
- the nature of the Pre and Post SLA MHS sample in terms of professional role and geographical location

It then explores the values that are shared by both services and their recognition of a common problem that face both agencies in their shared working. It presents how the perception of this problem has changed from the perspective of the CJS, post SLA.

The awareness of the liaison services post SLA are presented with comparisons being made between the Hampshire and Bristol/Bath regions. The change in awareness of MHS services post and pre SLA is also presented.

The self efficacy of CJS and MHS personnel is described and changes in this post SLA in CJS personnel explored. Levels of training that may contribute to levels of self efficacy are described.

Finally the chapter turns to levels of satisfaction on various dimensions of the liaison services post SLA. A comparison is drawn on these dimensions between the CARS and Hampshire based Court liaison service. A comparison on level of satisfaction on a range of satisfaction dimensions, post and pre SLA are made for the CARS service. Satisfaction with written reports pre SLA and satisfaction with Screening reports, HSC reports and Psychiatric reports post SLA are presented and compared.

5.2. Sample description

5.2.1. Pre SLA sample collected from CJS

Of 2107 questionnaires distributed to courts participating in the pilot, a sample of 479 questionnaires were returned. This represented a 22.7% response rate. Magistrates are the most represented professional group in the sample (379; 79.1%; n=479) (Table 10). Hampshire courts are most represented courts in the sample (274; 57.2%; n=479)(Table 11).

Table 10: Professional roles of sample

	Frequency	Percent
probation officer	24	5.0
legal advisor	24	5.0
Judge	16	3.3
defence lawyer	33	6.9
Magistrate	379	79.1
Total	476	99.4
Missing	3	.6
Total	479	100.0

Table 11: Courts participating in sample distributed by Bath/ Bristol versus Hampshire region

	Frequency	Percent
Hampshire	274	57.2
Bristol/Bath	196	40.9
Total	470	98.1
Missing	9	1.9
Total	479	100.0

5.2.2. Post SLA Court sample

A total of 1103 questionnaires were distributed post SLA. A total of 218 questionnaires were returned representing a 19.76% response rate.

The majority of the post CJS sample are magistrates (176; 76.6%; n=218) (Table 12) and Bristol/Bath courts are best represented (143; 65.5%; n=218)(Table 13).

Table 12 : Professional role of respondents in sample

	Frequency	Percent
probation officer	17	7.8
legal advisor	10	4.6
Judge	9	4.1
defence lawyer	11	5.0
Magistrate	167	76.6
Total	24	98.1
Missing	4	1.9
Total	218	100.0

Table 13: Court in which respondents are based

	Frequency	Percent
Bristol/Bath Courts	143	65.5
Hampshire Courts	66	30.4
Total	209	95.9
Missing	9	4.1
Total	218	100.0

5.2.3. Pre SLA Health sample

A total of 395 questionnaires were distributed to the mental health services in the Hampshire and Bath/Bristol areas. Of these 146 questionnaires were returned representing a 36.96% response rate; Nurses (68; 46.6%; n=46) are best represented in the sample (Table 14); Health and Social Care professionals from the Bristol/Bath region are the most represented in the sample (56, 38.4%; n=146) (Table 15).

Table 14: Professional Groups represented in the sample

	Frequency	Percent
Psychiatrist	27	18.5
Nurse	68	46.6
Social Worker	18	12.3
Psychologist/Psychotherapist	7	4.8
Other	23	15.8
Total	143	97.9
Missing	3	2.1
Total	146	100.0

Table 15: Geographical location of health and social care professionals in sample

	Frequency	Percent
Bristol/Bath	56	38.4
Hampshire	40	27.4
Not Known	50	34.2
Total	146	100.0

5.2.4. Post SLA Health sample

A total of 275 questionnaires were distributed to the MHS. 16 questionnaires were returned which represents a 5.82% response rate. Psychiatrists are best represented in this sample (11; 68.8%; n=16) (Table 16). Similarly, the Bristol/Bath region makes up more the majority of the sample (11; 68.8%; n=16) (Table 17).

Table 16 : Professional Groups represented in the sample

	Frequency	Percent
Psychiatrist	11	68.8
Psychologist	1	6.3
Nurse	2	12.5
support worker	1	6.3
Total	15	93.8
Missing	1	6.3
Total	16	100.0

Table 17: Geographical location of health and social care professionals in sample

	Frequency	Percent
Bristol/Bath	11	68.8
Hampshire	4	25.0
Total	15	93.8
Missing	1	6.3
Total	16	100.0

5.3. Common Values

At baseline, the evaluation explored the values held by both services by asking:

- MHS staff about their attitudes towards a patients (person x) in contact with the CJS
- CJS staff about their attitudes towards a defendant (person x) with mental health issues.

In each instance, from the perspective of each service, the evaluation collected opinion on:

- the importance of providing support to person x
- the normality of person x,
- their culpability,
- issues of punishment versus rehabilitation,
- the perceived danger person x may pose.

5.3.1. Values of CJS

The average scores on a range of attitudinal questions are presented in Table 18. These suggest that respondents in the CJS feel it is very important (Median =1) that the mental health needs of defendants are dealt with appropriately in court proceedings. There is also strong consensus on the normality of the condition:, i.e. they strongly agree that mental illness is like any other illness, that anyone can suffer from mental illness (median=1) and that the mentally ill should not be avoided (median=1). There is general agreement (although more

variation) in responses given to the statement that mental illness is common in the UK population (median =2) and that people with mental illness could live in the community if supported (median=2). Respondents are less clear of around issues that pertain to the culpability and punishment of the mentally ill defendant. This is reflected by more neutral responses when respondents were asked to indicate their agreement with the statements: "the mentally ill are responsible for their crimes" (median =3) and "the mentally ill should be treated like any other criminal" (median=2).

Table 18: Attitude of criminal justice system to defendants with mental health issues

Item	**Average rating given by participants (Median)**	**Measurement scale used**
IMPORTANCE		
The importance of defendants' mental health needs being dealt with appropriately in court	1 (very important) (n=457)	Very important (1) to not very important at all (5)
NORMALITY OF MENTAL ILLNESS		
Mental illnesses are very common in the UK population"	2 (agree) (n=471)	Strongly agree (1) to Strongly Disagree (5)
People with mental disorders can live in the community, if they receive appropriate support"	2 (agree) (n=472)	Strongly agree (1) to Strongly Disagree (5)
ACCEPTABILITY OF MENTAL ILLNESS		
Mental illness is a medical condition like other illnesses"	1 (strongly agree) (n=476)	Strongly agree (1) to Strongly Disagree (5)
Anyone can suffer from mental illness"	1 (strongly agree) (n=475)	Strongly agree (1) to Strongly Disagree (5)
CULPABILITY		
People with mental illness are to blame for the offences they commit	3 (neither agree nor disagree) (n=465)	Strongly agree (1) to Strongly Disagree (5)
PUNISHMENT VS REHAB		
With mentally ill offenders, treatment should take priority over punishment	2 (agree) (n=468)	Strongly agree (1) to Strongly Disagree (5)
Offenders with mental illness should be punished like any other offender	3 (neither agree nor disagree) (n=470)	Strongly agree (1) to Strongly Disagree (5)
DANGER		
People with mental illness are dangerous and should be avoided	5 (strongly disagree) (n=473)	Strongly agree (1) to Strongly Disagree (5)

5.3.2. Values of MHS

The average score presented in Table 19, suggest that respondents in the MHS feel it is very important that defendants' mental health needs are met (median=very important). They support the view that these clients in contact with the CJS are normal in supporting the view that clients in contact with the CJS be treated with respect (median=strongly agree) and that

these individuals have similar values to themselves (median=strongly agree). They strongly support the rehabilitation of these clients but are less clear on issues of culpability, i.e. whether defendants are victims of their circumstances (median =neither agree nor disagree)

Respondents were also less clear regarding safety aspects with respect to working with clients' in contact with the CJS as the majority of respondents indicated a neutral response when questioned about having to be on your guard when with working with clients in contact with the CJS (median=neither agree nor disagree), and again when questioned regarding clients in contact with the CJS needing to be under strict observation (median=neither agree nor disagree).

Table 19: Attitude of mental health services to clients in contact with criminal justice system

Item	**Average rating given by participants (Median)**	**Measurement scale used**
IMPORTANCE		
Importance of defendants' mental health needs being met by the CJS	1 (very important) n=137	Very important (1) to not very important at all (5)
NORMALITY		
Service users in contact with the CJS should be treated with respect just like anyone else	1 (strongly agree) (n=146)	Strongly agree (1) to Strongly Disagree (5)
The values of the service users in contact with the CJS are the same as the rest of us	1 (strongly agree) (n=139)	Strongly agree (1) to Strongly Disagree (5)
CULPABILITY		
Service users in contact with the CJS are victims of their circumstances	3 (neither agree nor disagree) (n=142)	Strongly agree (1) to Strongly Disagree (5)
REHABILITATION		
Rehabilitation of service users in contact with the CJS is a waste of time	5 (strongly disagree) (n=146)	Strongly agree (1) to Strongly Disagree (5)
DANGER		
You have to be constantly on your guard with service users in contact with the CJS	3 (neither agree nor disagree) (n=144)	Strongly agree (1) to Strongly Disagree (5)
Service users in contact with the CJS should be kept under strict observation	3 (neither agree nor disagree) (n=142)	Strongly agree (1) to Strongly Disagree (5)

An effective comparison cannot be drawn between the values reported by the CJS and MHS as the phrasing of questions to the CJS and MHS are not identical. However, a rudimentary comparison of views of workers in each service suggest that both services share similar views on the importance of addressing the mental health needs of the defendant positioned at the interface of the two agencies as well as the normality of this individual. Both services are

undecided around issues of culpability. These similarities should be emphasised in improving future interagency working. Services should be reminded that they are on the same side.

Not all perspectives are shared across services. Firstly, their views of the danger posed by individual x differ. Data suggests that the CJS are confident of their safety in dealing with person x. Unsurprising as systems are in place in the courts for them to feel this way. The mental health services, on the other hand, are less confident. Secondly, in terms of rehabilitation, the MHS are clear that rehabilitation is a worthwhile endeavour. The courts, however, struggle with the dilemma of balancing the need to rehabilitate/treat the defendant and their need to be held to account by society and punished accordingly. These results are again unsurprising based on the different professional foci of each service.

5.4. Recognition of a common problem

A more detailed description of the baseline descriptors of the problems faced by the CJS are described in greater detail in Interim Report 2 (appendix 9.10). Briefly, both the CJS and the MHS were asked how frequently they thought defendants were disposed of without adequate advice on mental health. 43.7% of the CJS sample rated this as occurring very frequently/frequently and 45.2% of respondents felt that this occurred frequently/very frequently (Table 20). There was a range of opinion as to how often MHS respondents believe defendants are disposed of with insufficient advice being given on their mental health with 44.6% of the sample rating this as occurring very frequently or frequently (Table 21)

Table 20: Distribution of CJS Responses on how frequently defendants are disposed of with insufficient advice being given on their mental health

	Frequency	**Percent**
very frequently	87	18.2
2.00	122	25.5
3.00	146	30.5
4.00	83	17.3
very seldom or never	31	6.5
Total	469	97.9
Missing	10	2.1
	479	100.0

Table 21: Distribution of MHS Responses on how frequently defendants are disposed of with insufficient advice being given on their mental health

	Frequency	Percent
Frequently/Very Frequently	66	45.2
Neutral	31	21.2
Seldom, very seldom or never	15	10.3
I don't know	33	22.6
Total	145	99.3
Missing	1	.7
	146	100.0

5.4.1. How has the perceived problem changed post SLA from the CJS perspective[2]

There is a significant relationship ($\chi 2$ (684; 4)=51.399; $p<0.001$) between the frequency with which the CJS believe respondents defendants are disposed of with insufficient advice being given on their mental health and the implementation of the SLA. Respondents post SLA now feeling this happens less frequently (Table 22).

Table 22: Cross Tabulation of pre and post SLA responses on how frequently defendants are disposed of without advice being given on their mental health

Type of Response	**Frequency of responses by CJS**		**Total**
very frequently	**Pre SLA**	**Post SLA**	
	87	10	97
2.00	18.6%	4.7%	14.2%
	122	40	162
3.00	26.0%	18.6%	23.7%
	146	62	208
4.00	31.1%	28.8%	30.4%
	83	67	150
very seldom or never	17.7%	31.2%	21.9%
	31	36	67
Total	6.6%	16.7%	9.8%
	469	215	684
	100.0%	100.0%	100.0%

5.5. Awareness of Liaison Services Available

Post SLA over 80% (167; n=218) of the CJS sample were aware of a liaison service available to them. A significant relationship ($\chi 2$ (217; 1) = 11.084; $p<0.005$) exists between the awareness of a liaison service (post SLA) and the region taking part in the pilot. The Bristol/Bath region was more likely to be aware of the service than the Hampshire region (Table 23).

[2] Disappointing responses from the MHS at post SLA data collection, prevents a comparison of pre, post SLA data for this group

Table 23: Cross tabulation of CJS responses to "Are you aware of a liaison service available to you from which you are able to receive advice on a defendant with a mental health issue?" and the court's geographic region

	Hampshire versus Bristol/Bath courts		**Total**
	Bristol/Bath	**Hants**	
Yes	124	44	168
	87.3%	66.7%	80.8%
No	18	22	40
	12.7%	33.3%	19.2%
Total	142	66	208
	100.0%	100.0%	100.0%

A comparison of pre and post SLA responses by the CJS on their awareness of the service found a significant relationship between awareness of a service offering support and the implementation of the SLA ($\chi 2$ (681; 1)= 40.136 $p<0.001$) with more people being aware of the service post SLA (Table 24).[3]

Table 24: Cross tabulation of CJS responses to **"**Are you aware of any service available to you from which you are able to receive advice on a defendant with a mental health issue? " versus pre/post SLA

			Total
	Pre SLA	**Post SLA**	
yes	261	176	437
	56.1%	81.5%	64.2%
no	204	40	244
	43.9%	18.5%	35.8%
Total	465	216	681

5.6. Levels of self efficacy

5.6.1. Self efficacy of CJS

The self efficacy of the CJS workers in dealing with cases where the defendant has a mental health issue was measured through ratings of:

- their knowledge of how to get an assessment for a defendant with a mental health issue

[3] This comparison slightly flawed as in PRE SLA, the CJS were asked to mention any service they were aware of , whereas in post SLA the question is confined to their awareness of a liaison service

- how frequently they report the need for mental health advice about a defendant but have been unsure whom to approach
- Their ability to identify a defendant with a mental health issue

Before the SLA, CJS respondents are not overly confident on any of the above dimensions (shown by a neutral median of 3 on each question) (Tables 25-27).

Table 25: Distribution of CJS ratings of their own knowledge of how to get an assessment for a defendant with a mental health issue

	Frequency	**Percent**
Extensive	21	4.4
2.00	142	29.6
3.00	146	30.5
4.00	94	19.6
Limited	67	14.0
Total	470	98.1
Missing	9	1.9
Total	479	100.0
Median	3	

Table 26: Distribution of CJS ratings of the frequency that they need mental health advice about a defendant but have been unsure whom to approach

	Frequency	**Percent**
very frequently	31	6.5
2.00	117	24.4
3.00	131	27.3
4.00	110	23.0
Very seldom or never	79	16.5
	11	2.3
	479	100.0
Median	3	

Table 27: Distribution of CJS ratings of their ability to identify a defendant with a mental health issue

	Frequency	**Percent**
Very high	27	5.6
2.00	149	31.1
3.00	191	39.9
4.00	86	18.0
Very low	18	3.8
Total	471	98.3
Missing	8	1.7
Total	479	100.0
Median	3	

5.6.2. Levels of self efficacy in health services

Whilst MHS workers rate relatively highly (Median =2; n=146)(Table 28) their ability to work with a service user who may happen to be in contact with the CJS, they are less confident in their ratings of their knowledge of the CJS (Median=3; n=146) (Table 29). This suggests that they are confident in dealing with the defendant themselves but less confident in the interagency working that may be required in dealing with these patients.

Table 28: Distribution of MHS ratings of their ability to work with a service user in contact with the CJS

	Frequency	**Percent**
Very High	26	17.8
2	48	32.9
3	44	30.1
4	22	15.1
Very Low	6	4.1
Total	146	100.0
median	2	

Table 29: Distribution of MHS ratings of their knowledge of the CJS

	Frequency	**Percent**
Extensive	11	7.5
2	27	18.5
3	42	28.8
4	31	21.2
Limited	35	24.0
Total	146	100.0
Median	3	

5.6.3. A comparison of CJS self efficacy before and after SLA

There is no significant relationship between the frequencies with which CJS respondents rated their knowledge of how to get an assessment, pre and post SLA ($\chi 2$ (652; 4)= 8.007; p=0.091)(Table 30)[4].

[4] Due to limited responses to questionnaires post SLA by MHS personnel, post SLA comparisons are not available

Table 30: Cross Tabulation of pre and post SLA responses on how CJS workers rated their knowledge of how to get an assessment for a defendant with a mental health issue

	Pre SLA	**post SLA**	**Total**
extensive	21	17	38
	4.5%	9.3%	5.8%
2.00	142	63	205
	30.2%	34.6%	31.4%
3.00	146	49	195
	31.1%	26.9%	29.9%
4.00	94	30	124
	20.0%	16.5%	19.0%
limited	67	23	90
	14.3%	12.6%	13.8%
Total	470	182	652
	100.0%	100.0%	100.0%

In contrast, there is significant relationship between the frequency with which respondents stated they had felt the need for mental health advice about a defendant but had been unsure whom to approach and the implementation of the SLA ($\chi 2$ (683; 4)= 50.988; $p<0.001$) (Table 31). Respondents post SLA feel this happens less frequently.

Table 31 Cross Tabulation of pre and post SLA responses on how frequently defendants are have felt the need for mental health advice about a defendant but have been unsure whom to approach

	Pre SLA	**Post SLA**	**Total**
Very frequently	31	5	36
	6.6%	2.3%	5.3%
2.00	117	36	153
	25.0%	16.7%	22.4%
3.00	131	36	167
	28.0%	16.7%	24.5%
4.00	110	51	161
	23.5%	23.7%	23.6%
vey seldom or never	79	87	166
	16.9%	40.5%	24.3%
Total	468	215	683
	100.0%	100.0%	100.0%

Data suggests that CJS personnel are now more aware of *who* to go to for advice but remain unclear of the how the advice is then obtained. We recommend an exploration of how the CJS engage with the service, now that they are better aware of its existence.

5.7. Levels of Training

CJS workers were asked if they had received training on dealing with defendants with mental health issues. The majority of the sample (78.9%; n=479) had never received training on how to deal with defendants with mental health issues. Similarly, the majority of the MHS sample (67.8%; n=146) had never received training on how to support service users in contact with the CJS.

Open ended questions asked CJS and MHS workers to expand qualitatively on the nature of the training they may have received. CJS workers identified formal training opportunities on mental health taking the form of in-house training, often part of wider training programmes (e.g. magistrate induction). Training was also obtained through their professional role outside of the court services (e.g. as teachers or HSC professionals). Training was described as highly variable and limited. Informal learning also took place through own reading or experience of working with mentally ill defendants and MH services

Workers in the MHS also describe formal training opportunities on how to support patients in contact with the CJS. They list their pre qualifying programme as HSC professional as one source and occasionally their participation in post qualification formal training. In house training may be provided but this largely focussed upon dealing with violent behaviour. Informal learning takes place through their experience of working with the offenders/defendants and participating in shadowing exercises, within the courts but also other colleagues. These opportunities were largely ad hoc with few formal opportunities for mental health staff to develop understanding of CJS roles or the processes involved.

There was little evidence of interagency training in which shared opportunities to learn with, from and about each other could take place between mental health services and members of criminal justice system. Some few exceptions included:

- One individual mentioning multi agency training. However, this occurred between the police and magistrates and no mention of health service involvement was made
- There was some evidence of health professionals delivering training to the CJS but this was usually members of liaison services wishing to raise awareness of their service.
- There was no evidence of CJS running course for the mental health services

Workers in the MHS also make little reference to interagency training but, where this did happen, it was quoted as being with police or between health and social care services rather than with the court services

5.8. Satisfaction with liaison services

5.8.1. Satisfaction with liaison service form CJS perspective post SLA

Post SLA, CJS Workers assessed the liaison service on

- Their satisfaction with the provision of mental health advice to the court by the liaison service
- How easy it was to make contact with the service
- The nature of their relation with the service

The distribution of responses on these three questions varies with opinion lying at a median of 3 for all three items (Tables 32-34).

Table 32: Satisfaction with the provision of mental health advice to the court by the liaison service post SLA

	Frequency	**Percent**
Very satisfied	28	12.8
2.00	58	26.6
3.00	59	27.1
4.00	24	11.0
very dissatisfied	7	3.2
Total	176	80.7
Missing	42	19.3
	218	100.0
Median	3	

Table 33: Distribution of responses on the ease of making contact with members of the above liaison service for advice on defendants with mental health issues

	Frequency	**Percent**
Very easy	39	17.9
2.00	41	18.8
3.00	54	24.8
4.00	27	12.4
very difficult	12	5.5
Total	173	79.4
	45	20.6
	218	100.0
Median	3	

Table 34: Distribution of responses to the nature of the relationship with the liaison service

	Frequency	Percent
non existent	32	14.7
2.00	43	19.7
3.00	45	20.6
4.00	35	16.1
very well developed	22	10.1
Total	177	81.2
Missing	41	18.8
Total	218	100.0
Median	3	

5.8.2. A comparison of satisfaction with liaison service form CJS perspective post SLA across the CARS versus Hampshire Court liaison service

A comparison was made between responses to the Court liaison service in Hants and the CARS service in Bristol. There were no significant differences between the regions in terms of :

- The ease of making contact with the service ($\chi 2$ (218; 4)=7.854; p=0.097)
- The nature of the relationship with the service ($\chi 2$ (218; 4)=4.681 p=0.322)
- Satisfaction with the provision of mental health advice to the courts by the service ($\chi 2$ (218; 4)=8.275; p=0.082)

There was one significant difference in terms of the frequency with which mental health issues of defendants were brought to court workers' notice ($\chi 2$(166; 4)=10.576; $p<0.05$); cases appearing to be more frequently reported in the CARS service (Table 35).

Table 35: Cross tabulation of CJS responses to the frequency with which mental health issues of defendants were brought to court workers' notice **"**by location of liaison service

	CARS	Court liaison service
very frequently	6	1
	4.8%	2.4%
2.00	28	5
	22.6%	11.9%
3.00	47	12
	37.9%	28.6%
4.00	29	11
	23.4%	26.2%
very seldom or never	14	13
	11.3%	31.0%
Total	124	42
	100.0%	100.0%

5.8.3. A comparison of pre/post SLA satisfaction with CARS liaison service form CJS perspective

A comparison with pre SLA and post SLA evaluations was completed for the CARS service. Only 23 people had mentioned CARS as the mental service with whom they had the most frequent contact when looking for mental health advice in the pre SLA data. This makes a pre SLA, Post SLA comparison a tenuous one. As it stands, there were no significant differences between pre and post test SLA ratings of the services in terms of:

- the ease of contact ($\chi 2$ (148; 2)=5.264; p=0.072);
- the nature of the relationship with the service ($\chi 2$ (151; 2)=1.828; p=0.401);
- or the satisfaction with the service ($\chi 2$ (150; 2)=0.524; p=0.769).

The general conclusion is therefore that whilst the awareness of the service has increased, the pilot now needs to improve engagement with the service.

5.9. Satisfaction with reports

Pre SLA participants were asked to rate the usefulness of all written reports. Participants in general found written reports to be useful or very useful (median=2) (Table 36)

Table 36: Distribution of CJS responses on the usefulness of written reports pre SLA

	Frequency	**Percentage**
very useful	191	39.9
2.00	166	34.7
3.00	75	15.7
4.00	14	2.9
not useful at all	9	1.9
Total	455	95.0
	24	5.0
	479	100.0
Median	2	

Post SLA participants were asked to rate the usefulness of the newly introduced screening reports, Health and Social Circumstance reports and psychiatric reports. Participants found all three report types useful (a median of 2 for each report; Table 37).

Statistical comparisons cannot be made between pre and post SLA data as questions are not identical but a review of the distribution of participant responses in Table 37 suggest that the screening reports post SLA are rated similarly to other existing reports in terms of usefulness (all show a similar median of 2) and are not dissimilar from rating of all written reports prior to SLA (median=2).

Table 37: Frequency distributions of rating son usefulness of the three types of report

	Screening reports		**Health and social circumstance reports**		**Psychiatric reports**	
	Frequency	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Very useful	61	28.0	41	18.8	55	25.2
2	66	30.3	60	27.5	65	29.8
3	27	12.4	35	16.1	32	14.7
4	8	3.7	16	7.3	8	3.7
Not very useful at all	10	4.6	6	2.8	4	1.8
Total	172	78.9	158	72.5	164	75.2
Missing	46	21.1	60	27.5	54	24.8
Total	218	100.0	218	100.0	218	100.0
Median	2		2		2	

5.10. Conclusions

Both the CJS and MHS services show positive attitudes towards defendants with mental health issues and both services recognise that defendants are often disposed of with insufficient advice being available on their mental health. There is a suggestion that, from the CJS perspective, the extent of the problem has improved post SLA.

There is a high awareness of liaison services post SLA especially in the Bristol/Bath region and post SLA, the CJS are more aware of services to whom they may turn than they were pre SLA. There is a suggestion, that although respondents are more aware of services available, they may still be unclear of how to interact with these services. This is confirmed by neutral ratings on satisfaction with the provision of the service, the ease of contact with service and the nature of relationship with the service and the lack of change in these rating pre and post SLA.

Respondents are as satisfied with the new screening reports as they have been with previous report types provided pre SLA.

5.11. Recommendations

In the future development of liaison services, providers should:

- Focus on the commonalities between the services focussing on the values they share and their common recognition that the mental health needs of defendants need to be addressed and provision of support improved.
- Provide formal training to individuals in both the MHS and CJS in order to develop their understanding of each other roles and responsibilities as

well as organisational processes. Ideally this should be interprofessional where both services learn alongside each other.

- Training should promote an awareness of how to actively engage with the liaison service effectively; as well as an awareness of the service itself.

Chapter 6. QUALITATIVE EVALUATION

6.1. Introduction

This chapter presents the free responses provided by CJS and MHS personnel when asked to describe the impact that the SLA had made to provision of mental health advice to the court over the past 6 months. They also asked how the service could be improved in the future.

The qualitative elements of the questionnaire were analysed using thematic analysis (Holloway and Wheeler 2002) to identify common themes that arose from responses. Extracts of the participants' responses are included to illustrate each theme.

6.2. Evaluations by court workers: what had changed over the past 6 months

6.2.1. Enhanced practice

Responses from court workers were divided into two overall themes: those that reported an enhanced level of practice versus those who reported no observable impact.

Court workers who report an enhancement of practice referred to three main outcomes:

6.2.1.1. More appropriate reports and means of disposal

More appropriate forms of reporting and disposal are evident and have been achieved through individual mental health needs of the defendant now being more effectively taken into consideration during court proceedings. Reports are useful in supporting them in making appropriate disposal decisions.

Rarely in previous 11 years as a magistrate have I seen any MH interventions. Last week twice in one day! In both cases the defendant escaped punitive measures because a much better arrangement had been out into place. (Magistrate, Hants)

I have found the service incredibly useful over the last 6 months. I have previously felt that MH issues are overlooked in the CJS and feel this is a step in the right direction. I would welcome a more prominent service nationwide. Overall I have found the CARS team to be extremely helpful and easy to contact and hope that the service stays in place. (Bristol/Bath magistrate)

The MH screening report is easy to obtain and provides a good starting point when ascertaining whether a defendant had MH problems. It is also much easier to obtain than a full psychiatric report through the service. The MH screening report has all but replaced the Health and Social Circumstances Reports (Legal advisor, Hants)

6.2.1.2. More timely disposals

The service is quoted as having enabled much speedier assessment of clients' mental health needs.

Access to MH service advice and service providers is easier to obtain. Provision of psychiatrists reports have improved. Cases can be disposed of quicker, less need to rely on prison service (Bristol/Bath legal advisor)

*(*I am) a*ble to make more informed decision more quickly avoiding further delays and stress for the individuals* (Bristol/Bath magistrate)

6.2.1.3. An increase in confidence/self efficacy and awareness of services when dealing with cases in which defendants have mental health issues.

Since the introduction of the SLA, CJS workers indicated they felt more confident in dealing with cases where the defendant has a mental health need and this may be due to development of a better understanding of mental health by the court workers during their interactions with the service.

Makes me feel more confident about disposing of cases efficiently when there is a MH aspect. (Bristol/Bath magistrate)

Training and information about CARS has made magistrates more aware of MH issues and the need for assessment/reports, before sentencing (Bristol/Bath magistrate)

6.2.2. No Impact

When respondents indicated that there had been less impact on practice, they refer to:

6.2.2.1. a continued lack of awareness or experience of the service

A number of respondents identified a lack of experience of this service in the courts in which they sit, and this has implications with respect to parity of service provision. Some court workers were still not aware of the service and hence were not accessing or utilising it.

In my experience as a magistrate, there has, regrettably been no impact. We had some training from the CARS service at a quarterly meeting but have seen no reports of any kind from them so far. Nor is there general awareness of the possible usefulness of the service, neither from my fellow magistrates not from the court legal advisor, nor from defence solicitors whose clients may benefit from input by the service (Bristol/Bath magistrate).

I feel this service was introduced without too much publicity, at least I was told about it by a colleague in court. It's good to know that people with MH problems are brought to the

attention of a supporting organisation but it still feels as though they still have to be dealt with in Frome (Bristol/Bath magistrate).

I have limited personal experience if the service, but have the impression that colleagues have found it very helpful (Bristol/Bath magistrate).

6.2.2.2. Service does not address all needs of CJS

Some court workers require that the mental health practitioners to make judgements and recommendations regarding the appropriate disposal of defendants and feel this need is not being met.

Sometimes I need more information and I am not able to get this as there is insufficient relevant information/ill considered information in screening reports. The staff don't seem sufficiently qualified to comment on risk – i.e. impact of MH and likelihood of offending. The screening can put a barrier between my requirements for information I want a more analytical/theoretical view from a properly qualified MH practitioner. However I would comment that not all psychiatric reports are useful as they are not addressing forensic issues often (Probation officer, Hants).

6.2.2.3. Unclear how to engage with the service

Some CJS workers showed themselves to be aware of the service but less clear on how practically to engage with the service.

The new pilot has detracted a useful service (Mendos) from the court it has blurred the situation for magistrates and judges. The staff are ignorant and fail to engage with those who might be able to offer info. (Probation officer, Hants).

The number of reports on defendants with MH issues is minimal. It is not clear when a magistrate can request such a report without the consent of the defendant or his legal advisor. This brings uncertainty into the proceedings (Bristol/Bath magistrate).

6.2.3. How could the service be improved

The responses showed four key themes:

6.2.3.1. Further development of liaison protocol

CJS workers requested further development of the protocol underpinning various dimensions of the liaison process further. Suggestions include improved liaison with GPs, closer working between liaison and probation services and previous assessments by the liaison services being kept on the defendants records

Sometimes I have picked up cases where they have been assessed previously by the CARS team and I was not aware – so it would be beneficial for assessments to remain accessible somehow. (Bristol/Bath magistrate)

More lateral thinking and collaboration with defendants' medical records through their GP. Or if that is not available a routine assessment prior to sentencing (Bristol magistrate).

It would be useful to know if report has been done by CARS prior to completing the PSR, this doesn't always happen. Provision of these reports a bit hit and miss, improved admin/liaison/systems between probation and CARS locally would help (Bristol probation).

6.2.3.2. Further development of report content

There were calls to the content of the reports and their readability. The use of medical jargon was often mentioned which many of the CJS felt they did not understand due to a lack of training in mental health. Some respondents still felt that the reports were still not provided within a timely fashion and requested speedier reports. The reports were not always seen as helpful in decision making related to sentencing. The latter confirms some of the baseline findings reported in interim report 2 and later reported in Hean et al. (in press)(see appendix 9.8)

Ensure that the CARS report (…. and …..) does not refer to conditions by letters but by naming a condition in full – we are not all medically qualified! It should be common practice in a professional report (Bristol/Bath magistrate).

6.2.3.3. A call to expand the service.

There were requests to increase the numbers of liaison staff so that more courts would have access to this services especially within the youth service. Some respondents called for a dedicated mental health presence within the courts at all times, even though they knew this was a probably unrealistic request (due to costs).

Well qualified health professionals in adequate numbers to assess the MH needs of defendants and issue of speedy comprehensive reports (Bath/Bristol magistrate).

Nationalise it so that if someone lived in another court area it is just as easy to get the information required from another local CARS team (Bath/Bristol magistrate).

Having a known point of contact in the court would be even more reassuring that we can help criminal offenders who have MH issues. The reports are great but CARS so far is a faceless and nameless service. Just having a point of contact would be even better than the already excellent reports we now receive (Bath/Bristol magistrate).

6.2.3.4. Increase the current awareness of the service

Respondents recommended that the service be advertised more. Suggestions included

- A full written explanation of the service sent to all magistrates and in solicitor rooms
- Presentations at magistrates meetings
- More training to JPs, legal advisors, court clerks
- Development of aide memoire, a small leaflet of bullet points on whose who and what they can offer and when.

Possibly to make themselves more visible- such as the magistrates' quarterly meetings etc. Many of our "clients" have serious drug issues which sometimes mask the deep mental health problems they also have. I realise the difficulties, but since CARS was introduced it has made it easier and quicker to access help (Bath/Bristol magistrate).

Better training for magistrates and with court users to aid recognising MH problems to ensure that CARS are involved when ever appropriate (Bath/Bristol magistrate).

Practitioners having a better knowledge of CJS. PC072

6.3. Evaluations by MHS workers: what had changed over the past 6 months

Only 16 questionnaires were returned in the health survey and as such there is limited data. One of the few themes that could be identified from the limited data was that, like their CJS peers, some respondents have limited exposure to the service.

As I have minimised contact with this group I cannot comment (Psychiatrist, Bristol/Bath)

*Not really. As a psychologist I am not involved in the working of CARS team (*Psychologist, Bristol/Bath)

As I have not been directly involved with someone requiring this input, I can't comment sufficiently on the changes (Nurse, Bristol/Bath)

However, others had noticed change over the past 6 months, namely that fewer inappropriate reports requests were being made to the MHS.

Working with in forensic psychiatry I've noticed less requests for medico-legal reports over the last 6 months and more notably less inappropriate requests which suggest the screening provided by the liaison service is helpful in identifying defendants needing (or not) reports (Psychiatrist, Hants).

Big decrease in what were often odd or inappropriate requests for psychiatric reports from court (Psychiatrist, Bristol/Bath)

Respondents from the MHS had offered some recommendations and echoed their CJS peers as to the need to increase awareness of the service

I would not know how to contact them if I need to and I do not know how to refer to them or who refers to them. Maybe informing secondary services about their role? (Nurse, Bristol/Bath)

"Making people more aware of the service" (Nurse, Bristol/Bath)

Again there was a call for increased clarity regarding roles and responsibilities

"Clarity regarding responsibility for court reports and the way the system functions" (Psychiatrist, Bristol/Bath)

"Remuneration/payment should be made promptly, Better coordination with appointments at prison. Admin at CARS should be responsible to make the appointments at prison" (Psychiatrist, Bristol/Bath)

"Develop methods of court liaison for those detained in prison (not necessarily diversion to, or liaison at hospital)" (Psychiatrist, Bristol/Bath)*)*

Respondents also stress the need to increase feedback from the Court to the MH service

"Perhaps providing feedback from the services to psychiatric services in the area relating to the number of referrals etc. Obtaining feedback from the courts to ascertain whether they are finding it helpful" (Psychiatrist, Bristol/Bath)

6.4. Overall Conclusions

There is qualitative evidence that over the past 6 month there has been an enhancement of practice in both the CJS and MHS. This complements and supports the quantitative data that supports this claim in Chapters 3 and 4. CJS respondents report improved timeliness in report delivery, more informed decision making and increased feelings of confidence for those in the CJS working with mentally ill defendants. MHS personnel recognise the decrease in inappropriate requests for reports.

For those CJS and MHS personnel that reported a less positive experience, a lack of awareness of the service or how to engage with it remained. For CJS workers there is a perceived need for the content of the report to reflect more closely the needs required by the CJS.

6.5. Recommendations

Respondents recommend:

- Promoting a greater awareness of the current service to both the MHS and CJS

- Further development of the liaison protocol and increased clarity regarding roles and responsibilities
- Development of the report content and feedback mechanism on the content of the report whereby the court can communicate their needs to the MHS and vive versa
- An expansion of the current service increase the number of workers available in the courts and to include other courts in the region.

Chapter 7. CONCLUSIONS AND RECOMMENDATIONS

In this chapter we summarise the key findings of the evaluation and offer recommendations for the service in the future.

7.1. Key findings

The evaluation collected data on individual defendants for whom mental health advice had been requested by the Courts. It suggests that the SLA has lead to an increase in cases dealt with without adjournment, that the time from initial hearing to disposal has been reduced and that there is an increase in the number of defendants with mental health issues receiving community orders.

The evaluation has highlighted the limited and inconsistent record keeping systems in both the CJS and MHS and has introduced a new pilot record keeping system into CARS that has lead to an improvement in the consistency and utility of data collected by this liaison service. The evaluation has helped articulate key variables required within this database.

Both CJS and MHS personnel show positive attitudes towards defendants with mental health issues and both services recognise that defendants are often disposed of with insufficient advice being available on their mental health. There is a suggestion that, from the CJS perspective, the extent of this problem has improved post SLA. There is a higher awareness of liaison services post SLA especially in the Bristol/Bath region. Although respondents may be more aware of services available, some are still unclear of how to interact with these services. Respondents are as satisfied with the new screening reports as they have been with the health and social circumstances and psychiatric report provided pre SLA.

Qualitative evidence supports the numerical evidence that there has been an enhancement of practice in both the CJS and MHS, post SLA. Respondents from the CJS report improved timeliness in report delivery, more informed decision making and increased feelings of confidence when working with mentally ill defendants. MHS personnel recognise the decrease in inappropriate requests for reports.

For those CJS and MHS personnel that reported a less positive experience, they describe a continued lack of awareness of the service or know-how of how to engage with the service. For CJS workers there is a perceived need for the content of the report to reflect more closely the needs of the CJS.

7.2. Recommendations for the future

- The new record keeping system introduced into the CARS service requires further development, specifically around the consistency with which data is entered into the database.

- The liaison service is a key gatekeeper that facilitates the movement of information on defendants with mental health issues between the CJS and MHS. In this role, they are essential in promoting effective interagency working ensuring that the outcomes of the two services are compatible. In this role, liaison workers should remember the commonalities between the services and focus on the values they share and their common recognition that the mental health needs of defendants need to be addressed.

- Further investment is required to provide formal training to individuals in both the MHS and CJS in order to develop their understanding of each other roles and responsibilities as well as organisational processes. Ideally this should be interprofessional where both services learn together with and from each other. Training should promote an awareness of how to actively engage with the liaison service effectively; as well as an awareness of the service itself.

- Further development of the liaison protocol is required to increase clarity regarding roles and responsibilities.

- Further projects could concentrate on the development of the report content itself, in addition to the timeliness of their provision which has been the focus of the current pilot project. The expectations of the CJS and MHS on what a report should contain need to be mapped to reach consensus on what will be both beneficial to both agencies. For the CJS, the report should contain information that promotes their decision making processes during court proceedings. For the MHS, the information they provide in the report must remain appropriate and within their remit. Formal feedback mechanism between the CJS and MHS also need to be established so the court can

communicate their needs to the MHS and vive versa, opening up clear communication channels between the two agencies.

- Further investment is required to expand the current provision of liaison service through an increase in presence of mental health workers physically available in the courts and to include other courts in the region.

- Finally, all interventions need time to be well embedded for their impact to be evaluated effectively. We would recommend that the service be re evaluated when this has been allowed to occur.

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Chapter 9. APPENDICES

9.1. Monitoring sheet for court services

INFORMATION SHEET

EVALUATION OF SOUTH WEST MENTAL HEALTH ASSESSMENT AND ADVICE PILOT PROJECT

Dear XXX

You may be aware that the South West Courts Service in partnership with the Health Service is undertaking a pilot project to improve the provision of mental health assessment for defendants with mental health issues. The project is funding Bournemouth University to carryout an evaluation of the current service and the impact of any new agreements reached.

What is the purpose of the evaluation?

Many requests are made by Magistrates' and Crown Courts for psychiatric opinions on defendants who may have a mental health issue. These requests are made of Mental Health services. This need to communicate across sectors is often a difficult and lengthy process.

If these processes are not functioning optimally the psychiatric advice required in court may not be forthcoming or be delayed. Defendants may then wait unnecessarily long periods on remand and their disposal may occur without the benefit of such advice. Mentally disordered offenders sometimes face, therefore, inappropriate imprisonment or fail to access community support.

We wish to evaluate the quality of service between the courts and health services. We will do this by collecting data from court records on their needs for mental health assessment/advice. Similarly we are collecting data from the records of mental health services on the demand for, and their provision of, this advice.

Information will be fed back to Project's leaders and steering group who will act on the information to develop the existing systems.

What will I be expected to do?

Between **15 May 2007** and **15th November 2007** you will be asked to take note of any or new cases passing though your court that have a mental health issue associated with them. If such a case arises, the legal advisor should complete a monitoring sheet (see FORM A attached). This should be attached to the case records and then completed if and when information is forthcoming. Instructions for the legal advisors in how to complete these forms have been attached to each sheet. We will supply you with a store of these sheets to distribute to legal advisors. **Please send these forms out to all courts for which you are responsible.**

Attached to Form A is a form B designed for the health services. Legal advisors are requested to send form B to the health services with the request for assessment/advice/report. Form B should be returned by the Health Service to the Courts with the assessment/report.

Legal advisors have been asked to return both form A and B to yourself when the case reaches disposal.

At the end of each month (beginning 31 May 2007) we will send you a request and a stamp addressed envelope in which the monitoring sheets for all cases that have reached final disposal may be returned to the evaluators. It is possible that evaluators will need to access identified case records to extract additional information. If this is necessary we will contact you directly and arrange when and how this may be best convenient for you.

What are the possible benefits and disadvantages of taking part?

The benefit of taking part is that you will be able to contribute to the evaluation and development of service between mental health services and the courts. This will be of benefit to defendants with mental health issues enabling them to receive appropriate care whilst passing through the court. There are no disadvantages to the study other than the sacrifice of your time to complete and return the monitoring sheets.

Why have I been invited to take part?

You have been chosen to be part of the evaluation because of your role within the magistrates' or crown court that is taking part in the pilot. We believe that you have valuable insight into how requests for mental health assessment and advice are currently processed.

Please find a covering letter endorsing the evaluation from Lyn Emslie Lead consultant for Health and social care in criminal justice - (Care services Improvement programme) and Peter Risk, Regional Director, South West Courts services.

We realise this is over and above your existing workload and greatly appreciate the efforts you are making to contribute to the evaluation of the system. Please let us know if there is any way in which we can facilitate for you any of the processes involved in completing these monitoring sheets.

What if there is a problem?

Any complaint about the way you have been dealt with during the evaluation please refer to

Sue Staddon
Project manager
Sue.staddon@nimhesw.nhs.uk Mobile: 07917 593470

Will my taking part in the study be kept confidential?

The monitoring sheets and associated electronic databases will be stored securely in the offices of Bournemouth University under the custodianship of Dr Sarah Hean. This raw data will only be available to the two evaluators and no one else (Dr Jerry Warr and Dr Sarah Hean). Information provided to project leaders, the steering group and other audiences will be anonymised in reports and other means of dissemination. Monitoring sheets will be stored for 5 years and then destroyed. Members of the court that have provided us with monitoring sheets and the defendants associated with the record have the right to check the accuracy of data held about them and correct any errors.

What it will be used for.

The data from the initial evaluation will be summarised in a report to the South West Mental Health Assessment and Advice Pilot. This will underpin the development of current systems. A second report will summarise the change in systems that may take place following this development. We also aim to publish the outcomes of the evaluation in related practice and academic journals. The identity of all participants will be anonymised in these presentations. Copies of these presentations may be sent to participants at their request.

Thank you for participation in the evaluation and I look forward to working with you over the coming year.

Best wishes

Dr Jerry Warr and Dr Sarah Hean

Contact details

If you want to discuss this study further or have any queries please contact:

Dr Jerry Warr

Reader

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FORM A FOR COURTS

MONITORING SHEET FOR DEFENDANTS EXPERIENCING MENTAL HEALTH ISSUES

Has a mental health issue being identified in the defendant:

Yes ☐

No ☐

If yes, please complete this **Form A,** following instructions:

- This form should be completed by the appropriate legal advisor.
- Please can you fill in this form (FORM A) in any case where a **mental health** issue is mentioned and advice is required from the health services.
- **One** form should be completed for each defendant where a mental health issue is identified.
- The form should **not** be completed for cases where a report or advice is paid for by legal aid.
- You should **not** use this form for a case where information is requested about a physical condition only.
- The form can be started at any time while a case is proceeding through the court.
- The form should remain with the file until the case reaches disposal. Each legal advisor involved in the case can fill in parts of the form as appropriate.
- When the case reaches disposal, this form (form A) should be detached and delivered to **XXX. YYY court** to be retained for collection by Bournemouth University at the end of each calendar month.
- If a case is committed to Crown Court the form should be copied. One copy should accompany the file to the Crown Court, the other copy delivered to XXXX for collection by Bournemouth University.
- The **Health Service version of this form (Form B)** attached to this form should also be sent with any request for a mental health assessment/report made for the defendant to the health services. When this sheet is returned from the health services with the report, please attach and deliver to **XXXX** along with Form A.

Bournemouth University

FORM A: FOR COURTS

MONITORING SHEET FOR DEFENDANTS EXPERIENCING MENTAL HEALTH ISSUES

DETAILS ABOUT DEFENDANT

1. Court Case number:

2. Name of defendant

3. Court dealing with case

4. Is this court a

Crown Court ☐

Magistrates' Court ☐

5. Is the defendant

Female ☐

Male ☐

6. What is the ethnic group code for the defendant as taken from the police charge sheet?

7. What is the date of birth of defendant (dd/mm/yyyy)**?** -/ - - /- - - -

8. What is the main (most serious) offence of which the defendant is accused?

MENTAL HEALTH ASSESSMENT/ADVICE

9. Was mental health assessment/advice requested *(please tick the appropriate box)***?**

Yes ☐

No ☐

10. If your answer to question 10 was YES, why was request made (*briefly summarise the reasons in the box below)***?**

11. If your answer to question 10 was NO, why was a request not made (*briefly summarise the reasons in the box below)***?***

12. Date the request for report/advice was made (dd/mm/yy) - -/ - - /- - - -

13. From whom did the request for advice originate *(please tick the appropriate box)***?**

Legal advisor	☐	Probation	☐
Judge/magistrate	☐	Other: (Please specify)	☐
		----------	

14. What type of assessment/advice was requested *(please tick the appropriate box)***?**

Psychiatric report	☐	Informal advice	☐
Forensic Psychiatric report	☐	Other: Please specify	☐
Health and Social circumstance report (HAMPSHIRE COURTS ONLY)	☐	----------	

15. Was the assessment/advice easily accessible *(please tick the box under the number that best represents your opinion on this statement)***?**

Very accessible……Not accessible at all

1	2	3	4	5
☐	☐	☐	☐	☐

16. From what source was mental health assessment/advice requested *(please tick the appropriate box)***?**

MENDOS *(HAMPSHIRE COURTS ONLY)*	☐	Independent Psychiatrist	☐

Ravenswood House Medium Secure Unit	☐	Court Assessment and referral scheme (CARS) (*BRISTOL ONLY)*	☐
Fromeside Medium Secure Unit	☐	Other: (Please specify)	☐
Prisons	☐	----------	

17. Date that report/advice was expected to be returned (dd/mm/yy) - -/ - - /- - - -

18. Date report/advice received (dd/mm/yy) - -/ - - /- - - -

19. Reasons given for any delay in return of report/assessment/advice

20. Was a Nil report retuned *(please tick the appropriate box*?)

Yes ☐
No ☐

*If **a further report/assessment/advice** is requested for the defendant, please record information about this second report under the section in Question 21 to Question 31). If not, please go to Question32.*

21. Was a further mental health assessment/advice requested *(please tick the appropriate box)***?**

Yes ☐
No ☐

22. If your answer to question 10 was YES, why was request made (*briefly summarise the reasons in the box below)***?**

23. Date the request for report/advice was made (dd/mm/yy) - -/ - - /- - - -

24. Who made the request for advice *(please tick the appropriate box)***?**

Legal advisor	☐	Probation	☐
Judge/magistrate	☐	Other: Please specify	☐

---

25. What type of assessment/advice was requested *(please tick the appropriate box)***?**

Psychiatric report	☐	Informal advice	☐
Forensic Psychiatric report	☐	Other: Please specify	☐
Health and Social circumstance report *(HAMPSHIRE COURTS ONLY)*	☐	----------	

26. Was the assessment/advice easily accessible *(please tick the box under the number that best represents your opinion on this statement)***?**

Very accessible……Not accessible at all

1	2	3	4	5
☐	☐	☐	☐	☐

27. From what source was mental health assessment/advice requested *(please tick the appropriate box)***?**

MENDOS *(HAMPSHIRE COURTS ONLY)*	☐	Independent Psychiatrist	☐
Ravenswood House Medium Secure Unit	☐	Court Assessment and referral scheme (CARS) *(BRISTOL ONLY)*	☐
Fromeside Medium Secure Unit	☐	Other: Please specify	☐
Prisons	☐	----------	

28. Date that report/advice was expected to be returned (dd/mm/yy) - -/ - - /- - - -

29. Date report/advice received (dd/mm/yy) - -/ - - /- - - -

30. Reasons given for any delay in return of report/assessment/advice

31. Was a Nil report retuned *(please tick the appropriate box***?)**

Yes	☐
No	☐

ADJOURNMENTS

32. How many adjournments were associated with this case? ☐

33. How many of these adjournments were related to requests for mental health assessments/reports/advice? ☐

34. When advice was being sought, was the defendant remanded to *(please tick the appropriate box)***:**

Bail ☐
Custody ☐

DISPOSAL OF DEFENDANT

35. Did the report /advice contain an explicit recommendation for disposal *(please tick the appropriate box)***?**

Yes ☐
No ☐

36. How useful was the report in reaching a decision on the means of disposal *(please tick the box under the number that best represents your opinion on this statement)***?**

Very useful……Not very useful at all

1	2	3	4	5
☐	☐	☐	☐	☐

37. What was the eventual date of disposal for the defendant? - -/ - - /- - - -
(dd/mm/yy)

38. What was the eventual means of disposal of the defendant *(please tick the appropriate box)***?**

Custodial sentence	☐	Community Order with requirement of:	
Committed to Crown Court	☐	Unpaid work	☐
		Supervision	☐
Hospital admission under Mental Health Act (specify section……..)	☐	Programme (accredited)	☐
		Drug rehabilitation	☐
Conditional discharge	☐	Mental Health treatment	☐
Discharged	☐	Residence	☐
Suspended Sentence	☐	Specified activity	☐
		Alcohol treatment	☐
		Prohibited activity	☐

	Exclusion	☐
	Curfew	☐
	Attendance centre	☐
Other, please explain	----------	☐

39. Do you have any comments to make on your experience of requesting and receiving advice on the mental health of the defendant and the usefulness or appropriateness of this advice (*briefly summarise your comments in the box below)***?**

ONCE THE CASE HAS REACHED DISPOSAL, PLEASE RETURN THIS SHEET TO, XXX, CROWN COURT MANAGER, XXX Any queries in how to complete this form please contact Dr Sarah Hean 01202 962201 or Sue Staddon, 0791 593470

- -/ - - /- - - -

Returned to XXX on date (dd/mm/yy)

9.2. Monitoring sheet for mental health services

NB TO THE COURT SERVICES: PLEASE ATTACH FORM B TO ANY REQUEST FOR A MENTAL HEALTH ASSESSMENT/REPORT MADE TO THE HEALTH SERVICES

NB TO THE HEALTH SERVICES: PLEASE ATTACH THE COMPLETED FORM B WHEN THE ASSESSMENT/REPORT IS RETURNED TO THE COURT SERVICES

Bournemouth University

FORM B

FOR MENTAL HEALTH SERVICES COMPLETING REPORTS FOR THE COURT SERVICES

MONITORING SHEET FOR DEFENDANTS EXPERIENCING MENTAL HEALTH ISSUES

Instructions to mental health worker/psychiatrist completing mental health assessment/report

- Please fill in this form in any case where a mental health report/assessment or any other advice (formal or otherwise) has been requested by the **court services**.
- This form should be completed by the mental health worker/psychiatrist making the report for or giving the advice to the court services.
- **One** form should be completed for each mental health report/assessment/advice requested.
- Please attach the form to the mental health report when returning it to the court.

Bournemouth University

FORM B FOR MENTAL HEALTH SERVICES

MONITORING SHEET FOR MENTAL HEALTH REPORTS ON DEFENDANTS EXPERIENCING MENTAL HEALTH ISSUES

DETAILS ABOUT DEFENDANT

1. **Court Case number *(if known):***

2. **Health record number**

3. **Institution/service issuing report/assessment/advice**

4. **Is the defendant**

Male ☐
Female ☐

5. **What is the date of birth of defendant** (dd/mm/yyyy)**?** - -/ - - /- - - -

6. **What is the ethnic group of defendant** *(please tick the appropriate box)*?

White
British ☐
Irish ☐
Any Other White background ☐
(please write in space provided) ----------

Mixed
White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
Any Other Mixed background ☐
(please write in space provided) ----------

Asian or Asian British
Indian ☐
Pakistani ☐
Bangladeshi ☐
Any Other Asian background ☐
(please write in space provided) ----------

Black or Black British
Caribbean ☐
African ☐
Any Other Black background ☐
(please write in space provided) ----------

Chinese or Other ethnic group
Chinese ☐
Any Other ethnic group ☐
(please write in space provided) ----------

7. **What is the main (most serious) offence of which the defendant is accused**

MENTAL HEALTH ASSESSMENT/ADVICE/REPORT PROVIDED

8. When was the request for advice/assessment /report made *(dd/mm/yyyy)*? - -/ - - /- - - -

9. Which Court made the request?
(*Indicate whether this is the crown or magistrates court)***?**

10. When was the defendant seen (dd/mm/yyyy)? - -/ - - /- - - -

11. Is the defendant currently known to the mental health service *(please tick the appropriate box)***?**

Yes ☐

No ☐

12. Has the defendant been known to the mental health service in the past *(please tick the appropriate box)***?**

Yes ☐

No ☐

13. Why was the request for assessment/advice/report made (*briefly summarise the reasons in the box below)***?**

14. What type of assessment/advice/report was requested *(please tick the appropriate box)*?
Please fill out a separate monitoring sheet if more than 1 form of advice has been requested

Psychiatric report	☐	Informal advice	☐
Forensic Psychiatric report	☐	Other: Please specify	☐
Health and Social circumstance report *(HAMPSHIRE COURTS ONLY)*	☐	----------	

15. Was the type of assessment/advice/report requested appropriate *(please tick the appropriate box)***?**

Yes ☐

No ☐

16. If you answered NO to the above (question 15), please explain why the type of report

requested may have been inappropriate and what type of request should have been made ideally (*briefly summarise your response in the box below)***?**

17. Who provided the assessment/advice/report requested *(please tick the appropriate box)***?**

Forensic consultant psychiatrist	☐	Consultant psychiatrist	☐
Mental health worker	☐	Other: (Please specify)	☐
		----------	

18. Was the request for assessment/advice/report made to the appropriate service *(please tick the appropriate box)***?**

Yes	☐
No	☐

19. If you answered NO to the above (question 18), please explain why the request may have been inappropriate and why or to whom the request should have been made ideally (*briefly summarise your response in the box below)***?**

20. Was the request for assessment/advice referred to another service *(please tick the appropriate box)***?**

Yes	☐
No	☐

22. If you answered YES to the above (question 21), please explain why and to whom the referral was made (*briefly summarise the reasons in the box below)***?**

23. When was the request for advice/assessment/report due to be retuned to the courts (dd/mm/yyyy)**?** - -/ - - /- - - -

24. When was the request for advice/assessment/report actually sent to the courts (dd/mm/yyyy)**?** - -/ - - /- - - -

25. What was the reason behind any delays (*briefly summarise the reasons in the box below)***?**

26. Was a Nil report retuned for this patient *(please tick the appropriate box)***?**

Yes ☐

No ☐

DISPOSAL OF DEFENDANT

27. Did the report/assessment/advice contain an explicit recommendation for the disposal/sentencing of the patient *(please tick the appropriate box)***?**

Yes ☐

No ☐

28. What were these recommendations *(briefly summarise these in the box below)***?**

29. Do you have any comments to make on your experience of the requests being made of your service by the courts for advice on the mental health of the defendants/patients and the appropriateness of these requests?

PLEASE RETURN THIS FORM WITH THE REPORT TO THE COURT SERVICE MAKING THE REPORT REQUEST

Any queries in how to complete this form please contact Dr Sarah Hean 01202 962201 or Sue Staddon, 0791 593470

Returned to Court service on date (dd/mm/yy) - -/ - - /- - - -

Name of person completing monitoring sheet

9.3. Variables included in Phase 1 Post SLA record keeping system

DATE OF ENTRY
CASE NUMBER
GENDER
DATE OF BIRTH
AGE
ETHNIC GROUP
GP
PREVIOUS HISTORY WITH HEALTH SERVICES
MENTAL HEALTH NEEDS OF DEFENDANT
PERCEIVED RISK TO SELF AND OTHERS
COURT WHERE SCREENING CONDUCTED
ROLE OF PROFESSIONAL CONDUCTING SCREENING ASSESSMENT
HEALTH OUTCOME
ACCOMMODATION SITUATION
SOURCE OF REFERRAL
DATE OF REFERRAL
SERVICE CONDUCTING SCREENING REPORT
DATE SCREENING REPORT COMPLETED
RECOMMENDATION
NEED FOR PSYCHIATRIC REPORT INDICATED BY COURT
PSYCHIATRIC REPORT REQUESTED BY CARS
DATE PSYCHIATRIC REPORT REQUESTED
DATE PSYCHIATRIC REPORT COMPLETED
HEALTH SERVICE PROVIDING REPORT
RECOMMENDATION
HEALTH AND SOCIAL CIRCUMSTANCE REPORT REQUESTED
DATE HEALTH AND SOCIAL CIRCUMSTANCE REPORT REQUESTED
DATE HEALTH AND SOCIAL CIRCUMSTANCE REPORT COMPLETED
HEALTH SERVICE PROVIDING REPORT
RECOMMENDATION
OFFENCE
DATE OF FIRST APPEARANCE
NUMBER OF ADJOURNMENTS
REMAND STATUS
PSR REQUESTED
DATE OF DISPOSAL
COURT OUTCOME
COMMENTS

9.4. Survey of court personnel PRESLA

INSTRUCTIONS

1. Please read the attached information sheet and retain this document for your own information

2. Please complete the enclosed questionnaire.

3. When you have completed the question please return it Dr Sarah Hean in the stamp addressed envelope provided as soon as possible. We are working to a deadline of the 21st February 2008.

4. Please attempt to complete all questions. In some cases, you may need to provide a generalized response, when the answer might depend on specific contexts.

5. Please feel able to be as open with your responses as possible, as the data you provide is given anonymously given and cannot be traced to you individually.

Bournemouth University

INFORMATION SHEET

EVALUATION OF SOUTH WEST MENTAL HEALTH ASSESSMENT AND ADVICE PILOT PROJECT

You may be aware that the South West Courts Service in partnership with the Health Service is undertaking a pilot project to improve the provision of mental health assessment for defendants with a mental health illness. The project has commissioned Bournemouth University to carry out an evaluation of the current service and the impact of any new agreements reached.

What is the purpose of the evaluation?

Many requests are made by Magistrates' and Crown Courts for psychiatric opinions on defendants who may have a mental health issue. These requests are made of Mental Health services. This need to communicate across sectors is often a difficult and lengthy process.

If these processes are not functioning optimally the psychiatric advice required in court may not be forthcoming or be delayed. Defendants may then wait unnecessarily long periods on remand and their disposal may occur without the benefit of such advice. Mentally disordered offenders sometimes face inappropriate imprisonment or fail to access community support.

We wish to evaluate the quality of service between the courts and health services. We will do this by collecting the opinions of personnel in both the court and mental health services through versions of this questionnaire

.

Information will be fed back to the Project's leaders and steering group who will act on the information to develop the existing systems.

Do I have to take part?

Taking part in the evaluation is entirely voluntary. It is up to you to decide. We ask you to read this information sheet. If you indicate an interest in participating, please complete the attached questionnaire and return it to us in the stamped addressed envelope provided before **21st February 2008.** By returning your questionnaire, this implies you have consented for us to use your data in our evaluation.

What will happen to me if I take part?

You will be asked to complete the attached questionnaire that addresses the quality of the current service. The questionnaire should take 20 minutes to complete. At a later date you may be approached again to complete a follow up survey asking you how things may have changed after new agreements have been put in place. You are under no obligation to fill in this or the later questionnaire.

Will my taking part in the study be kept confidential?

The data you provide us in this questionnaire is given anonymously and cannot be traced to you individually. The questionnaires and associated electronic databases will be stored securely in the offices of Bournemouth University under the custodianship of Dr Sarah Hean. This raw data will only be available to the two evaluators and no one else (Dr Jerry Warr and Dr Sarah Hean). Information provided to Project leaders, steering group and other audiences will be anonymised in reports and other means of dissemination. Questionnaires will be stored for 5 years and then destroyed.

What are the possible benefits and disadvantages of taking part?

The benefit of taking part is that you will be able to contribute to the evaluation and development of communications between mental health services and the courts. This will be of benefit to defendants with mental health issues enabling them to be diverted where appropriate into care.

There are no disadvantages to the study other than the sacrifice of your time to complete the questionnaire.

What if there is a problem?

Any complaint about the way you have been dealt with during the evaluation please refer to

Sue Staddon

Project manager

Sue.staddon@nimhesw.nhs.uk Mobile: 07917 593470

What will the information you provide be used for.

The data from the initial evaluation will be summarised in a report to the South West Mental Health Assessment and Advice Pilot. This will underpin the development of current systems. A second report

will summarise the change in systems that may take place following this development. We also aim to publish the outcomes of the evaluation in related practice and academic journals. The identity of all participants will be anonymised in these presentations. Copies of these presentations may be sent to participants at their request.

Thank you for your consideration of our study.

Contact details

If you want to discuss this study further or have any queries please contact:

Dr Jerry Warr
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Dr Sarah Hean
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E: <mailto:shean@bournemouth.ac.uk

Bournemouth University

IMPORTANCE OF MENTAL HEALTH ISSUES

1. **In your professional role, how important is it to you that the mental health needs of a defendant are dealt with appropriately during court proceedings** *(please tick the box under the number that best represents your opinion)***?**

Very important ☐ ☐ ☐ ☐ ☐ Not important at all

2. **Although circumstances change from one context to another, please try to indicate on a scale of 1 to 5 the extent to which you agree or disagree in general with the each of the following statements** *(please tick the box under the number that best represents your opinion)*

	Strongly agree 1	2	3	4	**Strongly disagree** 5
(a) Mental illnesses are very common in the UK population as a whole	☐	☐	☐	☐	☐
(b) Mental illness is a medical condition like other illnesses	☐	☐	☐	☐	☐
(c) Anybody can suffer from mental illness	☐	☐	☐	☐	☐
(d) People with mental disorders can live in the community, if they receive appropriate support	☐	☐	☐	☐	☐
(e) People with mental illness are dangerous and should be avoided.	☐	☐	☐	☐	☐
(f) People with mental illness are to blame for the offences they commit	☐	☐	☐	☐	☐
(g) Offenders with mental illness should be punished like any other offender	☐	☐	☐	☐	☐
(h) With mentally ill offenders, treatment should take priority over punishment	☐	☐	☐	☐	☐
(i) Men sufficient su when passing th gh the court ser es	☐	☐	☐	☐	☐

MENTAL HEALTH AWARENESS

3. **How would you rate your ability to identify a defendant with a mental health issue** *(please tick the box under the number that best represents your opinion***?**

Very high				Very low
1	2	3	4	5
☐	☐	☐	☐	☐

4. **How would you rate your knowledge of how to get an assessment for a defendant with a mental health issue** *(please tick the box under the number that best represents your opinion)***?**

Extensive				Limited
1	2	3	4	5
☐	☐	☐	☐	☐

5. **Have you ever received any training on how to deal with offenders/defendants with mental health issues?**

Yes ☐
No ☐

6. **If YES, please could you describe this training** (e.g. the type, provider, duration and usefulness of this training).

When the mental health of a defendant is relevant to the court, this may be brought to your notice in several ways.

7. **Generally, in your dealings with defendants, HOW FREQUENTLY do each of the following services/people bring the mental health issues of defendants to your notice?**

Please respond to each item. If you have had not dealings with a particular service, tick the seldom or never box (box 5). If you are in fact one of these services/people mentioned please tick the not applicable column.

I generally am made aware of a mental health issue in a defendant by:

	Very frequently				**Seldom or never**	**Not applicable**
	1	**2**	**3**	**4**	**5**	
(a) A liaison service or diversion scheme (e.g., (MENDOS) *(Hants only)***; CARS** *(Bristol only)*	☐	☐	☐	☐	☐	☐
(b) Security services (e.g., Reliance/Premier)	☐	☐	☐	☐	☐	☐
(c) Defence solicitor	☐	☐	☐	☐	☐	☐
(d) Prosecutor	☐	☐	☐	☐	☐	☐
(e) Court usher	☐	☐	☐	☐	☐	☐
(f) Mental health worker	☐	☐	☐	☐	☐	☐
(g) Probation officer	☐	☐	☐	☐	☐	☐
(h) Police/custody sergeants	☐	☐	☐	☐	☐	☐
(i) Forensic medical examiner or custody nurse	☐	☐	☐	☐	☐	☐
(j) An appropriate adult (e.g. family member, carer, friend)	☐	☐	☐	☐	☐	☐
(k) The defendant him/herself	☐	☐	☐	☐	☐	☐
(l) My own observation of defendant's behaviour	☐	☐	☐	☐	☐	☐
(l) Another source (please explain) _____	☐	☐	☐	☐	☐	☐

SUPPORT FROM MENTAL HEALTH SERVICES

8. **How often have you felt the need for mental health advice about a defendant but have been unsure whom to approach** *(please tick the box under the number that best represents your opinion)***?**

Very frequently — Very seldom or never

1	2	3	4	5
☐	☐	☐	☐	☐

9. **Are you aware of any service available to you from which you are able to receive advice on a defendant with a mental health issue?**

Yes ☐
No ☐

10. **If YES, please name below all of those you are likely to approach?** *(if NO, go to question 15)*

11. **Of the list you have drawn above, name the service with which you have most frequent contact.**

12. **How do you find making contact with members of this mental health service for advice/assessment of defendants with mental health issues** *(please tick the box under the number that best represents your opinion)***?**

Very easy — Very difficult

1	2	3	4	5
☐	☐	☐	☐	☐

13. **How would you describe the nature of your relationships with members of this mental health service** *(please tick the box under the number that best represents your opinion)***?**

Non existent — Very well developed

1	2	3	4	5
☐	☐	☐	☐	☐

14. **How satisfied are you with the provision of mental health assessment/advice to the court by this service** *(please tick the box under the number that best represents your opinion***?**

Very satisfied — Very dissatisfied

1	2	3	4	5
☐	☐	☐	☐	☐

DEMAND FOR MENTAL HEALTH SERVICES

15. In the last year, how frequently have you had contact with cases/defendants with mental health issues? *(please tick the box under the number that best represents your opinion)***?**

Once or more a week	Between two and three times a month	Once a month	Once or twice in the last 3 months	Not within the last3 months.
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

16. How often do you think defendants are disposed of with insufficient advice being given on their mental health *(please tick the box under the number that best represents your opinion*?

Very frequently				Very seldom or never
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

17. If you felt there was insufficient advice can you explain why you think this is the case?

USEFULNESS OF COURT REPORTS

18. In general, how would you rate the usefulness of any VERBAL reports/advice you receive at court from the mental health services?

Very useful				Not very useful at all
1	2	3	4	5
☐	☐	☐	☐	☐

19. In general, how would you rate the usefulness of any WRITTEN reports you receive at court from the mental health services?

Very useful				Not very useful at all
1	2	3	4	5
☐	☐	☐	☐	☐

20. What is good about the current provision of mental health assessments/advice in the court *(briefly summarise in the box below)***?**

21. What are the limitations in the current provision of mental health assessments/advice in the court *(briefly summarise in the box below)***?**

22. How could the provision of mental health advice and the quality of reports to the courts be improved in the future *(briefly summarise in the box below***)?**

We collect this data simply to establish if there are any potential differences in approaches, opinions and beliefs in professionals of different role, experience, age, gender etc. in order that any future dev all demographic groups

23. To which court are you attached

24. What is your current role in the court

Probation officer	☐	Defence lawyer	☐
Legal advisor	☐	Magistrate	☐
Judge	☐	Other (please explain)	☐

_____

25. Are you:

Female ☐
Male ☐

26. How long have you worked in the court environment? _____ **years**

27. What is your year of birth (e.g. 1968)? **19** _____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.
PLEASE RETURN THE QUESTIONNAIRE TO DR SARAH HEAN IN THE ENVELOPE ATTACHED BY THE 21st FEBRUARY 2008 AT THE LATEST.

9.5. Survey of personnel from mental health services PRESLA

Bournemouth University

EVALUATION OF SOUTH WEST MENTAL HEALTH ASSESSMENT PILOT QUESTIONNAIRE

WORKING WITH SERVICE USERS IN CONTACT WITH CRIMINAL JUSTICE SYSTEM (CJS)

1. **Thinking of your overall case load, how important is it to you that the mental health needs of a person in contact with CJS are met** *(please tick the box under the number that best represents your opinion)***?**

Very important — Not important at all

1	2	3	4	5
☐	☐	☐	☐	☐

2. **Although circumstances change from one context to another, please try to indicate on a scale of 1 to 5 the extent to which you agree or disagree in general with the following statements.** ***(****please tick the box under the number that best represents your opinion)*

	Strongly agree 1	2	3	4	Strongly disagree 5
(a) The Criminal Justice System (CJS) is effective in dealing with people with a mental illness accused of a crime	☐	☐	☐	☐	☐
(b) Service users in contact with the CJS should be treated with respect just like anyone else	☐	☐	☐	☐	☐
(c) The values of service users in contact with the CJS are the same as the rest of us	☐	☐	☐	☐	☐
(d) You have to be constantly on your guard with service users in contact with the CJS	☐	☐	☐	☐	☐
(e) Service users in contact with the CJS should be kept under strict observation	☐	☐	☐	☐	☐
(f) Trying to rehabilitate service users in contact with the CJS is a waste of time.	☐	☐	☐	☐	☐
(g) Service users in contact with the CJS are victims of their circumstances.	☐	☐	☐	☐	☐
(h) If endorsed by my Trust, I am willing to be involved in the treatment of service users in contact with the CJS.	☐	☐	☐	☐	☐

AWARENESS OF THE CRIMINAL JUSTICE SYSTEM

3. **How would you rate your knowledge of the Criminal Justice System** *(please tick the box under the number that best represents your opinion)***?**

Extensive				Limited
1	2	3	4	5
☐	☐	☐	☐	☐

4. **How would you rate your ability to work with a service user who is in contact with the Criminal Justice System** *(please tick the box under the number that best represents your opinion***?**

Very high				Very low
1	2	3	4	5
☐	☐	☐	☐	☐

5. **Have you ever received any training on how to deal with service users in contact with the Criminal Justice System?**

Yes ☐
No ☐

6. **If YES, please describe this training** (e.g. the type, provider and usefulness of this training)

7. **How often do you think service users/defendants progress through the Criminal Justice System with insufficient advice being given on their mental health** *(please tick the box under the number that best represents your opinion***?**

Very frequently				Very seldom or never	I don't know
1	2	3	4	5	
☐	☐	☐	☐	☐	☐

DEMAND FOR MENTAL HEALTH SERVICES

8. In the last year, have you worked with a service user in contact with the Criminal Justice System

Yes	☐ IF YES, PLEASE GO TO QUESTION 10
No	☐ IF NO, PLEASE GO TO QUESTION 9

9. If NO can you explain why you think this is?

IF YOU ANSWERED NO TO QUESTION 8, PLEASE GO TO QUESTION 25. OTHERWISE PLEASE CONTINUE TO QUESTION 10.

10. In the last year, how frequently have you worked with service users in contact with the Criminal Justice System *(please tick the box under the number that best represents your opinion)**?***

Once or more a week	Between two and three times a month	Once a month	Once or twice in the last three months	Not within the last three months	I do not work with service users in contact the CJS
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

11. If you have worked with service users in contact with the Criminal Justice System, please estimate over the last year how frequently you have taken part in the following court related activities *(please tick the box under the number that best represents your opinion***?**

	Once or more a week	Between two and three times a month	Once a month	Once or twice in the last three months	Not within the last three months	I do not have contact with defendants
	1	2	3	4	5	6
(a) Assessed defendants at the request of the court	☐	☐	☐	☐	☐	☐
(b) Supported defendants through their court case	☐	☐	☐	☐	☐	☐
(c) Delivered verbal/oral reports on a defendant's mental health to the courts	☐	☐	☐	☐	☐	☐
(c) Prepared psychiatric reports on defendants' mental health for the court	☐	☐	☐	☐	☐	☐
(d) Prepared health and social circumstance report for the court *(HAMPSHIRE ONLY)*	☐	☐	☐	☐	☐	☐
(d) Provided informal advice on defendants' mental health to the court	☐	☐	☐	☐	☐	☐
(e) Referred defendants on to other services	☐	☐	☐	☐	☐	☐
(e) Returned a request for advice to the court as an inappropriate referral	☐	☐	☐	☐	☐	☐
(f) Other (please specify) ---------- ---------- ----	☐	☐	☐	☐	☐	☐

SUPPORT FROM THE CRIMINAL JUSTICE SYSTEM

12. Do you have people working in the court with whom you liaise directly when you work with service users in contact with the Criminal Justice System?

Yes ☐
No ☐

13. **If YES, please indicate below the roles of all person(s) in the court with whom you have contact** (e.g. defence lawyer, legal advisor, probation officer)**.**

14. **Of the list above, indicate the role of the key person in the court with whom you have the *most* contact** (e.g. defence lawyer, legal advisor, probation officer)**?**

15. **Thinking of the above person, how do you find making contact with this member of the court on issues related to service users in contact with the Criminal Justice System** *(please tick the box under the number that best represents your opinion)***?**

Very easy				Very difficult
1	2	3	4	5
☐	☐	☐	☐	☐

16. **How would you describe the nature of your professional relationship with this member of the court** *(please tick the box under the number that best represents your opinion)***?**

Virtually non existent				Very well developed
1	2	3	4	5
☐	☐	☐	☐	☐

USEFULNESS OF COURT REPORTS

17. **The Courts may request advice/information from the mental health services on the mental health of a defendant. These services address these requests by providing the following reports/advice. Within how many days would *your* mental health services be able to respond to these requests if required?**

(a) Verbal/Oral reports __ __ days

(b) Psychiatric/Forensic Psychiatric reports __ __ days

(c) Health and Social circumstance reports *(HAMPSHIRE* __ __ days

ONLY)

(d) Informal Advice __ __ days

(f) Other __ __ days
*(please specify)*_____

18. How useful do you think the courts find the VERBAL/ORAL reports provided by the mental health services?

Very useful				Not very useful at all	I do not know
1	2	3	4	5	
☐	☐	☐	☐	☐	☐

19. How useful do you think the courts find the FULL PSYCHIATRIC REPORTS provided by the mental health services?

Very useful				Not very useful at all	I do not know
1	2	3	4	5	
☐	☐	☐	☐	☐	☐

20. How useful do you think the courts find HEALTH AND SOCIAL CIRCUMSTANCE REPORTS provided by the mental health services? (*Hampshire only)*

Very useful				Not very useful at all	I do not know
1	2	3	4	5	
☐	☐	☐	☐	☐	☐

21. How satisfied are you that the courts act effectively on the content of any reports/advice provided by the mental health services?

Very satisfied				Not satisfied at all
1	2	3	4	5
☐	☐	☐	☐	☐

22. **What is good about the workings between the Criminal Justice System and Mental Health Services in your area** *(briefly summarise in the box below)***?**

23. **What are the current limitations about workings between the Criminal Justice System and Mental Health Services in your area** *(briefly summarise in the box below)***?**

24. **How could the workings between the Criminal Justice System and Mental Health Services in your area be improved in the future** *(briefly summarise in the box below)***?**

DEMOGRAPHIC DATA

25. **To what mental health service are you attached?**

26. **What is your current role in the service?**

Psychiatrist	☐	MENDOS worker	☐
Psychologist	☐	Support Time & Recovery worker	☐
Cognitive Psychotherapist	☐	Manager	☐
Community Psychiatric Nurse	☐	CBT Specialist	☐
Community Mental Health Nurse	☐	Occupational therapist	☐
Social worker	☐	Support worker	☐
Administrator	☐	Other (please specify) _____	☐

27. Are you:

Female ☐
Male ☐

28. How long have you worked in mental health services? **years**

29. What is your year of birth (e.g. 1968)? **19 ____ _____**

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.
PLEASE RETURN THE QUESTIONNAIRE TO Dr SARAH HEAN, IN THE STAMPED ADDRESSED ENVELOPE PROVIDED BY THE 13 June 2008

9.6. Survey of personnel from court personnel POST SLA

Courts

EVALUATION OF SOUTH WEST MENTAL HEALTH ASSESSMENT AND ADVICE PILOT PROJECT QUESTIONNAIRE

INSTRUCTIONS

6. Please read the attached information sheet and retain this document for your own information

7. Please complete the enclosed questionnaire.

8. When you have completed the question please return it to Dr Sarah Hean in the addressed envelope provided as soon as possible. No postage is required. Please return by 1 April 2009.

9. Please attempt to complete all questions. In some cases, you may need to provide a generalized response, when the answer might depend on specific contexts.

10. Please feel able to be as open with your responses as possible, as the data you provide is given anonymously given and cannot be traced to you individually.

1. Over the past 6 months, how frequently do you think defendants are disposed of with insufficient advice being given on their mental health (please tick the box under the number that best represents your opinion?

Very frequently — Very seldom or never

1	2	3	4	5
☐	☐	☐	☐	☐

2. Over the past 6 months, how often have you felt the need for mental health advice about a defendant but have been unsure whom to approach *(please tick the box under the number that best represents your opinion)***?**

Very frequently — Very seldom or never

1	2	3	4	5
☐	☐	☐	☐	☐

3. Are you aware of a liaison service available to you from which you are able to receive advice on a defendant with a mental health issue? *(please tick one of the boxes below)*

Yes ☐

No ☐

If NO, please go to question 13

If YES, please go to question 4

4. Name the liaison service available to you: *(please tick one of the boxes below)*

CARS (Bristol, Bath) ☐

Court liaison service (Hampshire**)** ☐

Other ☐
(Please identify)

_____

5. **How would you rate your knowledge of how to obtain advice from the above liaison service for a defendant with a mental health issue** *(please tick the box under the number that best represents your opinion)***?**

Extensive — Limited

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

6. **How frequently does the above liaison service bring the mental health issues of defendants to your notice?** *(please tick the box under the number that best represents your opinion)***.** .

Very frequently — Very seldom or never

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

7. **How do you find making contact with members of the above liaison service for advice on defendants with mental health issues** *(please tick the box under the number that best represents your opinion)***?**

Very easy — Very difficult

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

8. **How would you describe the nature of your relationships with members of this liaison service? (***please tick the box under the number that best represents your opinion)?*

Non existent — Very well developed

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

9. **How satisfied are you with the provision of mental health advice to the court by this liaison service?** *(please tick the box under the number that best represents your opinion***?**

Very satisfied — Very dissatisfied

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

10. **In general, how would you rate the usefulness of brief SCREENING REPORTS you receive at court through the above liaison service?** *(please tick the box under the number that best represents your opinion?*

Very useful — Not very useful at all

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

11. In general, how would you rate the usefulness of HEALTH AND SOCIAL CIRCUMSTANCE REPORTS you receive at court through the liaison service? *(please tick the box under the number that best represents your opinion?*

Very useful				Not very useful at all
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

12. In general, how would you rate the usefulness of PSYCHIATRIC REPORTS you receive at court through the liaison service? *(please tick the box under the number that best represents your opinion?*

Very useful				Not very useful at all
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

CONTEXT

In courts in Bath, Bristol, and Hampshire, a protocol between the mental health service provider (AWP and HPT) and Her Majesty's Court Services has been agreed with the aim of improving the provision of information to sentencers about defendants who may have mental health issues, and to improve the flow of information to mental health colleagues about patients appearing before the court. The service in Bristol and Bath provided by CARS started in April 2008, the Court Liaison Service in Hampshire began in August 2008.

The service involves the mental health service provider preparing 'brief screening reports' on all defendants referred to them or already known to them. These will be done on the day or within one working day of the referral. If further information is required a Health and Social Circumstances Report or a psychiatric report will be provided to agreed timescales.

13. Can you describe the impact that the above changes have made to provision of mental health advice to the court over the past 6 months? *(briefly summarise in the box below)*

14. How can we improve the service further in the future? *(briefly summarise in the box below)*

DEMOGRAPHIC DATA

15. Please name the main court within which you work

Bristol Crown Court	☐	Winchester Crown	☐
Bristol Magistrates	☐	Southampton Combined	☐
Bath magistrates	☐	Southampton magistrates	☐
Portsmouth Crown	☐	New Forest magistrates	☐
		Other (Please specify)	
		_____	_____

16. What is your current role in the court

Probation officer	☐	Defence lawyer	☐
Legal advisor	☐	Magistrate	☐
Judge	☐	Other (please explain)	☐

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

PLEASE RETURN THE QUESTIONNAIRE TO DR SARAH HEAN IN THE ENVELOPE ATTACHED BY THE 1 APRIL 2009 AT THE LATEST.

9.7. Survey of personnel from health personnel post SLA

Bournemouth University

HEALTH

EVALUATION OF SOUTH WEST MENTAL HEALTH ASSESSMENT AND ADVICE PILOT PROJECT QUESTIONNAIRE

INSTRUCTIONS

17. Please read the attached information sheet and retain this document for your own information

18. Please complete the enclosed questionnaire.

19. When you have completed the question please return it to Dr Sarah Hean in the stamp addressed envelope provided as soon as possible. Please return by the 1 April 2009.

20. Please attempt to complete all questions. In some cases, you may need to provide a generalized response, when the answer might depend on specific contexts.

21. Please feel able to be as open with your responses as possible, as the data you provide is given anonymously given and cannot be traced to you individually.

Bournemouth University

1. Over the past six months, how often do you think your service users have progressed through the Criminal Justice System with insufficient advice being given on their mental health *(please tick the box under the number that best represents your opinion***?**

Very frequently				Very seldom or never	I don't know
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	☐

2. In the last year, how frequently have you worked with service users in contact with the Criminal Justice System *(please tick the box under the number that best represents your opinion)***?**

Once or more a week	Between two and three times a month	Once a month	Once or twice in the last three months	Not within the last three months	I do not work with service users in contact the CJS
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

3. If you have worked with service users in contact with the Criminal Justice System, please estimate over the last 6 months how frequently you have taken part in the following court related activities *(please tick the box under the number that best represents your opinion)?*

	Once or more a week	Between two and three times a month	Once a month	Once or twice in the last three months	Not within the last three months
	1	2	3	4	5
(g) Assessed defendants at the request of the court	☐	☐	☐	☐	☐
(h) Supported defendants through their court case	☐	☐	☐	☐	☐

4. Are you satisfied with the information you get from the courts when you are required to assess or support a service user in contact with the criminal justice system? *(please tick the box under the number that best represents your opinion)?*

Very satisfied				Very dissatisfied
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

5. Are you aware of a liaison service in the courts in your area which is available to patients in contact with the criminal justice system? *(please tick one of the boxes below)*

Yes ☐

No ☐

If NO, please go to question 6
If YES, please go to question 12

6. Name the liaison service available to you: *(please tick one of the boxes below*

CARS (Bristol, Bath) ☐

Court liaison service (Hampshire**)** ☐

Other (Please identify) ☐

_____

7. How would you rate your knowledge of the above liaison service? *(please tick the box under the number that best represents your opinion)***?**

Extensive				Limited
1	2	3	4	5
☐	☐	☐	☐	☐

8. How frequently does the above liaison service bring the court case of the defendants to your notice? *(please tick the box under the number that best represents your opinion)).*

Very frequently				Seldom or never
1	2	3	4	5
☐	☐	☐	☐	☐

9. How do you find making contact with the above liaison service *(please tick the box under the number that best represents your opinion)?*

Very easy				Very difficult
1	2	3	4	5
☐	☐	☐	☐	☐

10. How would you describe the nature of your professional relationship with this liaison service *(please tick the box under the number that best represents your opinion)*?

Virtually non existent				Very well developed
1	2	3	4	5
☐	☐	☐	☐	☐

11. How satisfied are you with the provision of mental health advice to the court by this liaison service? *(please tick the box under the number that best represents your opinion***?**

Very satisfied				Very dissatisfied
1	2	3	4	5
☐	☐	☐	☐	☐

CONTEXT

In courts in Bath, Bristol, and Hampshire, a protocol between the mental health service provider (AWP and HPT) and Her Majesty's Court Services has been agreed with the aim of improving the provision of information to sentencers about defendants who may have mental health issues, and to improve the flow of information to mental health colleagues about patients appearing before the court. The service in Bristol and Bath provided by CARS started in April 2008, the Court Liaison Service in Hampshire began in August 2008.

The service involves the mental health service provider preparing 'brief screening reports' on all defendants referred to them or already known to them. These will be done on the day or within one working day of the referral. If further information is required a Health and Social Circumstances Report or a psychiatric report will be provided to agreed timescales.

12. Can you describe the impact that the above changes have made to provision of mental health advice to the court over the past 6 months? *(briefly summarise in the box below)?*

13. How can we improve the service further in the future? *(briefly summarise in the box below)?*

DEMOGRAPHIC DATA

12. To which Health Trust are you attached?

Avon Wiltshire Partnership Trust ☐
Hampshire Partnership Trust ☐

13. What is your current role in the service?

Psychiatrist	☐	Court Liaison worker (MENDOS/CARS)	☐
Psychologist	☐	Support Time & Recovery worker	☐
Cognitive Psychotherapist	☐	Manager	☐
Nurse	☐	CBT Specialist	☐
Social worker	☐	Occupational therapist	☐
Administrator	☐	Support worker	☐
Other (please specify)	☐		

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.
PLEASE RETURN THE QUESTIONNAIRE TO Dr SARAH HEAN, IN THE STAMPED ADDRESSED ENVELOPE PROVIDED BY THE 01 April 2009

9.8. Paper in press, Medicine, Science and the Law

Challenges at the interface of working between mental health services and criminal justice system

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Jerry Warr (PhD) School of Health and Social Care, University of Bournemouth

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Abstract

Background:
Provision of mental health reports for defendants in contact with the criminal justice system is problematic.

Aim
To explore factors that facilitate the flow of information on a defendant between the courts and the mental health services by:

- identifying key challenges to this information transfer from a court worker's perspective
- Exploring potential mismatches in the expectations held by the criminal justice system and the mental health services of the timeframes in which reports should be delivered.
- Exploring the perceived usefulness of reports

Method:
In part 1, questionnaires were distributed to a population of 2107 court workers. In part 2, monitoring forms were completed by court and health professionals on each report request made over a 7 month period.

Results:
Three key challenges to information transfer were identified:

- delays in report production
- perceived inadequacies in the report content and
- report funding

Perceived timelines with which respondents believed reports should be delivered varied and there is mismatch between the expectations of the two services on these timeframes. Perceptions on the usefulness of court reports also varied.

Conclusion
Poor interagency communications are caused by lack of a clear, shared protocol outlining agreed timelines, report content and lines of responsibility related to resource provision. Clear service level agreements are required between services to achieve clarity.

Declaration of interest.
none

Background

The prevalence of mental health issues in the prison population (Joint Prison Service and National Health Service Executive, 1999; Reed, 2003; Department of Health, 2007).
may partially be attributed to prisoners not being screened effectively for mental illness during earlier contact with the criminal justice system (CJS). For defendants to be effectively screened when passing through court, cooperation between the CJS and mental health services (MHS) is required. One dimension of this is the transfer of information on the mental health of the defendant between services in the form of written reports. Reports follow the assessment of the defendant by the MHS usually at the request of the court or other party. The report should enable the defendant to access the treatment they require and/or assist the sentencer in making an informed decision on an appropriate means of disposal. Reports range from written in depth psychiatric/forensic psychiatric reports provided by a psychiatrist in more serious cases to abbreviated, less detailed reports (screening or health and social circumstance (HSC) reports) for less severe conditions and provided by any mental health professional. Reports may also be made verbally to the court.

This dimension of interagency working has proved difficult in the past as might be expected of working between two public services so distinct in their expectations, priorities and working culture. In response to these difficulties, a partnership between the Criminal Justice System and The Mental Health Services was formed in a region of the SW of England and a pilot project was funded (South West Mental Health Assessment Pilot; 2007-2009) to implement a formal Service Level agreement (SLA) between the MHS and CJS to optimise the provision of reports.

To inform the nature of this SLA and evaluate its impact on interagency working, it was necessary to first identify the current challenges that face the assessment and advice provided to the CJS. Although it is widely accepted in practice that the provision of mental health assessment and report writing are unsatisfactory, there are few research studies that have explored this in any detail (Vaughan *et al.*, 2003; Vaughan, 2004; Grondahl *et al.*, 2007). Vaughan, (2004), for example, evaluated a system in the courts in which abbreviated screening reports replaced unnecessary requests for lengthy and more time consuming full psychiatric reports. He found that introducing screening reports reduced the time spent by the defendant in the court and the number of adjournments necessary when waiting for reports to be completed. Similarly Grondahl *et al.* (2007) evaluated a scheme in which screening reports were introduced as a mechanism to determine if full forensic psychiatric reports were required. In this instance, the relevance of screening reports was evaluated, specifically the validity of the recommendations and the degree to which the recommendations of screening reports were followed. Findings showed that at the time of evaluation there was some lack of clarity around the purpose of screening reports and that the recommendations of the screening report were often not followed up.

The current paper builds on the findings of these authors. It aims to provide further evidence that will facilitate the flow of information on a defendant with a mental illness between the courts and the mental health services. One challenge to information transfer identified by Vaughan (2004) and Grondahl *et al.* (2007) is the delay in report writing. This has been addressed with varying success through the introduction of screening reports. The study presented in this paper will explore the challenges from the court's perspective, more widely to determine if delays are in fact the only issue that compromises information transfer.

The study also explores the nature of the delay in report writing in greater depth by testing the assumption that the perception of a delay, is not only a failure in service delivery by the MHS as suggested by Vaughan (2004), but may arise equally arise from a mismatch in the expectations held by the CJS and MHS of acceptable timeframes in which a report should be delivered.

Finally, the paper considers other potential mismatches in expectations between services, specifically that surrounding the content and purpose of the report.

By addressing these three aims, the study will provide practitioners with evidence necessary to determine if screening reports are an appropriate and the only intervention necessary to improve information transfer between services.

Method

Prior to the implementation of the SLA, baseline data was collected in two streams (part 1 and part 2). Data were collected in Part 2 on expectations related to reports provision, through monitoring data on individual report requests over a fixed time period.

Part 1

To determine the range of challenges to information transfer between services, a questionnaire was distributed to court workers in all courts participating in the pilot project. These represented 7 magistrates' courts and 5 crown courts. All personnel in each court, likely to request reports from MHS, were selected (i.e., all judges, legal advisors, probation officers and defence lawyers). This represented a total population of 2107 court personnel (Table 1). A total of 479 questionnaires were returned representing a 22.5% response rate.

Table 1: Distribution of returned questionnaires by type of court worker

Profession	Location	Number of questionnaires returned	% of total sample-
Judges	**Crown courts**	16	3.3
Legal Advisors	**Magistrates' courts**	24	5.0
Lawyers	**Magistrates' and crown courts**	33	6.9
Magistrates	**Magistrates' and crown courts**	379	79.1
Probation	**Magistrates' and crown courts**	24	5.0
No profession declared		3	0.6
TOTAL		479	100.0

The questionnaire was designed and piloted in conjunction with the project manager and steering group. These members represented both the health and court services. They formed a panel to review the validity of the questions based on their expertise and experience in both mental health and criminal justice services.

In open ended questions, respondents were asked to comment on:

- The adequacy of advice received from MHS?
- What is good about current provision?
- The limitations of current provision?
- How provision could be improved in the future?

A thematic analysis of these open responses was conducted. Only themes that relate specifically to interagency working are presented here.

Respondents were also asked to provide an overall rating (on a Likert scale of 1 to 5) of the usefulness of written reports provided by the MHS.

Part 2 Monitoring sheets

A second phase of data collection focussed on collecting information on each report request made by the CJS. A monitoring form template was designed that could be used to record key variables on each request for a court report. A supply of these forms was distributed to key contacts in each court

participating in the project. The contact was requested to complete this form for every request for mental health report made of MHS and which was paid for directly by this court service. This precluded reports requested for and paid for by defence solicitors as well as reports paid for through legal aid. The data collection period was over a 7 month period. Forms were collected monthly from each contact. The form collected data from which information on perceived and actual delays in report writing could be assessed. These included the

- The type of reports requested
- When the report was requested
- When the completed report was expected to be delivered
- When the completed report was actually received
- The usefulness of the report

In a triangulation exercise to ensure that all report requests were recorded during the evaluation period, a similar and complementary monitoring form was distributed to key contacts in the mental health services from which courts in the study regularly requested reports. The form collected data on a range of variables including the:

- The type of report requested of the service by the courts
- When the report was requested
- When the completed report was expected to be delivered
- When the completed report was actually received

Monitoring sheets recorded defendants case and health record numbers (the latter anonymised) in order that duplicate cases recorded by both court and mental health service could be identified. The two monitoring forms were designed and piloted in conjunction with the pilot project manager and steering group. Forms were administered to all the court services participating in the pilot project and to MHS known to have contact with these courts. This comprised of two diversion/liaison services; two prison in reach teams, one community mental health ream, two medium secure units and one hospital psychiatric ward.

Sixty nine monitoring forms were collected in a 7 month period (see Table 2). The majority (65.2%; n=69) of requests recorded where for psychiatric or forensic psychiatric reports.

Table 2: Type and number of reports requested by the courts over the evaluation period

	Frequency	**Percent**
psychiatric report	27	39.1
Forensic psychiatric report	18	26.1

health and social circumstance report	11	15.9
informal advice/oral report/other	5	7.2
clinical psychologist report	1	1.4
Type of report not specified	7	10.1
Total	69	100.0

Descriptive statistical data collected from Monitoring forms was processed using the package *SPSS 14.0.*

The monitoring sheets and questionnaires and associated electronic databases were stored securely in university offices under the custodianship of the report authors. Raw data in part 2 was only made available to the research team. Part 1 questionnaires were fully anonymised. Members of the court who provided completed monitoring sheets and the defendants associated with the record had the right to check the accuracy of data held about them and correct any errors.

Results:

Challenges that compromise information transfer.

The thematic analysis of open ended questions in part 1 of the study identified three key themes. As anticipated the delay in production of court reports was a predominant theme mentioned by respondents. However, two other central themes were raised namely:

- the content of the report itself
- the cost of the report

Each of these themes is described below.

*Theme 1: Delays in production of court report**s***

Delays in report writing was a strong and contentious issue reported by court personnel (178 respondents mention this theme). There was a clear consensus that length of time taken for reports to be returned by the MHS to the courts was unacceptable. Psychiatric reports were particularly problematic. Delays were attributed to a lack of mental health services or mental health service staff available to the court to perform assessment. Although, it was suggested that mental health professionals, responsible for compiling the reports, were not meeting court deadlines, court workers did recognize that delays may also be caused by a potential mismatches between the timescales expected by the court services and those recognised by the health services. Respondents also suggested that a lack of direct contact between individuals in the CJS and MHS, and reliance on an intermediary

for interagency communication, was frustrating. They understood that delays could also be caused by the defendant not being known to the mental health service and that defendants not attending assessment delayed procedures further.

Some respondents explored the impact of delays on the court processes itself with lengthy and multiple adjournments and delays in court proceedings as key outcomes. They indicated that the latter discouraged court personnel from requesting reports and that court cases often proceeded to sentencing without information on the mental health of the defendant as a result. They were aware that the latter posed a potential risk to the public and facilitated reoffending if defendant was released on bail. Participants were less vocal on the impact of delays on the defendant themselves but acknowledged that delays in court process subsequently impacted on the defendants and their potential treatment. Prolonged court processes meant defendants and their families remained unsupported, in stressed states, for longer than necessary. In some cases defendants remained on remand longer than a sentence commensurate with their offence. These were all outcomes respondents felt were caused by delays in report writing and which discouraged the court from requesting this advice.

Respondents offer a range of solutions to the perceived challenges of delays in report writing. They suggest an alternative fast track system, a service providing reports on the day or within the week that would reduce the demand for full reports. Short/brief reports (screening reports) or verbal reports were seen as means of attaining this. They also suggest that delays would be reduced if other professionals other than psychiatrists were able to provide these. The presence of a mental health professional dedicated to each court was also encouraged. The latter was a central theme discussed by respondents although the breadth of this theme is beyond the scope of this paper. Alternatively a named contact in MHS was seen as essential.

Attention to clear protocol was recommended with attention given to set timescales agreed by both the CJS and MHS. This should include the provision of a clear consent protocol to facilitate release of information by MHS to the CJS if required and the need for clear record keeping from the moment of arrest to disposal.

Theme 2 Content of report

The second theme identified in part 1 of the study related to the content of the report with 191 respondents mentioning this topic. Sentencers were clear about what they wanted a report to contain. They acknowledged that their own knowledge of mental health issues were insufficient and looked to reports to provide this information. They saw reports as resources through which they could better their understanding of the:

- case and the defendant

- up-to date account of the defendant's history, previous/current treatment
- relationship between the criminal behaviour and mental illness-culpability
- public risk
- treatment required and the effect of treatment on future offending
- Impact of sentence on defendant, a prison sentence in particular.
- moral issue of punishment versus treatment
- Wider range of sentencing options, especially in less severe cases.

There was wide variation in perceived quality/usefulness of reports, however, and whether reports in reality satisfied the above needs. Some court workers were very complimentary of reports, others less so. Those who felt reports to be useful, described these as clear and well written in lay language. Psychiatric reports were seen as particularly thorough. They valued the input of the expert in identifying the existence of a mental health issue in the defendant and felt provision was both professional and impartial. Reports were also seen as useful in differentiating mental illness from related drug and alcohol misuse.

For others, reports proved difficult to understand especially when using complex medical terminology. Some reports were seen as vague, inconclusive with no concrete or practical advice relevant or useful as how best to proceed with defendant. The abbreviated reports (e.g. Health and social circumstance-HSC- and general practitioner reports) were described as superficial, identifying little more than the presence of a mental health issue. On the other hand, psychiatric reports could be longwinded and confusing. Sometimes the information within reports, and professional opinion expressed within them appeared conflicting.

Court workers were able to present clear strategies to improve the content of reports. They called for reports that more closely address the requirements of the court especially in terms of clear and concrete recommendations related to sentencing. They saw ready access to the report writer as desirable. A report writer on site, for example, would allow the court to clarify the report content if necessary.

Theme 3 Report Cost

A third key theme that arose from the data related to the cost of report provision. The cost of reports was described by 63 respondents, consensus being that funds available to courts to purchase reports were too low. Respondents identified a range of implications. Firstly, court personnel were loath to request reports because of their expense and some sentencers actively elected for prison as disposal as a cheaper alternative to obtaining a report. Secondly, the cost of the report was in itself inadequate to tempt psychiatrists to provide this service for the low fee offered. Some suggested that psychiatrists

could charge more than suggested guidelines because of the shortage of psychiatrists willing to complete this function. Court workers reported that it was often unclear which service should pay for the report (legal aid versus the court, for example) and that the insufficient funds available to pay for reports meant that the court often refused to take responsibility for finding psychiatrists to conduct them.

Comparison of perceived and actual delays in report delivery

In part 2 the theme of delay was explored further. In monitoring forms sent to the courts, information was extracted on when the court worker expected the report to be returned and when the report was actually returned.

Expectation of when reports should be returned (as reported by court personnel)

Of 35 monitoring sheets returned by the courts, 29 recorded when the report was expected to be returned. Expectations varied widely and ranged from expectations that full reports be returned within 1 week (7 days) to more than three months (95 days). There was some consensus at around 6 -8weeks (42-56 days; 9 of the 21 reports) with an overall average (median) of 45 days (Figure 1).

Court personnel expected abbreviated HSC reports to be returned in a range from 1 week (7days) to 1 month (31 days); Some consensus was shown at between 1 and 2 weeks (7 to 14 days; 6 of the 7 reports) with a median of 10 days. The variation is less extreme than for full reports (Figure 1).

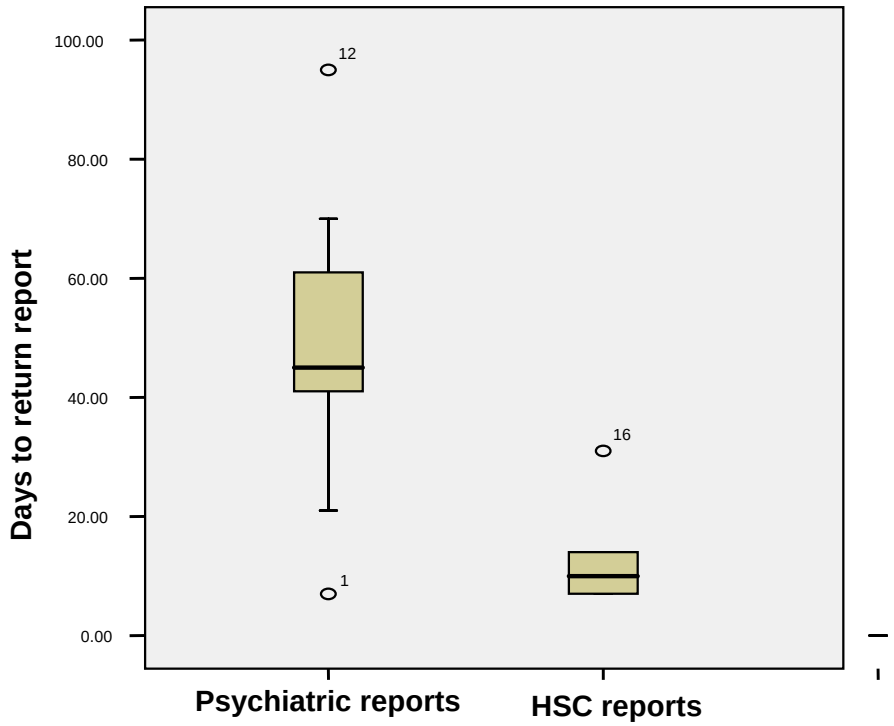

Figure 1: Box plot of days in which reports are expected to be returned to the court

Actual time in which report returned (as reported by court personnel)

Court personnel were asked to record when reports were returned. This information was recorded for 24 of the 35 forms returned. The time in which reports were returned varied widely. For full reports this varied from just over 5 weeks (37days) to around 4 months (124days) with a median of 55.5 days (a figure higher than the 45 days in which reports were expected) (Figure 2). For HSC reports, the time of return ranged from 2 to 18 days, with a median of 10 days (the same as the expected return times).

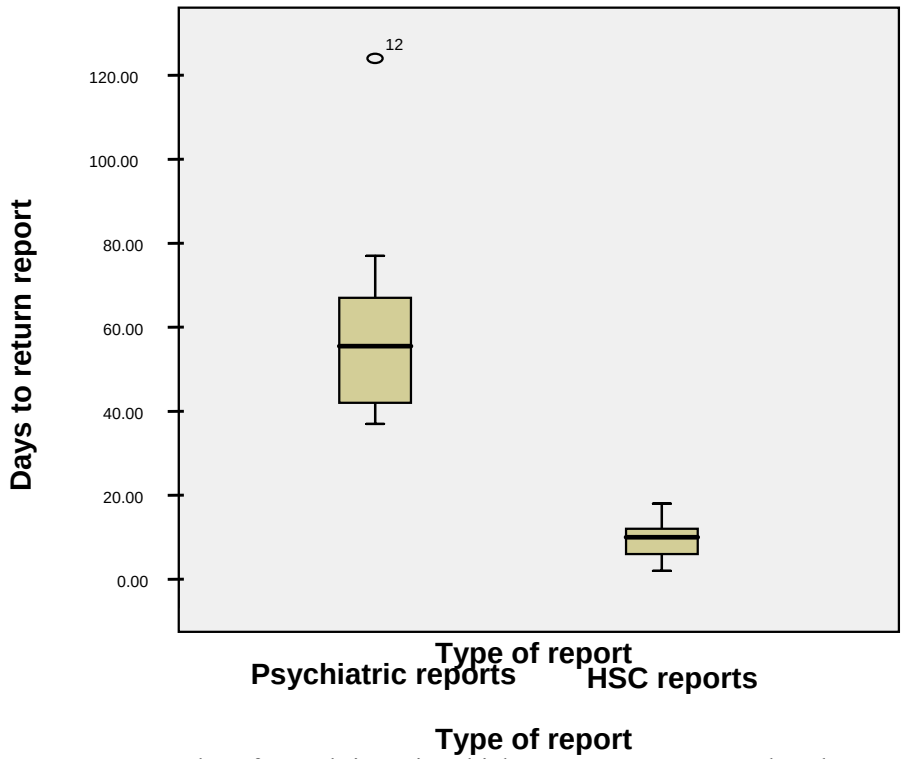

Figure 2: Box plot of actual times in which reports were returned to the court

Differences in time Between Court Expectations and reality

To determine whether there is potential for court personnel to be frustrated by a lack of timeliness in which reports are returned to courts, the expected and actual times in which reports are delivered are compared. A summary of reports that are delayed and those delivered in time or received earlier than expected is made in Table 3.

Table 3: Differences in time Between Court Expectations and Reality

	Full reports	**HSC reports**	**Total**
Number of reports calculated as being delayed	9 (52.9%)	1 (20.0%)	10 (45.5%)
Number of reports calculated as being early or on time	8 (47.1%)	4 (80.0%)	12 (54.5%)
Total	17 (100%)	5 (100%)	22 (100%)

A delay is defined as a negative mismatch between the expected time of delivery and the actual time of delivery. Of 22 comparisons, 10 delays are reported, 9 of which were delays in the return of full

reports. Delays ranged from 30 days to 2 days. Twelve reports were delivered on time or earlier than expected (from same day delivery to 23 days earlier than expected);

Expectation of when reports should be returned (as reported by health personnel)

In monitoring forms sent to the mental health services, information was extracted on when the health professionals expected reports to be completed and when these were actually returned. There are data on 33 reports. Health workers expected reports to be returned between 0 and 262 days. On average (median), full reports are expected back at 55 days and HSC reports within 13 days (Figure 3).

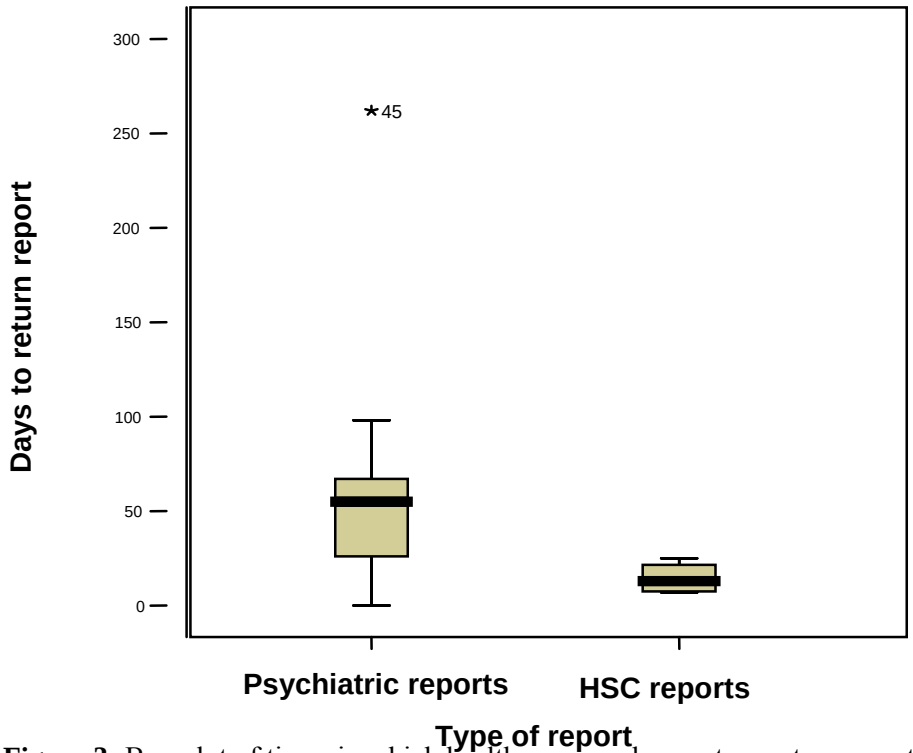

Figure 3: Box plot of times in which health personnel expect reports were returned to the court

Actual time in which report returned (as reported by health personnel)

There is information on actual dates of return in 29 monitoring sheets returned and times vary from the same day to 262 days. Health workers state that full reports are sent back in reality on average (median) in 43.5 days (Figure 4) (quicker than expected time of 55 days) and HSC reports are returned in 55 days (also quicker than anticipated).

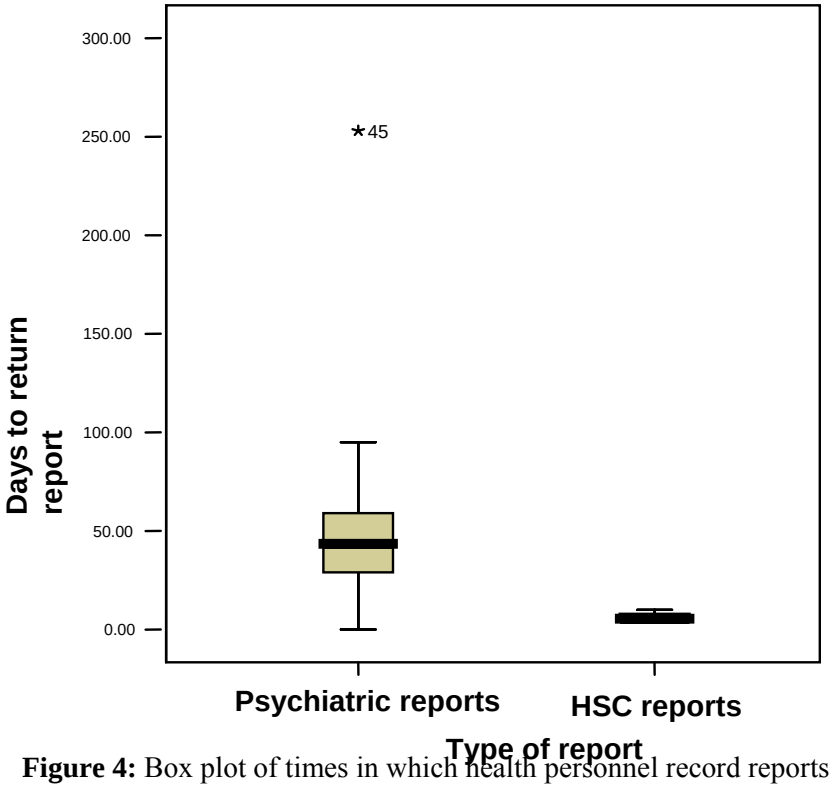

Figure 4: Box plot of times in which health personnel record reports to have actually been returned to the court

Differences in time between health professionals' Expectations and reality

Comparison was made between data on 22 of the reports. Of these (Table 4), only 2 delays were reported (in the case of 1 full report and in 1 HSC report). From the perspective of health personnel, the majority of reports (90.9%) were recorded as being returned earlier than expected.

Table 4: Differences between the expected time of return and actual time in which reports are returned.

	Full report	**HSC report**	**Total**
Number of reports calculated as being delayed	1 (6.3%)	1 (16.7%)	2 (9.1%)
Number of reports calculated as being early or on time	15 (93.7%)	5 (83.3%)	20 (90.9%)
Total	16 (100%)	6(100%)	22 (100%)

Perceived usefulness of reports

The content of the reports were rated quantitatively by court workers in the questionnaire in part 1 of the study. Respondents were asked to rate on a 5point scale how useful they felt written reports to be

generally. Most of the respondents rated the usefulness of written reports highly, i.e. 357 respondents rated the usefulness of the report as 1 or 2 (rating 1 being very useful) (77.5%; n=455) (Table 5).

Table 5: Perceived usefulness of written reports

	Frequency	**Valid Percent**
very useful (1)	191	42.0
2.00	166	36.5
3.00	75	16.5
4.00	14	3.1
not useful at all (5)	9	2.0

The usefulness of reports was confirmed in part 2 of the study, where court contacts were asked to rate the usefulness of the particular report they received (again on a scale of 1 to 5). All abbreviated HSC reports were rated as either neutral (3 reports; rating 3) or less than useful (2 reports, rating 4) (Table 6). There was more variation in opinion when it came to the more detailed full psychiatric reports with 60% (12 reports; n=20) being rated as useful (ratings between 1 and 2). However, 30% of full reports (4 reports; n=20) were given neutral ratings on this scale (rating 3) and 10% (2 reports; n=20) were seen as not useful at all (rating 5).

Table 6: Ratings by court personnel of the usefulness of full psychiatric versus HSC reports

	Full Psychiatric reports	**HSC reports**
very useful	6 (30%)	0
2.00	6 (30%)	0
3.00	6 (30%)	3 (60%)
4.00	0	2 (40%)
not very useful at all	2 (10%)	0
Total	20	5

DISCUSSION

This study explored factors that facilitate the flow of information between the courts and the mental health services. From the perspective of court workers, three key challenges to this information transfer have been identified. These are the delays in receiving reports from the mental health services, the content of reports and the cost of the reports

Court personnel perceive there to be unacceptable delays when waiting for reports on the mental health of defendants. They see this as having a negative impact on both court process and the defendant themselves. By identifying delays as a key issue, and recognising that abbreviated reports such as screening reports are a way of alleviating these delays, respondents have confirmed findings of other studies nationally and internationally (Vaughn, 2004; Grondahl *et al,* 2007). They suggest other measures in addition to this that include a change in the division of labour surrounding report writing, moving towards a greater involvement of a wider range of mental health professionals. Recommendations also include a health professional in court or at least a named contact within the MHS and to whom assessments could be addressed. Clear protocols, in which joint expectations of appropriate timing are shared, are other ways respondents believe delays may be reduced. In general, therefore, respondents are looking towards improving and clarifying the systems of communication between services.

Although delays are reported as a key issue, actual delays in report writing may not be as wide spread as court workers perceive them to be. From the court workers' perspective, only just over half of full reports are delayed in reality and from the health services view point only 1 of 16 reports are delayed. The courts expect full reports to be returned on average within 45 days whereas health services expect these should be returned on average in 55 days. Furthermore, there is wide variation within the court responses themselves on what the expected time of report returns should be. The difference observed here between the expectations of health professionals and court workers points to a lack of consensus on the timeframes in which reports should be delivered. This may lead to the frustrations illustrated in the qualitative data presented in this article. There is a need to align expectations between services with clear and shared guidelines in which time frames are agreed and made transparent during interagency working and communications.

A failure of communication across services takes place in other ways at a number of levels. The study has shown that there is also a lack of shared expectation when it comes to the content of reports as well. Court workers list the information they required in a report to assist them in their decision making (e.g. an indication of the relationship between criminal behaviour and mental illness-, an understanding of public risk). Although reviews of reports lacked consensus and ratings of reports varied (See Table 5 and 6), it is suggested that not all reports provide the information the courts require. Variation in opinion suggests the quality and content of reports may differ from service to service and from one health professional to another. It may also occur because the purpose and scope of a psychiatric or other report is not understood equally across services and the feedback channels on the content of the report from the court back to the mental health service provider are not well developed.

As data suggests that reports are not standardised and that their quality may be a factor of the skill of the writer, a standardised reporting system with clear guidelines and training would be recommended for report writers to ensure that all reports are of the quality required. Report writers should also be reminded to consider the audience for whom they are writing in terms of both the content they provide and the language they employ. Further research is also required to explore the shared understanding of the purpose of a court report by both services. An investigation of the current feedback mechanisms and ways of developing these is also required.

There is a potential conflict between the two challenges identified around delays and the content of the report. Some respondents suggest the increased use of abbreviated reports as a means of decreasing the number of requests for lengthier fuller psychiatric reports However, qualitative data and the ratings of HSC versus psychiatric reports (Table 6) suggest that respondents perceive more detailed reports as far more useful. Therefore, although it may be suggested that abbreviated reports be used as quick screening tool to pre-empt a full psychiatric report, the outcomes of such an intervention may not be wholly straightforward. This is confirmed by Grondahl *et al,* 2007 evaluation of screening reports who questioned the validity of the system and whether the use of screening reports was fully understood by court professionals. A further evaluation of the system in the UK context is now required.

Finally, the costs of reports and who pays for the report was the third challenge. Although extra financial resources may be a solution, clear communication on how financial resources will be managed and made available is likely to be equally if not more effective. Clarity on the level of fees and the key services to whom they will be directed could provide a sustainable and regular service. Block contracts pre agreed between CJS and MHS in which costs are predetermined and a set number of reports are purchased is one strategy. This would prevent the uncertainty around fees, failure by both services to seek out or provide reports and the difficulties in locating services to provide reports in sufficient time periods

Conclusion

The study has identified three challenges at the interface of interagency working between the mental health services and the criminal justice system. All three challenges (delays in report writing, the report content and the costs of reports) appear to be products of poor interagency communications and caused by a lack of a clear and shared protocol outlining the agreed timelines, court requirements and lines of responsibility related to resource provision. There is evidence that a mismatch in expectation around the content of reports and in expected time frames for report delivery may lead to frustrations that hinder interagency working. It is hoped that the Service level agreement drawn up as part of the South West Mental Health Assessment Pilot project will work towards achieving some clarity and improved systems that facilitate information transfer between services.

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9.9. Interim report 1

Bournemouth University

INTERIM REPORT

REPORT ON PHASE 1 BASELINE OF THE EVALUATION OF THE SOUTH WEST MENTAL HEALTH ASSESSMENT AND ADVICE PILOT

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MAY 2008

INTRODUCTION

Many requests are made by Magistrates' and Crown Courts for psychiatric opinions on defendants who may have a mental health issue. These requests are made of Mental Health services. This need to communicate across sectors is often a difficult and lengthy process.

If these processes are not functioning optimally the psychiatric advice required in court may not be forthcoming or be delayed. Defendants may then wait unnecessarily long periods on remand and their disposal may occur without the benefit of such advice. Mentally disordered offenders sometimes face, therefore, inappropriate imprisonment or fail to access community support.

In response to this, the South West Health and Social Care in Criminal Justice (HSCCJ) Partnership Board are working with Her Majesty's court service to improve the service available to defendants appearing in court who are presenting as having mental health difficulties.

A Service Level Agreement (SLA) has been developed that is clear about:

- responsibilities
- timescales
- fees and mechanisms to pay
- costs to other organisations
- governance agreements

It is hoped that the implementation of this agreement will bring about:

- A reduction in the length of time defendants with mental health problems are remanded in custody.
- Improved links between Prison Mental Health Care Services, Courts, Community Health Care Teams, Police and Probation Services.
- A reduction in the number of prisoners with serious Mental Health problems needing to be transferred from prison to hospital.

Selected magistrates and crown courts in Hampshire, Bath and Bristol have been involved in the pilot of the SLA. Before the implementation of the pilot, there was a different level of service across the courts in the pilot areas:

In Hampshire, a protocol had been drawn up in 2003 that provided the magistrates' courts with access to information about a defendant's mental health through the provision of a Health and Social Circumstances (H&SC) report. This involved the courts being able to request in the first instance an abbreviated report from local Community Mental Health Teams (CMHT's) or Mentally Disordered Offenders (Mendos) schemes depending on the area of residence of the defendant. This protocol allowed for the courts to access H&SC reports without making a payment. However, if psychiatrist report was required subsequently, a fee would be paid in the normal way. If a H&SC report suggested that a psychiatric report was needed, in many areas, it was up to the court to find a psychiatrist to carry out the assessment.

In addition to the HSC protocol, there is an agreement between the local medium secure unit and the crown courts in Hampshire. Wessex Forensic Psychiatry Services agreed to prepare reports requested from the crown courts within an agreed timescale. Reports prepared were paid for on receipt of an invoice in the usual way.

Bath Magistrates' court have no service. Bristol Magistrates' court have a Court Assessment and Referral Scheme (CARS). This was implemented by the Criminal Justice Liaison Service in Avon and Wiltshire Partnership NHS Trust (AWP). The scheme has its own steering group and is funded directly by Bristol PCT. The scheme began in 2005 and has developed as part of the pilot.

Bristol Crown Court have an informal agreement with the medium secure unit in which forensic psychiatrists prepare reports requested by the court. There is no agreed protocol formalising this agreement including relevant timescales.

The current report presents the findings of one part of an evaluation of the quality of existing services between the courts and health services. This produces baseline information upon which the effectiveness of the SLA can be evaluated. The outcome of the first phase of this baseline stage, specifically assessing the demand for reports, is presented here in full. Progress on a second phase of the baseline stage, assessing the views of court and mental health service personnel is also presented..

OBJECTIVES OF STUDY

The overall objective of the study is to evaluate the effectiveness of the Service Level Agreement introduced into Bath magistrates, Bristol Magistrates and Bristol crown courts.

The objectives of the first phase of the baseline study are to explore:

- the demand for Mental Health Assessment of defendants in contact with the Criminal Justice System
- the existing links between the court services making this demand and the health services providing assessment.
- the level of involvement of court and health personnel at the interface of the health and court services
- the timeliness of Mental Health Assessment provision
- the disposal and remand outcomes for defendants requiring Mental Health assessment.
- the levels of satisfaction with Mental Health assessment.

METHODOLOGY

Method

To evaluate the impact of the SLA upon health and court services, a longitudinal design comprising of two data collection points was implemented:

- Pre SLA implementation (baseline audit),
- Post SLA implementation (final audit)

Each data collection point will involve two phases:

- Phase 1: Monitoring of service demand
- Phase 2: A satisfaction survey of court and mental health service personnel

This document focuses on the outcomes of phase 1 of the Pre SLA implementation (baseline audit).

A monitoring form (appendix 9.1) was distributed to key contacts in the *court services* participating in the project. The contact was requested to complete this form for every incidence in which a request for

mental health assessment/report was made of mental health services and which was paid for directly by this court service. This precluded reports requested for and paid for by defence solicitors as well as reports paid for through legal aid. The data collection period was between 15 May 2007 and 31 December 2007. Forms were collected monthly from each contact. The form collected data on a range of variables including the

- Number and type of psychiatric reports, assessment and advice requested
- The health service from which psychiatric reports, assessment and advice are requested
- The timeliness in which reports, assessment and advice are received
- The usefulness of reports, assessment and advice received
- The number of case adjournments
- The status of defendants (Bail, remand)
- The demographic details, offence and means of disposal of the defendant

A similar and complementary monitoring form (see Appendix 9.2) was distributed to key contacts in *the mental health services* to collect monthly data on a range of variables including the

- Number and type of psychiatric reports, assessment and advice requested of the service by the courts
- The court service from which psychiatric reports, assessment and advice are requested
- Whether the defendant is known to the health service
- The time taken for reports, assessment and advice to be completed and reasons for any delays
- The appropriateness of the referral
- The type of mental health worker completing the report, assessment and advice

Monitoring sheets recorded defendants case and health record numbers (the latter anonymised) in order that duplicate cases recorded by both court and mental health service could be identified.

Instrument development

The two monitoring forms were designed and piloted in conjunction with the SLA project manager and the steering group of the project. These members represented members of both the health and court services. These members were used as a panel of judges felt to have the expertise and experience in both services to be able to comment on the content and construct validity of the questions employed.

Sample

Forms were administered to contacts in a convenience sample of court services selected by the project manager of the SLA as part of the pilot implementation project. These services represented 1 crown court (Bristol Crown Court) and 2 magistrates' court (Bristol and Bath magistrates' courts) within the

counties of Avon and Wiltshire and the 4 crown courts (Winchester Crown, Isle of Wight Crown, Portsmouth Crown and Southampton Combined Courts) and 4 magistrates' courts (Isle of Wight, Basingstoke, Southampton and Portsmouth magistrates' court) in the county of Hampshire.

Ethical considerations

The monitoring sheets and associated electronic databases were stored securely in the offices of Bournemouth University under the custodianship of the report authors. Raw data was only made available to the report authors and no one else. Information (other than court and mental health service name) that was provided to project leaders, the steering group has been anonymised in this report. Both of these will also be anonymised in any academic dissemination of the findings. Monitoring sheets will be stored for 5 years and then destroyed. Members of the court who provided completed monitoring sheets and the defendants associated with the record have the right to check the accuracy of data held about them and correct any errors.

RESULTS OF PRE SLA BASELINE DATA: PHASE 1: MONITORING OF SERVICE

Demand

The results presented in this section are the outcome of the analysis of the pre SLA baseline line data collected in phase 1. Individual monitoring sheets were completed for each defendant requiring mental health assessment over the data collection period. 47 monitoring sheets were returned from court services. 50 monitoring sheets were returned from the mental health services. Duplicate cases were removed where data collected in both sheet was the same (e.g. demographic data; court in which defendant is in contact). Monitoring sheets in which a mental health problem had been assessed but in which no report was requested were also removed.

Demographics

The demographics of the defendants recorded (see Table 1, II and III) show that defendants tend to be younger males, of a white background.

Table I: Age of defendants

	Frequency	Percent
18-20	6	8.6
21-30	21	30.0
31-40	9	12.9
41-50	12	17.1
51-60	6	8.6
61-70	1	1.4
Total	55	78.6
Missing	15	21.4
Total	70	100.0

Table II: Gender of defendants

	Frequency	Percent
Female	7	10.0
Male	62	88.6
Total	69	98.6
Missing	1	1.4
Total	70	100.0

Table III: Ethnicity of defendants

	Frequency	Percent
White	52	74.3
Other	2	2.9
	54	77.1
Missing	16	22.9
Total	70	100.0

MOST SERIOUS OFFENCE

Most offences related to assault and theft/robbery and harassment (see Table IV). This question was asked in both health and court versions of the monitoring sheets. The vast majority of respondents from health services did not answer this question suggesting they may not be aware of the nature of offence or choose to ignore this in their assessment (44 of the 50 monitoring sheets completed by health service: -88% -did not complete this question).

Table IV: The main offence of which defendant is accused

Offence	Number of defendants committing offence as registered by court personnel	Number of defendants for whom assessment requested by court	Number of defendants committing offence as registered by health professionals
Assault	12	7	1
Theft/robbery	8	7	3
Harassment	6	3	1
Sex offence	4	4	1
Criminal damage	3	1	0
Public Nuisance	3	3	0
Breach of order	2	2	0
Possession of weapons	2	2	0
Possession of drugs	1	1	0
Driving offence	1	1	0
Attempt murder	1	1	0
Arson	1	1	0
Bomb hoax	1	1	0
Driving offence	1	0	0

SUPPLY AND DEMAND

In this section the demand for reports, the type of reports requested and the services providing these reports are explored.

Demand

Tables V, VI and VII give an indication of the demand for court reports (as filed by each court service specifically) across the regions in the pilot. Reports were collected from Mid May to December 2007. Most report request came from Southampton and Winchester Combined/Crown Courts and the IOW magistrates court with about 10 requests for reports being recorded each over about a 6 month period. July and November were particularly busy months in terms of the number of reports requested. Of the 70 reports, 11 had no date or court data associated with records.

Table V: Demand for all reports made by court services over data collection period (excluded youth report)

Court	Bristol Crown Court	Bristol Magistrates Court	Bath Magistrates	IOW Magistrate	IOW Crown Court	Southampton Crown Court	Southampton Magistrates	Southampton Youth	Portsmouth Crown	Portsmouth Magistrates	Basingstoke Magistrate	Winchester Crown Court	Total
Reports requested	8	7	4	10	1	10	4	1	8	2	4	10	69

Table VI: Demand for all reports made by court services broken down by month of data collection

2007	Bristol crown court	Bristol magistrates court	Bath magistrates	IOW Crown Court	IOW magistrate	Southampton magistrates	Portsmouth crown court	Portsmouth magistrates	Southampton youth	Winchester crown court	Southampton crown court	Basingstoke magistrate	Total
May	3	0	0	0	1	0	0	1	1	0	0	0	6
June	0	0	2	0	1	0	1	0	0	2	3	0	9
July	1	0	1	0	1	0	0	1	0	4	3	0	11
Aug	2	1	0	1	0	2	0	0	0	1	0	1	8
Sept	1	4	0	0	0	0	0	0	0	0	1	1	7
Oct	0	1	0	0	1	0	1	0	0	0	2	0	5
Nov	1	0	0	0	5	0	3	0	0	1	0	1	11
Dec	0	0	0	0	1	0	1	0	0	0	0	0	2
Total	8	6	3	1	10	2	6	2	1	8	9	3	59

Type Of Reports

Of the 69 reports: 11 were Health And Social Circumstance Reports; 5 were recorded as oral/verbal, informal or other reports and 27 were full reports; there were 7 reports for which there was no information.

Table VII: Type of reports requested

	Frequency	Percent
psychiatric report	27	39.1
forensic psychiatric report	18	26.1
health and social circumstance report	11	15.9
informal advice/oral report/other	5	7.2
clinical psychologist report	1	1.4
Total	62	89.9
Missing	7	10.1
	69	100.0

Services Providing Reports

Table VIII maps the services to which courts are turning to complete their reports. In Hampshire there is a strong reliance on Ravenswood House to conduct full reports. In Bristol, Fromeside is a key service as are independent psychiatrists.

Table VIII: The type of court reports requested by court and mental health service/

		Bristol crown court	Bristol magistrates court	Bath magistrates	Southampton crown court	Southampton youth	Southampton magistrates	Portsmouth crown	Portsmouth magistrates	Winchester crown court	Basingstoke magistrate	IOW Magistrate	IOW Crown Court	
	Ravenswood (Wessex forensic psychiatry services)	0	0	0	8	1	0	8	0	8	1	0	1	27
	Fromeside	8	0	0	0	0	0	0	0	0	0	0	0	
	Prisons	0	0	1	0	0	0	0	0	0	0	0	0	
	Independent psychiatrist	0	3	2	0	0	0	0	0	0	0	0	0	
	Susan Britton Wills Unit of general hospital	0	1	0	0	0	0	0	0	0	0	0	0	
	CARS agreed to obtain psychiatric assessment	0	1	0	0	0	0	0	0	0	0	0	0	
	Mental health access and treatment service seven acres	0	0	0	0	0	0	0	0	0	0	1	0	
	East Wight CMHT	0	0	0	0	0	0	0	0	0	0	1	0	
	Total	**8**	**5**	**3**	**8**	**1**	**0**	**8**	**0**	**8**	**1**	**2**	**1**	**45**
e	**MENDOS**	0	0	0	0	0	1	0	2	0	1	4 *(recorded as mendos although no official service*	0	
	HMP Parkhurst	0	0	0	0	0	0	0	0	0	0	1	0	
	Mental health access and treatment service seven acres	0	0	0	0	0	0	0	0	0	0	2	0	
	Total	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**2**	**0**	**1**	**7**	**0**	**11**
	CARS		2											
	MENDOS						1				2			
	Total		**2**											
														61

PERSONNEL INVOLVED

Personnel in court who ask for reports

To identify key personnel involved in requesting and responding to requests for mental health assessment, court and health personnel were asked to indicate from whom requests had originated. Most requests for reports appear to originate from the judge of magistrate (Table IX).

TABLE IX: Court personnel from whom requests originated

		Full psychiatric reports	**HSC reports**	**other**	Total
from whom did the request for advice originate	**legal advisor**	6	3	0	9
	judge/magistrate	20	4	2	26
	probation	3	0	0	3
	defense or legal team/solicitor	7	2	0	9
	defendant	0	0	1	1
	MENDOS	0	0	1	1
	Total	36	9	4	49

Who Completed Report

Health personnel were also asked to record who had completed the report in each case. Generally, full reports were completed by trained psychiatrists and the HSC reports by other mental health workers (Table X). In 2 cases, however, full reports were recorded as having been completed by mental health workers.

TABLE X: Mental health personnel completing reports

		Full report	**HSC report**	**Other**	Total
who provided assessment/report	**forensic consultant psychiatrist**	8	0	0	8
	specialist registrar in forensic psychiatry	4	0	0	4
	specialist registrar psychiatrist	3	0	0	3
	mental health worker	2	4	2	8
	an administrator (discharge summary)	0	0	1	1
Total		17	4	3	24

TIMELINESS

Court personnel were asked to record data on when reports were requested, were expected to be retuned, when they actually retuned and any reasons for delays. Health service personnel were asked similar questions although they were asked additional information on when the defendant was seen.

Court Expectations

Of 35 monitoring sheets returned by the courts, 29 had recorded this information (Table XI). The expectations of court personnel as to when reports will be returned appear to vary. For full reports this varies from 1 week (7 days) to more than three months (95days); There is consensus at around 6 -8weeks (42-56 days; 9 of the 21 reports) with an average (median) of 45 days (Figure 1). The variation in expectations is marked. For HSC reports expected return times ranges from 1 week (7days) to 1 month (31 days); Some consensus is shown at between 1 and 2 weeks (7 to 14 days; 6 of the 7 reports) with a median of 10 days. Generally the variation is less extreme than for full reports with greater clarity (less variation) in what is expected of HSC reports than what is expected in terms of the fuller reports.

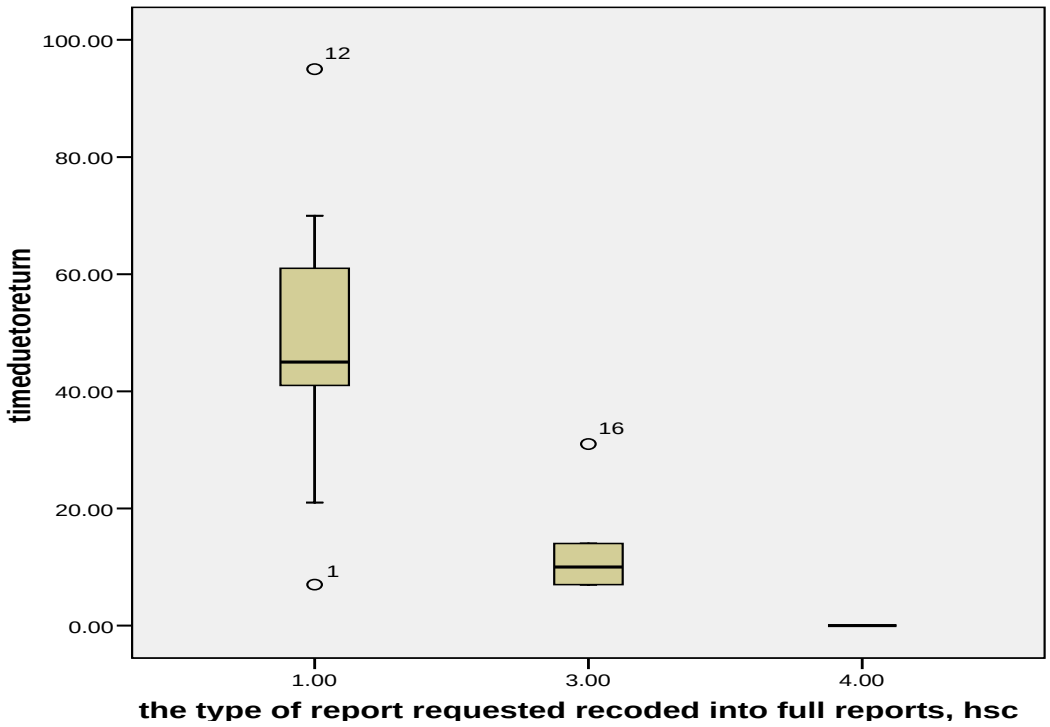

Figure 1: Box plot of times in which reports are expected to be returned to the court (1= full reports; 3=HSC reports; 4=informal advice)

Table XI: The time with which reports are expected to be returned

		Full reports	HSC reports	Informal advice	Total
Time due to be returned in days	.00	0	0	1	1
	7.00	1	3	0	4
	10.00	0	1	0	1
	14.00	0	2	0	2
	21.00	1	0	0	1
	27.00	1	0	0	1
	31.00	0	1	0	1
	32.00	1	0	0	1
	35.00	1	0	0	1
	41.00	1	0	0	1
	42.00	4	0	0	4
	45.00	2	0	0	2
	49.00	1	0	0	1
	56.00	2	0	0	2
	61.00	1	0	0	1
	63.00	1	0	0	1
	67.00	1	0	0	1
	69.00	1	0	0	1
	70.00	1	0	0	1
	95.00	1	0	0	1
Total		21	7	1	29

Court Reality

Court personnel were asked to record when reports were retuned. Of 35 reports, we have information on 24 of these. The time in which reports are returned again vary (Table XII). For full reports this varies from just over 5 weeks (37days) to around 4 months (124days) with a median of 55.5 days (a figure higher than the 45 days in which reports were expected) (Figure 2). Again the variation with which reports are returned is high. For HSC reports, time of return ranged from 2 to 18 days, with a median of 10 days (the same as the expected return times).

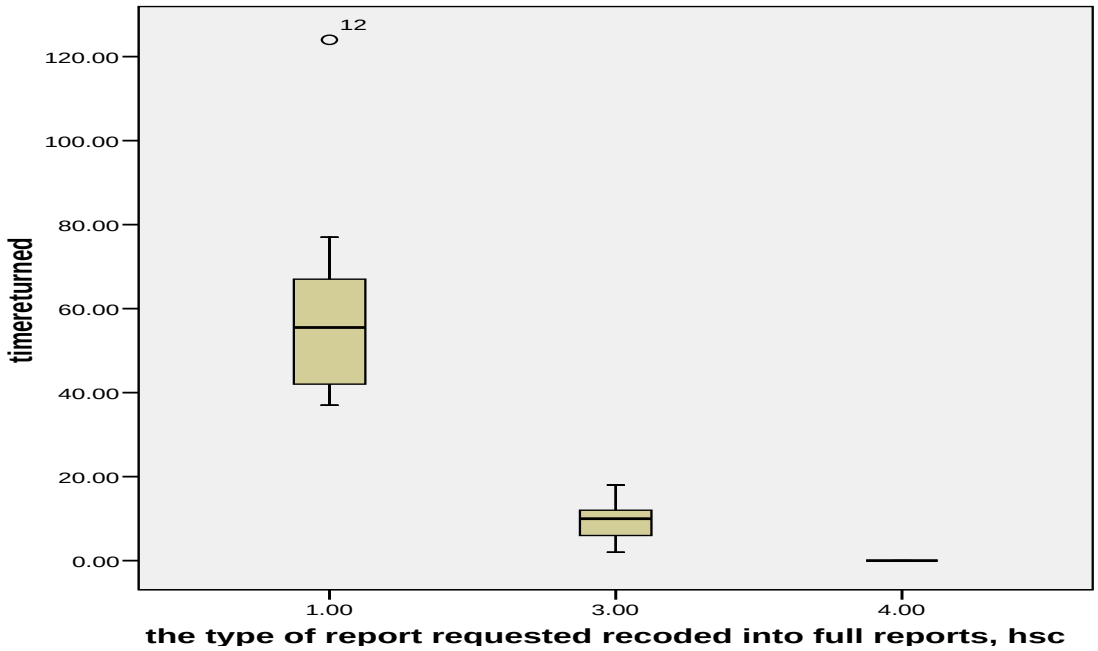

Figure 2: Box plot of actual times in which reports were returned to the court (1= full reports; 3=HSC reports; 4=informal advice)

Table XII: The actual times in which reports were returned to court

		Full reports	HSC reports	Informal advice	Total
Time returned (in days)	.00	0	0	1	1
	2.00	0	1	0	1
	6.00	0	1	0	1
	10.00	0	1	0	1
	12.00	0	1	0	1
	18.00	0	1	0	1
	37.00	1	0	0	1
	39.00	1	0	0	1
	41.00	1	0	0	1
	42.00	3	0	0	3
	47.00	1	0	0	1
	50.00	1	0	0	1
	55.00	1	0	0	1
	56.00	3	0	0	3
	59.00	1	0	0	1
	67.00	1	0	0	1
	71.00	1	0	0	1
	72.00	1	0	0	1
	77.00	1	0	0	1
	124.00	1	0	0	1
Total		18	5	1	24

Differences in time Between Court Expectations and reality

To determine whether there is potential for court personnel to be frustrated by a lack of timeliness in which reports are retuned to courts, the expected and actual times in which reports are delivered are compared. A comparison was possible in 23 of the reports (Table XIII).

Table XIII: Differences in time Between Court Expectations and Reality

			Full reports	HSC reports	Informal advice	Total
Time differences (in days)	-30.00	DELAYED	1	0	0	1
	-29.00		1	0	0	1
	-25.00		1	0	0	1
	-21.00		1	0	0	1
	-16.00		1	0	0	1
	-15.00		1	0	0	1
	-10.00		1	0	0	1
	-7.00		1	0	0	1
	-4.00		0	1	0	1
	-2.00		1	0	0	1
	.00		1	1	1	3
	1.00	EARLY	1	1	0	2
	2.00		0	1	0	1
	3.00		1	0	0	1
	5.00		0	1	0	1
	7.00		1	0	0	1
	8.00		1	0	0	1
	11.00		1	0	0	1
	15.00		1	0	0	1
	23.00		1	0	0	1
	TOTAL		17	5	1	23

Of the 23 comparisons, 10 were reported delays, 9 of which were delays in the return of full reports. Delays ranged from 30 days to 2 days. However on a positive note, 10 requests for assessment were delivered on time or earlier (from same day delivery to 23 days earlier than expected);

Reasons For Delays

Some court respondents gave reasons as to why they thought reports might have been delayed (if this was in fact the case). Reasons put forward included:

- Being unable to find someone to do the report
- Requests being directed at inappropriate services
- Administrative errors

The majority of respondents indicated that they did not know why the report had been delayed. Phase 2 of the baseline data explore these themes in greater detail.

Health Expectations

To understand the reasons for any potential delay in reports back to the court, health professionals were also asked to indicate by when they expected reports to be completed, actually retuned, as well as in what time they were able to see the defendant after a request for assessment had been made.

There is data on 33 reports. Health workers expected reports to be returned between 0 and 262 days (Table XIV). On average (median), full reports are expected back at 55 days and HSC reports within 13 days (Figure 3).

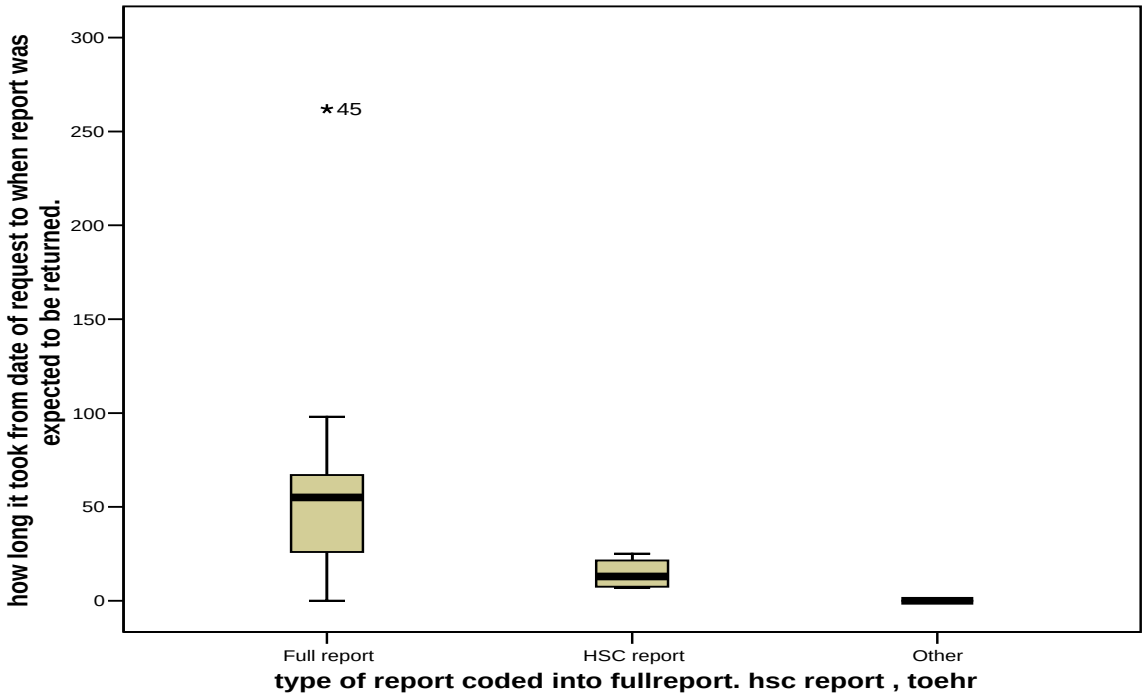

Figure 3: Box plot of times in which health personnel expect reports were returned to the court

Table XIV: Days in which reports are expected back to the courts

		Full report	HSC report	Other	Total
How long it took from date of request to when report was expected to be returned (days).	0	2	0	4	6
	6	1	0	0	1
	7	0	3	0	3
	8	0	1	0	1
	10	1	0	0	1
	18	0	1	1	2
	21	1	0	0	1
	25	0	1	0	1
	28	1	0	0	1
	31	1	0	0	1
	36	1	0	0	1
	38	1	0	0	1
	40	1	0	0	1
	46	1	0	0	1
	50	1	0	0	1
	51	1	0	0	1
	54	1	0	0	1
	56	1	0	0	1
	58	1	0	0	1
	60	1	0	0	1
	65	1	0	0	1
	69	1	0	0	1
	77	1	0	0	1
	98	1	0	0	1
	262	1	0	0	1
Total		22	6	5	33

Health Reality

There is information on actual dates of return in 29 monitoring sheets returned (of 50) and times vary from the same day to 262 days (see Table V). Health workers state that full reports are sent back in reality on average (median) in 43.5 days (Figure 4) (quicker than expected time of 55 days) and HSC reports are returned in 55 days (also quicker than anticipated).

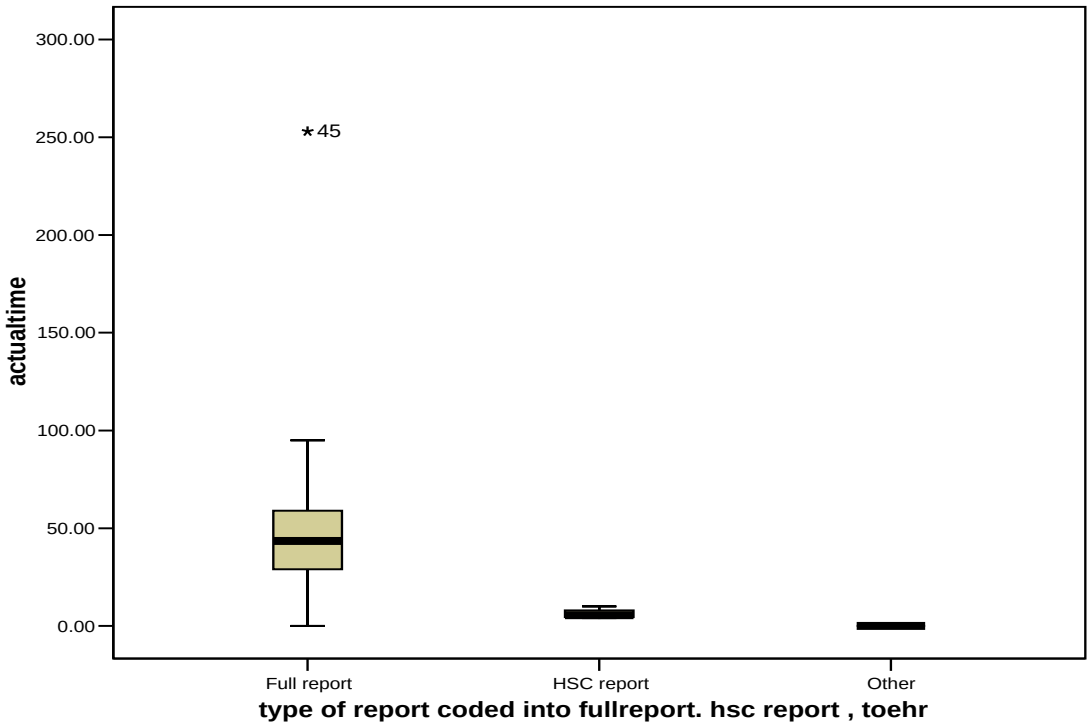

Figure 4: Box plot of times in which health personnel record reports to have actually been returned to the court

Table XV: Days in which reports are sent back to the courts

		Full report	HSC report	Other	Total
Actual time in which reports returned to court (in days)	.00	1	0	5	6
	4.00	0	2	0	2
	5.00	0	1	0	1
	6.00	1	1	0	2
	10.00	0	1	0	1
	13.00	1	0	0	1
	19.00	1	0	0	1
	27.00	1	0	0	1
	31.00	1	0	0	1
	32.00	0	1	0	1
	33.00	1	0	0	1
	35.00	1	0	0	1
	39.00	2	0	0	2
	48.00	1	0	0	1
	52.00	2	0	0	2
	56.00	1	0	0	1
	62.00	1	0	0	1
	70.00	1	0	0	1
	95.00	1	0	0	1
	253.00	1	0	0	1
Total		18	6	5	29

Differences Between Health Expected And Reality:

Comparison was made between data on 27 of the reports. Of these (Table XVI), only 2 delays were reported (in the case of 1 full report and in 1 HSC report. From the perspective of health personnel, the majority of reports were recorded as being returned earlier than expected.

Table XVI: Differences between the expected time of return and actual time in which reports are returned.

			Full report	HSC report	Other	Total
difference between expected time and actual time (in days)	-27.00	DELAYED	1	0	0	1
	-25.00		0	1	0	1
	.00	EARLY	3	0	4	7
	1.00		1	0	0	1
	2.00		0	1	0	1
	3.00		1	2	0	3
	6.00		1	0	0	1
	7.00		2	0	0	2
	8.00		3	0	0	3
	9.00		2	0	0	2
	11.00		1	0	0	1
	13.00		0	1	0	1
	15.00		0	1	0	1
	18.00		0	0	1	1
	21.00		1	0	0	1
Total			16	6	5	27

Reasons For Delays In Court Reports From Health Perspective

Again few reasons were given as to why delays may occur. From the health workers perspective delays in report writing may be related to:

- *Difficulties in obtaining court information.* e.g., Information from the court on a previous conviction was not easily accessible and the health worker felt this delayed report writing.
- *A defendant being unknown to service.* Writing the report appears challenging if this is the case. Suggestions are made that reports should be requested of services that have had previous contact with defendant to facilitate this process.
- *Little time for assessment*: some felt they were given little notice in which to complete reports

- In the case of informal or HSC reports, delays may have occurred if the mental health worker was *unaware that an assessment was required* or a request for an assessment made.
- *Lack of administrative information* . One record indicated that no obvious court contact . Request came in with no clear contact name or the date when request had been made.

Knowledge Of Defendant

One possible reason for a delay in a court report (as mentioned above) may relate to whether the defendant has had previous contact with the service providing the report. An assumption is that the service will provide a speedy report if the defendant is already known to the service. If true then the relatively high numbers of defendants that are not currently known (61.4%; n=44) (Table XVII) or have had no contact in the past (45.5%; n=44) (Table XVIII) with the service providing the report is of some concern. Directing defendants and report requests towards services with whom defendants have had previous contact would seem obvious, however, the practical implications of this may be a limiting factor. The relationship between current/previous contact with the defendant and the speed with which court reports are delivered should be explored in greater depth.

Table XVII: Current contact of defendant with mental health service providing report

		Frequency	Valid Percent
	Yes	17	38.6
	No	27	61.4
	Total	44	100.0
Missing		6	
Total		50	

Table XVIII: Previous contact of defendant with mental health service providing report

		Frequency	Valid Percent
Valid	Yes	24	54.5
	No	20	45.5
	Total	44	100.0
Missing		6	
Total		50	

Appropriateness Of Request

Another potential reason for delays in court reports is that reports are being requested unnecessarily or alternatively being directed at inappropriate services unable to comply with their requests. Health respondents were therefore requested to indicate whether reports had been appropriate (Table XIX) and whether these requests had been directed at the correct service.

Table XIX: Perceived appropriateness of type of court request

		Frequency	**Valid Percent**
was type of assessment/advice/report requested appropriate	Yes	24	82.8
	no	5	17.2
	Total	29	100.0
	Missing	5	
Total		34	

Most of the cases that responded to this question believe the requests made were appropriate (82.8%; n=29). Reasons for indicating that request was inappropriate related to the fact that the mental health worker believed that:

- The defendant had no psychiatric history or that there was no evidence of a mental disorder.
- That the service did not conduct the type of report requested of them by the courts
- The service felt they couldn't add to the report already conducted by probation.

Similarly most of respondents believed the requests had been made of the appropriate service (78.6%; n=28).

Table XX: Perceived appropriateness of service to which request was made

		Frequency	Valid Percent
was type of service to which request was sent appropriate	Yes	22	78.6
	No	6	21.4
	Total	28	100.0
	System	6	
Total		34	

Reasons for indicating that an inappropriate service had been accessed related to:

- the defendant not being from the health service's catchment area,
- the belief that a referral to another community service that had worked with the defendant previously or who were better suited to deal with the nature of their mental illness, would be more appropriate.

Again phase 2 of the study explores these issues with greater depth.

TIME TAKEN TO SEE DEFENDANT AFTER REQUEST FOR ASSESSMENT HAS BEEN MADE

Information was available on 34 (of 50 reports). Times varied ranging from the same day to 253 days after the request was made (Table XXI). On average (median), patients are seen 24 days after a Full Report request (Figure 5).

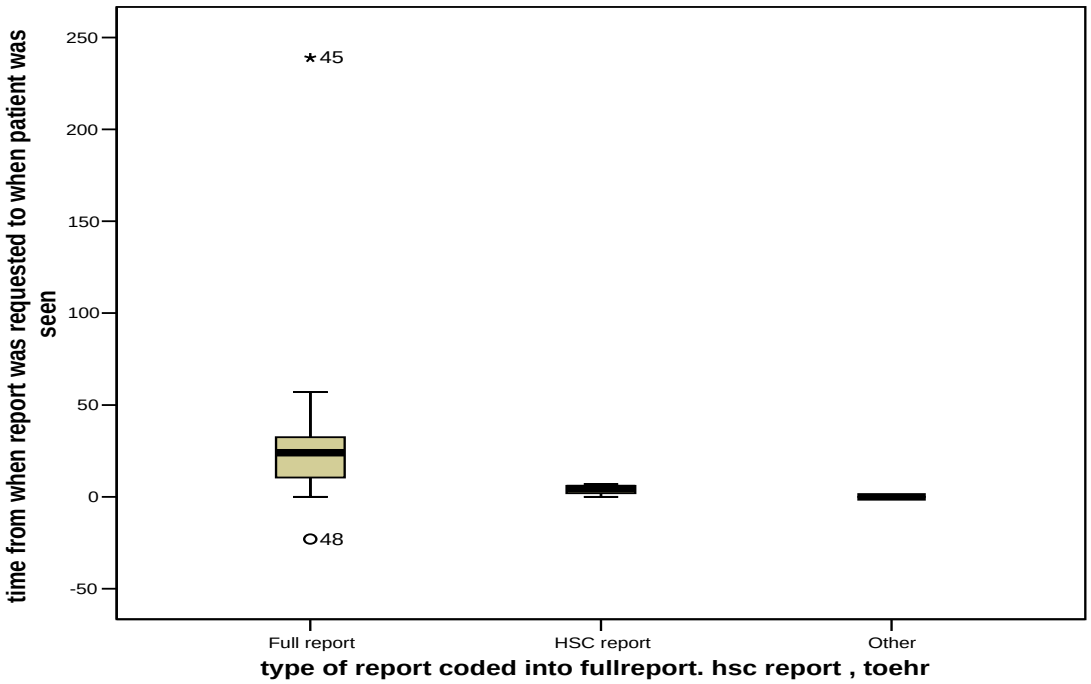

Figure 5: Box plot of time between date of request and when health worker assessed defendant

Table XXI: Days taken from time of request to seeing defendant

		Full report	HSC report	Other	Total
time from when report was requested to when defendant was seen	-23*	1	0	0	1
	-22*	1	0	0	1
	0	2	1	4	7
	1	1	0	0	1
	4	0	1	0	1
	5	0	1	0	1
	7	1	1	0	2
	9	2	0	0	2
	12	2	0	0	2
	19	1	0	0	1
	21	1	0	0	1
	24	2	0	0	2
	25	3	0	0	3
	27	1	0	0	1
	31	1	0	0	1
	32	1	0	0	1
	34	2	0	0	2
	37	1	0	0	1
	57	1	0	0	1
	81	1	0	0	1
	239	1	0	0	1
Total		26	4	4	34

The negative figures (*Table XXI) calculated through a comparison of the date the request was registered with the date when the defendants are seen by health/social care professional indicate that the dates recorded on monitoring sheets may not always be accurately completed by those completing the monitoring sheet. This may reflect the lack of formalized time scales and recording systems currently in place. Respondents may therefore be forced to record these figures from memory and hence the inaccuracy.

OUTCOME FOR DEFENDANTS WHEN AWAITING REPORT

The time taken to complete a mental health assessment on a defendant and return a report to court services may influence the number of adjournments associated with the case and lead to prolonged periods of remand. This may have an impact on the mental health status and subsequent timeliness of treatment of a defendant.

Adjournments Related To Waiting For Reports

Although causal relationships cannot be established from the data, an indication of the delays caused by court reports is obtained by reviewing the number of adjournments related to requests for mental health assessment. Table XXII shows that the majority of requests for assessment will result in at least one adjournment. In 8 cases (26.7% ; n=30), 2, 3 and up to 5 adjournments were associated with mental health assessments, all for cases in which full reports had been requested.

Table XXII: Number of adjournments related to requests for mental health assessment

		Full reports	**HSC reports**	**Informal advice**	Total
how many of these adjournments related to requests for mental health assessments/report	.00	3	1	1	5
	1.00	12	4	1	17
	2.00	4	0	0	4
	3.00	3	0	0	3
	5.00	1	0	0	1
Total		23	5	2	30

Remand

Fifty percent of defendants are kept in custody when waiting for mental health assessment (Table XXIII).

Table XIII: Remand status of defendant during court process

		Full reports	HSC reports	Informal advice	Total
was defendant remanded to bail or custody	bail	11	3	1	15
	custody	11	3	1	15
Total		22	6	2	30

DISPOSAL

Form Of Disposal

Just over a third of defendants for whom reports were requested (Table XXIV) received a custodial sentence.

Table XXIV: Means of disposal of defendants for whom reports have been requested

		Full psychiatric reports	HSC reports	other	Total
what was the eventual means of disposal of the defendant	**custodial sentence**	9	0	2	11
	committed to crown court	1	2	0	3
	hospital admission under mental health act	3	0	0	3
	conditional discharge	1	1	0	2
	suspended sentence	2	2	0	4
	Community order unpaid work	1	0	0	1
	Community order supervision	2	0	0	2
	Community order programme	1	0	0	1
	Community order curfew	2	0	0	2
	prosecution offered no evidence	1	0	0	1
Total		23	5	2	30

Time To Disposal

Of 35 reports, information was recorded on 21 of these. For defendants receiving full reports, disposal occurred between 32 days and 136 days after a report request (median=54 days) (Table XXV). For defendants receiving HSC reports, disposal occurred between the same day and 52 days.

Table XXV: Days taken from time of assessment request to disposal date of defendant

		Full reports	HSC reports	Informal advice	Total
date of request to date of disposal	.00	0	1	0	1
	28.00	0	2	0	2
	32.00	1	0	0	1
	35.00	1	0	0	1
	36.00	0	0	1	1
	42.00	3	1	0	4
	45.00	1	0	0	1
	49.00	0	1	0	1
	50.00	1	0	0	1
	52.00	0	1	0	1
	56.00	1	0	0	1
	67.00	1	0	0	1
	69.00	1	0	0	1
	70.00	1	0	0	1
	75.00	1	0	0	1
	91.00	1	0	0	1
	95.00	1	0	0	1
	96.00	1	0	0	1
	98.00	2	0	0	2
	106.00	1	0	0	1
	115.00	1	0	0	1
	117.00	1	0	0	1
	136.00	1	0	0	1
Total		21	6	1	28

A separate analysis compared the time to disposal in the crown and magistrates' courts. As would be expected in terms of the seriousness of offences in the crown court, the time taken to disposal in the crown court is significantly higher than the time taken for disposal at magistrates courts (MW=31; n=27; $p<0.01$)

SATISFACTION WITH CONTENT OF REPORTS

Accessibility Of Assessment

Court respondents were asked to rate (on a scale of 1 to 5) how accessible they felt assessment to have been on each case submitted. It would appear from Table XXVI that in the majority of HSC reports were rated as very accessible (3 reports; n=4). The majority of full reports (63.2%) were seen as being accessible (ratings 1 and 2). However, 4 reports were rated as neutral on this scale (21.1%; n=19) and 3 reports were not seen as having been readily accessible (ratings of 4 and 5). (15.8%; n=19). This appears to be in contradiction to the themes developing in the analysis of phase 2 in which lack of accessibility is a key issue.

Table XXVI: Ratings by court personnel of the accessibility of advice of each case

		Full reports	**HSC reports**	**Informal advice**	Total
was advice/assessment easily accessible?	very accessible	3	3	2	8
	2.00	9	0	0	9
	3.00	4	1	0	5
	4.00	1	0	0	1
	not accessible at all	2	0	0	2
Total		19	4	2	25

Usefulness Of Report

Court respondents were asked to rate (on a scale of 1 to 5) how useful they felt the report to have been on each case submitted. It would appear from Table XXVII that all HSC reports were rated as either neutral (3 reports; rating 3) or less than useful (2 reports, rating 4). There was more variation in opinion when it came to the more detailed full reports with 60% (12 reports; n=20) being rated as useful (ratings between 1 and 2). However, 30% of full reports (4 reports; n=20) were given neutral ratings on this scale (rating 3) and 10% (2 reports; n=20) were seen as not useful at all (rating 5). Phase 2 of the baseline studies explores the perceived usefulness of these reports in greater detail.

Table XXVII: Ratings by court personnel of the usefulness of reports

		Full reports	HSC reports	Informal advice	Total
how useful was report in reaching a decision on the means of disposal	very useful	6	0	0	6
	2.00	6	0	1	7
	3.00	6	3	0	9
	4.00	0	2	1	3
	not very useful at all	2	0	0	2
Total		20	5	2	27

Recommendations Within Report

Health and court personnel indicated whether they felt reports provided recommendations for disposal. 50 reports provided information on this question. Responses suggest that respondents saw HSC reports as containing no recommendations for disposal. Only 54.1% of full reports (20 ; n=37)(Table XXVIII) were perceived to contain recommendations. This suggests there is some dissatisfaction with the content of the report. This is explored further in phase 2.

Table XXVIII The presence of recommendations for disposal within reports as perceived by both court and health personnel

		Full report	HSC report	Other	Total
did report provide an explicit recommendation for disposal	Yes	20	0	1	21
	No	17	9	3	29
Total		37	9	4	50

Health respondents were also asked to comment on their perceptions of the content and usefulness of reports. Although responses to this question were limited, health service practitioners believe recommendations in the report relate to:

- The appropriateness of a hospital orders for the defendant

- a referral of the defendant to a more appropriate service (e.g. to a community psychiatrist or psychologist .
- the risk posed by the defendant
- sentencing of the defendant.

Again these perceptions and their fit with court perceptions are explored in phase 2.

WHY REPORT REQUESTED

Why Reports Requested From Perspective Of Court Services

Court Respondents were asked to indicate for each case the reason why an assessment had been requested. Of the 35 reports made, 34 respondents were forthcoming. The reasons given for requesting report were divided into two. First is a description of their reaction to some stimulus such as a:

- recommendation or request of court personnel (e.g. the defence lawyer, probation, judge asked for the report and therefore the respondent made the request)
- request of the defendant themselves
- observation of the defendant's behaviour
- defendant's previous mental health history
- preliminary assessment of the defendant by a mental health worker at court
- suspicion of a particular mental health condition in the defendant

The second theme related to the court worker needing information that :

- would inform a general understanding of the motive behind the defendant's crime/condition
- would inform court proceedings (e.g. determining fitness to plead, help with sentencing)
- would guide treatment of the defendant
- would inform the court of the dangerousness/public risk of the defendant

Why Reports Requested From Perspective Of Health Services

Health personnel were also asked why they felt reports had been requested. 26 of 34 cases responded to this question. Respondents indicated that reports had been requested because of the:

- concerns raised by other professionals (e.g. probation or another health worker)

- previous history of the defendant
- observations of the behaviour of the defendant
- at the request of the defendant

Health personnel believed information was required by the court that covered the:

- nature of crime
- defendant's fitness to plead
- risk posed by the defendant
- the most appropriate means of disposal/sentencing
- adequate rehabilitation of the defendant
- understanding of the motivation or mental state of the defendant at the time of the offence

It is reassuring that these reasons are very similar to those presented by the court services themselves, indicating there is some shared understanding between services as to why reports are needed. However, (Table XXVIII), suggest that this shared understanding does not translate into practice. There is some scope for investigating the match between court expectations of what a report should contain and the objectives of the report writers themselves. Preliminary phase 2 findings show that this mismatch in expectations is particularly strong in magistrates who find reports inadequate in guiding their decision making when it comes to appropriate disposal of defendants with mental health issues.

Why No Assessment Requested

Although the main aim of this study was to assess the number of mental health assessments requested over a 6 month period, some court services chose to return monitoring sheets that noted that a mental health issue had arisen but for which no assessment had been requested subsequently. There were 12 records of this type submitted. Reasons given as to why reports had not been requested included:

- That the defendant was already receiving treatment for their condition and further assessment was therefore not seen as necessary
- That information received from mental health workers already involved with the defendant was sufficient for the court to progress without the need for a report
- The mental health of the defendant was not seen as relevant or to have an impact on court proceedings

Again reasons for mental health issues being ignored by the courts is explored in phase 2.

KEY POINTS

The key points to be drawn from the completion of phase 1 of the baseline pre SLA data collection period are as follows:

- **There are no shared perception of whether delays occur or not**

There is no consensus as to the extent to which delays occur. From the court perspective, just over half of full reports are delayed. From the perspective of the health services, however, only 1 of 16 reports was delayed.

- **No shared expectation regarding time frames in which reports should be completed**

Within each service there was no agreed time frame in which reports should be returned. Unsurprisingly there was also no common expectation of such a time frame across services. For example, the courts expect full reports to be returned on average within 45 days whereas health services expect these should be returned on average in 55 days. This mismatch in expectation may lead to potentially poor relations across agencies. There is a need align expectation in the future with clear and shared guidelines in which time frames are agreed and made transparent across the two services.

- **Other reasons for delays**

It is unlikely that the mismatch in expectation is the sole reason for delays. Limited data on the reasons for delays suggests that the courts lack of knowledge of an appropriate person or service willing and able to make a report. Although, the health services feel requests for reports are mostly appropriate and of the appropriate service, access to the correct service in the first place is an issue.

Access issues may work both ways as delays may also be caused by the health services having difficulties in obtaining information held by the court on a defendant, information the report writer may feel is required to write the report.

The defendant not being known to them in the first place may also make report writing more difficult. As knowledge of the defendant might result in more speedy report making, it may be suggested that efforts are taken by the courts to request reports of services with which these defendants have current and previous contact. The findings here suggest that this happens in only about half of the requests made. We suspect that the practical limitations/implications of this will require further exploration.

Interagency administrative processes also require fine tuning. A lack of awareness :

- That a defendant was awaiting an assessment
- Of when a request for report had been registered with the health service
- of a named court contact

are indications that key formalized protocol and clear database management systems are required to manage and streamline interagency working.

- **Quality of reports**

There appears to be a shared understanding of why reports are requested by both parties (e.g. in term of fitness to plead, help with sentencing, estimation of public risk). However, when it comes to the report itself there are mixed feelings as to the usefulness of the reports and the recommendations they contain. Of particular interest is the lack of usefulness and recommendations covered in the health and social circumstance report. It may be that the objectives of report writers and court services need to be aligned. Alternatively, professional language differences may cause interpretation of reports to be misconstrued. The validity of these suggestions are explored further in the survey data in phase 2 of the baseline study. The purpose and expectation of the HSC report should be explored in greater depth.

KEY RECOMMENDATIONS

From the findings presented in this preliminary report we would recommend that the pilot should:

- Identify to the courts named services responsible for report provision for each court
- Encourage and/or develop interagency administrative processes at the interface of working between the courts and mental health services. This includes accurate and sustained recording of court requests for assessment. Detailed and shared databases should be established and maintained by both court and mental health services to achieve this.
- Encourage courts to request reports from services with whom defendants are known to have current and previous contact.
- Align the objectives of the court and report writers and encourage writers to use common lay language.

FEEDBACK ON ONGOING PROGRESS OF OTHER PHASES OF STUDY

COLLECTION OF BASELINE DATA: COURT SURVEY

Data collection for the baseline data for phase 2 involved canvassing opinion of court and health service personnel on issues related to mental health assessment of defendants in contact with the criminal justice system. The collection of questionnaires from the court services was completed in April 2008 (see Appendix 9.3). The survey canvassed opinion of judges, legal advisors, probation officers and defence lawyers that serve Bristol magistrates, Bristol Crown, Bath Magistrates, Southampton Crown, Southampton Magistrates, IOW magistrates and IOW Crown Courts. The target population and final sample achieved for this survey can be seen in Table XXIX.

Table XXIX: Sample from Survey to Court

Profession	**Location**	**Number of questionnaires sent**	**% of target population-(2107)**	**Number of questionnaires returned**	**% response rate**	**% of total sample-(479)**
Judges	Winchester, Southampton, Portsmouth/IOW, Bristol	27	1.3	15	55.6	3.1
Legal Advisors	Portsmouth, IOW, Basingstoke, Southampton, Bristol, Bath,	169	8.0	24	14.2	5.0
Lawyers	Southampton, Portsmouth, IOW, Basingstoke, Bristol, Bath	218	10.3	33	15.1	6.9
Magistrates	Portsmouth, Fareham, Southampton, Basingstoke, IOW, Bristol, Bath	1014	48.1	379	37.4	79.1
Probation	Hampshire, Avon/Wiltshire	29 AWP; 650 Hampshire	32.2	20	2.9	4.2
TOTAL	WITHOUT PROBATION	1428		479	33.5	
	WITH PROBATION	2107		479	22.7	

The views of probation are underrepresented in the sample. They make up 32.2 % of target population but they only represent 4.2% of the final sample achieved. The views of magistrates are over represented. Although magistrates do make up the biggest group in the target population (48.1%), they make up the 79.1% of the final sample. These imbalances are less obvious in the other groups, judges being slightly

over represented with lawyers and legal advisors being slightly under represented. If the probation group are excluded response rates to the survey are commensurate with any postal survey of its type. The lack of response from probation services was disappointing. This was the only group in which the questionnaire was distributed electronically to respondents. Electronic communication was dictated by pragmatic limitations and access to this group. The ineffectiveness of electronic communication as a means of questionnaire delivery to this group in the future post SLA evaluation should be explored.

Analysis of this data set is currently underway.

COLLECTION OF BASELINE DATA: HEALTH SERVICES SURVEY

Questionnaires canvassing the opinion of mental health services (Appendix 9.4) in the AWP and Hampshire Partnership Trusts have been distributed (May 2008). The data collection period completes on the 13 June 2008. Contact was made with Medium secure units and community mental health teams across the two Trusts.

The sample is unlikely to be representative of the population because of attrition at two levels:

- failure for information on staff to be returned by manager.
- Failure to return questionnaire by individual.

The target population can be seen in Table XXX.

Table XXX: Health and social care staff working in mental health services

	Number of questionnaires delivered	Percent
community psychiatric nurse/community mental health nurse	122	17.0
psychiatrist	96	13.4
psychologist	27	3.8
social worker	75	10.5
mental health worker	24	3.3
other nurse	199	27.8
other social work	2	.3
other worker	95	13.2
physiotherapist	1	.1
occupational Therapist	45	6.3
unknown	31	4.3
Total	717	100.0

PREPARATION FOR POST SLA DATA COLLECTION

The planning stage of data collection post SLA is now underway. There will be a change to the protocol in which post SLA data is collected. This change is required because:

- The SLA has introduced systems which make completion of monitoring sheets in their current form no longer viable.
- The reliability with which data is returned in the form of a monitoring sheet relies heavily on the cooperation and accuracy of a wide range of individuals across court and health services.

To increase the reliability of the data collected on individual requests for mental health assessment of each defendant, an alternative strategy to collect post SLA data has been established. An excel spreadsheet in which information on each variable, originally measured in the monitoring sheet, has been created. The aim of this was to provide a tool to be used by administrators within the courts and mental health services participating in the pilot. This tool will be used to store data already routinely collected by the services but in a format of use to both the service and the evaluation team. The creation of this database actions a key recommendation of phase 1 which was the development of a detailed and shared database, established and maintained by both court and mental health services.

PLANS FOR DISSEMINATION

Some of the findings of the analysis of the baseline court survey will be presented at the 8th Annual International Association of Forensic Mental Health Services Conference in Vienna, Austria July 14th - 16th 2008 The theme of the conference is *The interface between forensic and general mental health services.*

Abstract

In the Criminal Justice system in England and Wales, Magistrates' and Crown Courts wanting psychiatric opinion on a defendant, currently have to pay for that opinion from a psychiatrist working independently. If the psychiatric advice is not forthcoming or delayed defendants can wait unnecessarily long periods on remand in custody, failing to access mental health support and/or appropriate sentencing. This system can lead to tensions between the court and the mental health service providers.

To address this, a local partnership between Mental Health services and the Criminal Justice system in the SW of England has developed a Service System Development Project. Part of this is the collection of baseline data to identify current challenges to the system from the perspectives of both the Court and Mental Health service personnel. This paper explores the latter, namely the Court's perspective.

As part of the baseline of a longitudinal survey design, questionnaires were sent to all legal advisors, lawyers, magistrates/judges and probation officers linked to courts participating in the project.

Findings of the study revolved around their perceptions of the adequacy of current mental health advice provision and highlighted what they see as the strengths and limitations of the system.

The paper concludes with a discussion of potential resolutions to the above tensions, exploring where these perceptions may be in conflict with those held by the mental health system and how these relate to the needs of the defendant themselves.

- As an audience, participants will learn of the:
    - Challenges facing interprofessional working at the interface between the UK Court and mental health services.
    - Potential conflict between two working cultures
    - Ways in which these may be resolved.
- As presenters, we will learn:
    - How these challenges can be compared and contrasted with the experiences of international colleagues.

9.10. Interim report 2

INTERIM REPORT 2

EVALUATION OF THE SOUTH WEST MENTAL HEALTH ASSESSMENT AND ADVICE PILOT

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December 2008

INTRODUCTION

The evaluation of the SLA took a longitudinal design with two data collection points:

- Pre SLA implementation (baseline audit),
- Post SLA implementation (final audit)

Each data collection point involves two phases:

- Phase 1: Monitoring of service demand
- Phase 2: A satisfaction survey of court and mental health service personnel

Interim report 1 in May 2008 reported on the outcomes of phase 1 of the Pre SLA implementation (baseline audit).

The current document (Interim report 2 December 2008) will report on phase 2 of the baseline audit, focusing on specifically the satisfaction survey to the court. It will also report on the outcomes of phase 1 of the final audit, post the implementation of the SLA in April 2008.

METHODOLOGY

COLLECTION OF BASELINE AUDIT DATA - PHASE 2: THE COURT SURVEY

Data collection for the baseline data for phase 2 involved canvassing opinion of court and health service personnel on issues related to mental health assessment of defendants in contact with the criminal justice system. The collection of questionnaires from the court services was completed in April 2008 (see Appendix 9.3). The survey canvassed opinion of judges, legal advisors, probation officers and defence lawyers that serve Bristol magistrates, Bristol Crown, Bath Magistrates, Southampton Crown, Southampton Magistrates, IOW magistrates and IOW Crown Courts. The final sample achieved for this survey can be seen in Table 1

Table 1 Sample from Survey to Court

Profession	**Location**	**Number of questionnaires sent**	**% of target population-(2107)**	**Number of questionnaires returned**	**% response rate**	**% of total sample-(479)**
Judges	Winchester, Southampton, Portsmouth/IOW, Bristol	27	1.3	15	55.6	3.1
Legal Advisors	Portsmouth, IOW, Basingstoke, Southampton, Bristol, Bath,	169	8.0	24	14.2	5.0
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The views of probation are underrepresented in the sample. They make up 32.2 % of target population but they only represent 4.2% of the final sample achieved. The views of magistrates are over represented. Although magistrates do make up the biggest group in the target population (48.1%), they make up the 79.1% of the final sample. These imbalances are less obvious in the other groups, judges being slightly over represented with lawyers and legal advisors being slightly under represented. If the probation group are excluded response rates to the survey are commensurate with any postal survey of its type. The lack of response from probation services was disappointing. This was the only group in which the questionnaire was distributed electronically to respondents. Electronic communication was dictated by pragmatic limitations and access to this group. The ineffectiveness of electronic communication as a means of questionnaire delivery to this group in the future post SLA evaluation should be explored.

COLLECTION OF FINAL AUDIT-PHASE 1

One of the key recommendations of interim report 1 (May 2008) was to:

- *Encourage and/or develop interagency administrative processes at the interface of working between the courts and mental health services. This includes accurate and sustained recording of court requests for assessment. Detailed and shared databases should be established and maintained by both court and mental health services to achieve this.*

Acting upon this recommendation, a database was designed and implemented in the AWP region to monitor the cases assessed by CARS. Variables were chosen based on those identified in the phase 1 baseline data monitoring sheers (as agreed by steering group), in line with the requirements of the new SLA implemented in April 2008 and in consultation with CARS workers and court contacts who would complete the database (see Appendix 9.4).

The database is jointly administered by staff in the CARS and Court services.

As with the phase 1 of the baseline audit, data is collected on each individual defendant case independently. The criteria for inclusion of a case into the data base is the defendant being assessed by the CARS liaison service with each month of data collection. Data was collected over a 5 month period.

The database is stored by a CARS administrator and, for reasons of confidentiality, names are removed before being sent to the researcher.

This system is being piloted in the Hampshire region. This pilot is not included in the analysis presented here.

FINDINGS

COLLECTION OF BASELINE AUDIT DATA - PHASE 2: THE COURT SURVEY

DESCRIPTION OF SAMPLE

The vast majority of respondents were magistrates (79.1%; n=476) although officers, legal advisors, judges and defence lawyers are represented (Table 2).

The sample had similar numbers of male and female participants. (49.1% female; n=473) (Table 3)

The respondents tended to be older (M=56.2 years SD=9.8; n=458) with on average 12.3 years service in the courts (SD 9.2; n=469). The age of the sample related to the predominance of magistrates' in sample who tended to be older (Table 4).

Both counties were well represented although Hampshire participants (57.2%; n=470) outweighed those from Avon and Somerset (40.9%; n=470). This is likely to reflect the greater population of workers and courts participating from Hampshire in the first place.

Table 2: Professional roles represented in sample

	Frequency	**Percent**
probation officer	24	5.0
legal advisor	24	5.0
Judge	16	3.3
defence lawyer	33	6.9
Magistrate	379	79.1
Total	476	99.4
Missing	3	.6
Total	479	100.0

Table 3: Gender composition of sample

	Frequency	**Percent**
Female	235	49.1
Male	238	49.7
Total	473	98.7
Missing	6	1.3
Total	479	100.0

Table 4: Cross tabulation of role by age of respondent

	Current role in court					Total
	probation officer	**legal advisor**	**judge**	**defence lawyer**	**magistrate**	
20-30 years	4	2	0	4	1	11
	17.4%	9.5%	.0%	12.9%	.3%	2.4%
31-40 years	3	7	1	7	9	27
	13.0%	33.3%	7.7%	22.6%	2.4%	5.9%
41-50 years	4	7	1	10	48	70
	17.4%	33.3%	7.7%	32.3%	13.0%	15.3%
51-60 years	6	5	7	7	133	158
	26.1%	23.8%	53.8%	22.6%	35.9%	34.5%
61-80years	6	0	4	3	179	192
	26.1%	.0%	30.8%	9.7%	48.4%	41.9%
Total	23	21	13	31	370	458
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

PERCEIVED SCALE OF PROBLEM

EXPOSURE

In open ended qualitative discussion, some respondents point to a theme of LACK OF EXPOSURE to defendants' with mental health issues. This is reflected in responses to closed questions when respondents were asked to indicate how frequently, in the last year, they have had contact with cases/defendants with mental health issues. Overall, contact appears infrequent (once or twice in the last 3 months (39.2%; n=479)) (Table 5).

Table 5: Frequency of contact with defendants with mental health issues in the last year

		Frequency	Percent
	Once or more a week	32	6.7
	between two and three times a month	80	16.7
	once a month	106	22.1
	once or twice in the last 3 months	188	39.2
	not within the last 3 months	65	13.6
	Total	471	98.3
	Missing	8	1.7
Total		479	100.0

The overall result is skewed by the high proportion of magistrates in the sample. The perceived infrequency of contact of this group may relate to the part time nature of their appointments. The frequency of contact is much higher for the other professionals, especially probation (33.3%; n=479 who have contact with defendants with mental health issues once or more time a week) (Table 6).

Table 6: Cross tabulation of frequency of contact with defendants with mental health issues by professional role

	probation officer	**legal advisor**	**judge**	**defence lawyer**	**magistrate**	**Total**
Once or more a week	8	2	3	9	10	32
	33.3%	8.3%	18.8%	27.3%	2.7%	6.8%
between two and three times a month	3	7	4	9	56	79
	12.5%	29.2%	25.0%	27.3%	15.0%	16.8%
once a month	4	7	2	5	88	106
	16.7%	29.2%	12.5%	15.2%	23.6%	22.6%
once or twice in the last 3 months	6	6	6	8	162	188
	25.0%	25.0%	37.5%	24.2%	43.4%	40.0%
not within the last 3 months	3	2	1	2	57	65
	12.5%	8.3%	6.3%	6.1%	15.3%	13.8%
TOTAL	24	24	16	33	373	470
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

AMOUNT OF SUPPORT

Another theme raised in qualitative question, was the LACK OF SUPOPRT FOR DEFENDANTS with mental health issues. Again this was confirmed quantitatively when respondents were asked to quantify how often defendants were disposed of without appropriate mental health advice. There was a range of opinion as to how often respondents believe defendants are disposed of with insufficient advice being given on their mental health with 44.6% of the sample rating this as occurring very frequently or frequently (rating 1 or 2 on the 5 point scale).(Table 7)

Table 7: Responses to how frequently are defendants disposed of with insufficient advice being given on their mental health

		Frequency	**Percent**
	very frequently	87	18.2
	2.00	122	25.5
	3.00	146	30.5
	4.00	83	17.3
	very seldom or never	31	6.5
	Total	469	97.9
Missing	System	10	2.1
Total		479	100.0

SATISFACTION WITH PROVISION OF MENTAL HEALTH ASSESSMENT TO COURT

Respondents were asked to indicate how satisfied they were with the provision of mental health assessment/advice to the court by the mental health service. Responses to this item were evenly distributed ranging from very satisfied to not satisfied at all. The most popular response given was a neutral rating of 3 (108; 22.5%; n=470) (Table 8 and Figure 1).

TABLE 8: How satisfied are you with the provision of mental health assessment/advice to the court by this service

		Frequency	Percent
Valid	**very satisfied**	29	6.1
	2.00	58	12.1
	3.00	108	22.5
	4.00	54	11.3
	Not very satisfied at all	39	8.1
	Total	288	60.1
Missing	System	191	39.9
Total		479	100.0

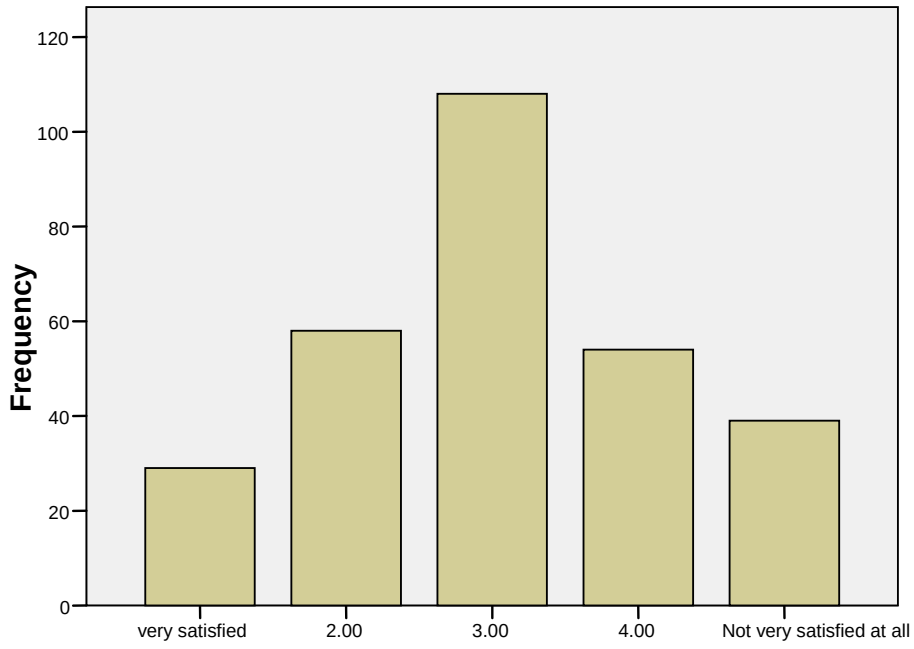

Figure 1: How satisfied are you with the provision of mental health advice/assessment

Table 9: Cross tabulation of satisfaction with provision of mental health assessment provision and type of service providing advice/assessment

	liaison service	probation	other mental health service/worker	other court service/worker	Total
very satisfied	18	1	4	1	24
	24.7%	1.8%	12.1%	7.1%	13.6%
2.00	18	13	6	6	43
	24.7%	23.2%	18.2%	42.9%	24.4%
3.00	27	26	13	4	70
	37.0%	46.4%	39.4%	28.6%	39.8%
4.00	8	10	6	2	26
	11.0%	17.9%	18.2%	14.3%	14.8%
Not satisfied at all	2	6	4	1	13
	2.7%	10.7%	12.1%	7.1%	7.4%
Total	73	56	33	14	176
	100.0%	100.0%	100.0%	100.0%	100.0%

Respondents appear to most satisfied with the advice/assessment received from liaison services (such as CARS and MENDOS), with 24.7% of the sample (Table 9) giving a rating of *very satisfied* with the advice they provide. The relationship between the service providing advice and level of satisfaction is a significant one (X^2 (12, 176) =21.793; p=0.04)

WHY ARE THEY DISPOSED OF WITHOUT SUFFICIENT ADVICE?

ATTITUDINAL

From qualitative data, a overarching theme was respondents' belief that defendants are often disposed of without sufficient advice because of attitudes held by court personnel. Some felt there was a LACK OF INTEREST IN MENTAL HEALTH ISSUES IN THE COURT. This lack of importance placed on the

mental health issues of defendants is interpreted more negatively by some respondents as a deliberate lack of interest, apathy or avoidance of the extra work needed in seeking mental health assessment/advice.

Other respondents feel that, although mental health issues are important, these are often LOW PRIORITY IN COURT. This low priority is linked with the PRESSURES ON THE COURTS FOR A QUICK DISPOSAL. The courts are therefore unwilling to adjourn because of the external time targets for a quick disposal or simply because of the high case load pressures placed upon them

There was also a feeling that NOONE TAKES RESPONSIBILITY for mental health issues in the court. No routine checks are performed on defendants as they enter the system and there can be a failure from anyone in court to take responsibility for identifying the issue or chasing for assessment. Magistrates, for example, state they cannot be expected to be social workers.

A few respondents felt that MENTAL HEALTH COULD BE USED AS AN EXCUSE for defendants to receive more lenient sentences.

Although attitude was a theme that arose from qualitative measures, more quantitative measures indicated that this feeling was not wide spread (see 3.2.5).

ATTITUDES TOWARDS THE MENTALLY ILL

The majority of respondents feel it is very important (77.5%; n=479)(Table 10; Figure 2) that the mental health needs of defendants are dealt with appropriately in court proceedings. There is also strong consensus on the normality of the condition:, i.e. that mental illness is like any other illness (61.4% strongly agree; n=479), that anyone can suffer from mental illness (77.7% strongly agree; n=475) and that the mentally ill should not be avoided. (Table 11a, b, c)

There is general agreement (although more variation) in responses given to the statement that mental illness is common in the UK population (26.1% strongly agree; 31.5% agree; 28.2% neither agree nor disagree; n=471) and that people with mental illness could live in the community if supported (39.2% strongly agree; 38.6% agree; 16.1% neither agree nor disagree; n=472) (Table 11d,e).

Respondents are less clear of around issues that pertain to the culpability and punishment of the mentally ill defendant. This is reflected by the neutral category of the rating scale being the popular response when respondents were asked to indicate their agreement with the statement: “the mentally ill are responsible

for their crimes" (47.2% neither agree nor disagree; n=475) and "the mentally ill should be treated like any other criminal" (39.0% neither agree nor disagree; n=475)(Table 11f, g)

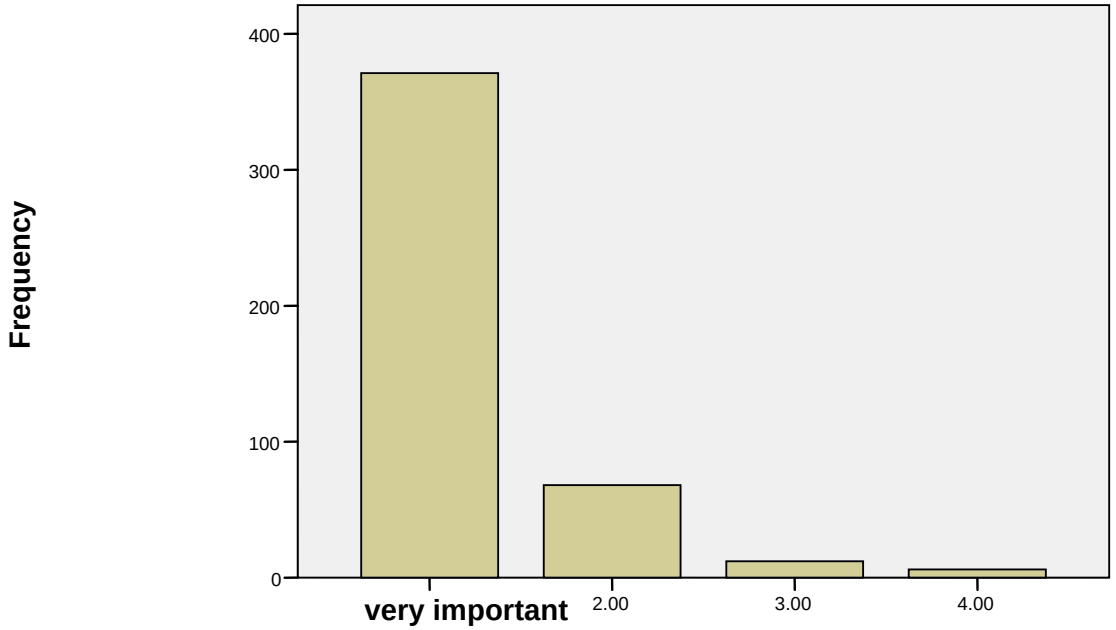

Figure 2: the importance of defendants' mental health needs being dealt with appropriately in court

Table 10: Responses to the importance of defendants' mental health needs being dealt with appropriately in court

		Frequency	Percent
	very important	371	77.5
	2.00	68	14.2
	3.00	12	2.5
	4.00	6	1.3
	Not very important at all	0	0.0
	Total	457	95.4
	Missing	22	4.6
Total		479	100.0

Table 11: Responses to items measuring normality, acceptability and issues of punishment/culpability

ACCEPTABILITY OF MENTAL ILLNESS

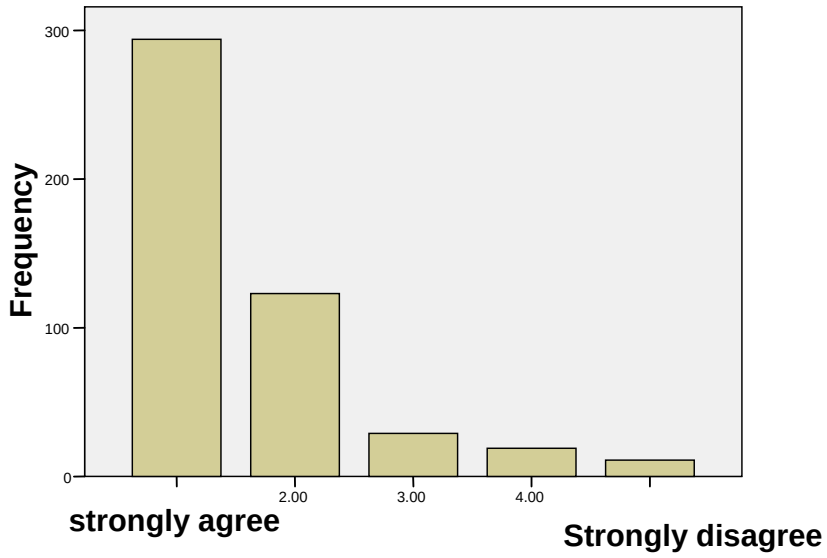

Figure 3: Distribution of responses to the statement "Mental illness is a medical condition like other illnesses"

Table 11a: Responses to the statement "Mental illness is a medical condition like other illnesses"

		Frequency	Percent
	strongly agree	294	61.4
	2.00	123	25.7
	3.00	29	6.1
	4.00	19	4.0
	strongly disagree	11	2.3
	Total	476	99.4
	Missing	3	.6
Total		479	100.0

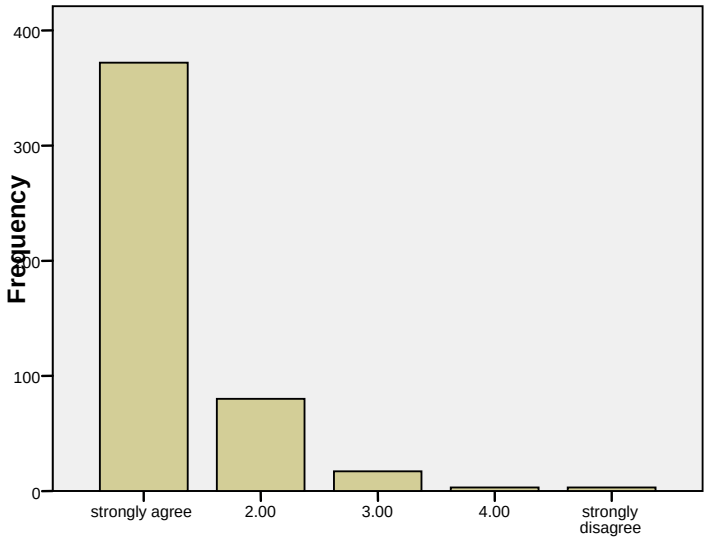

Figure 4: Distribution of responses to statement "anyone can suffer from mental illness"

Table: 11b: Responses to the statement "anyone can suffer from mental illness"

		Frequency	Percent
	strongly agree	372	77.7
	2.00	80	16.7
	3.00	17	3.5
	4.00	3	.6
	strongly disagree	3	.6
	Total	475	99.2
	Missing	4	.8
Total		479	100.0

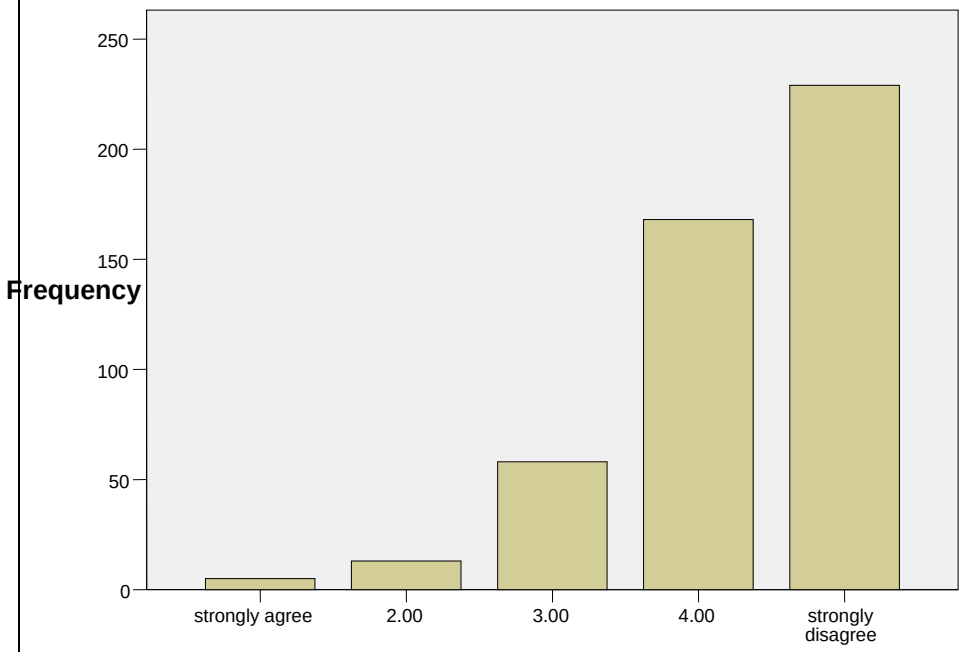

Figure 5: Distribution of responses to statement "People with mental illness are dangerous and should be avoided"

Table 11c: Responses to statement "People with mental illness are dangerous and should be avoided"

		Frequency	Percent
	strongly agree	5	
	2.00	13	
	3.00	58	
	4.00	168	
	strongly disagree	229	
	Total	473	
	Missing	6	
Total		479	

NORMALITY OF MENTAL ILLNESS

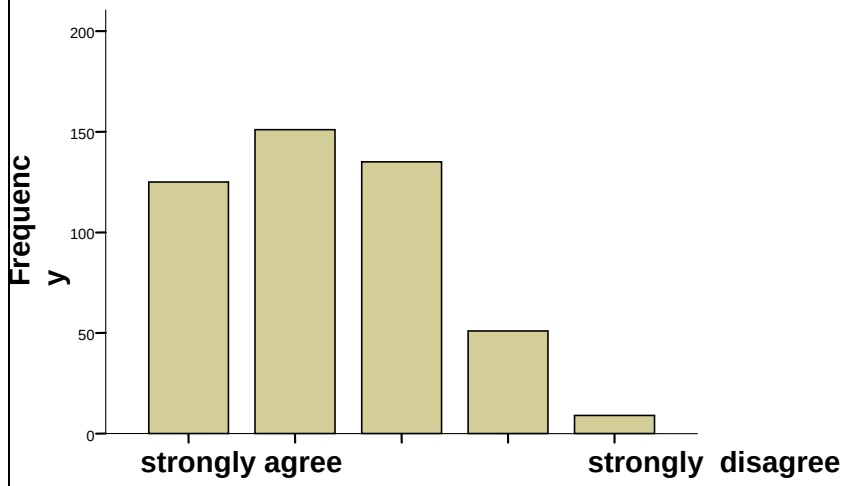

Figure 6: Bar chart of responses to statement "Mental illnesses are very common in the UK population"

Table 11d: Responses to statement "Mental illnesses are very common in the UK population"

		Frequency	Percent
	strongly agree	125	
	2.00	151	
	3.00	135	
	4.00	51	
	strongly disagree	9	
	Total	471	
	Missing	8	
Total		479	

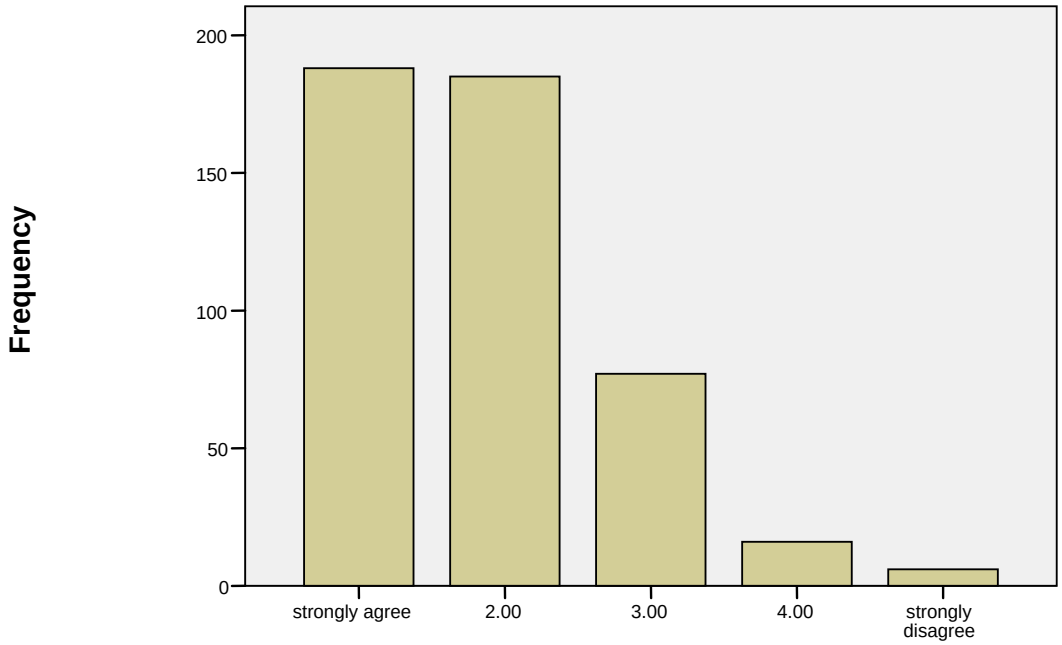

Figure 7: Distribution of responses to statement "People with mental disorders can live in the community, if they receive a support"

Table 11e: Distributions of responses to statement "People with mental disorders can live in the community, if they receiv appropriate support"

		Frequency	Percent
	strongly agree	188	
	2.00	185	
	3.00	77	
	4.00	16	
	strongly disagree	6	
	Total	472	
	Missing	7	
Total		479	

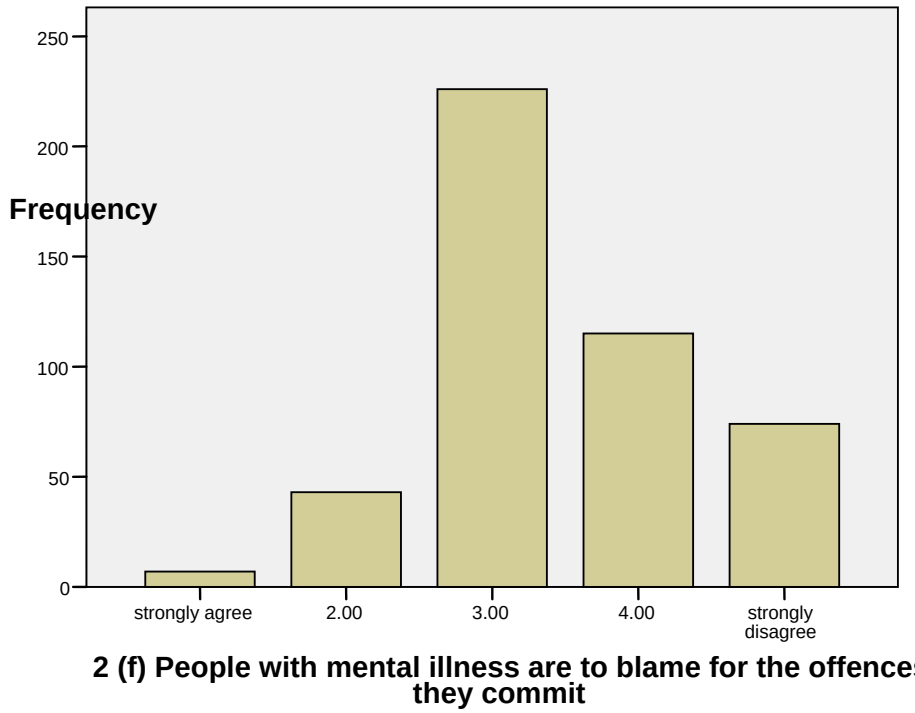

Figure 8: Bar chart of responses to statement "People with mental illness are to blame for the offences they commit
"

Table 11f: Frequency Distributions of responses to statement "People with mental illness are to blame for the offences the

		Frequency	Percent
Valid	strongly agree	7	
	2.00	43	
	3.00	226	
	4.00	115	
	strongly disagree	74	
	Total	465	
	Missing	14	
Total		479	

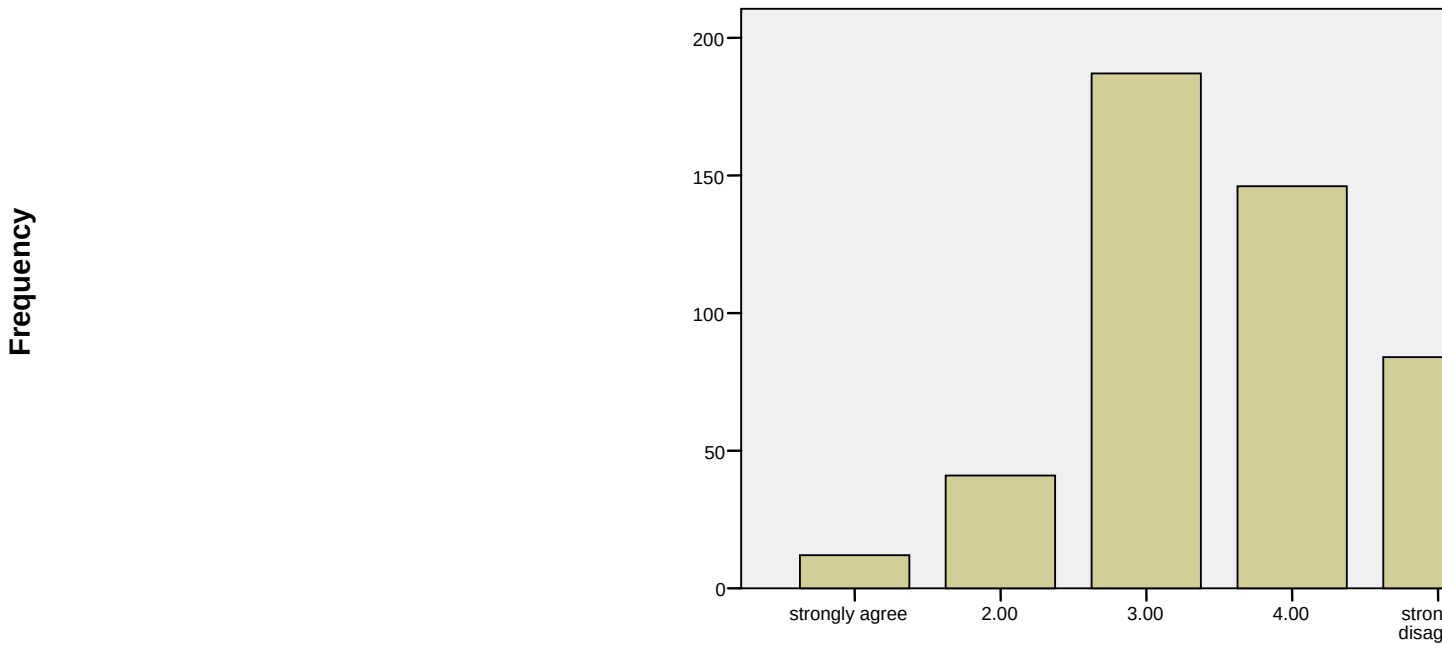

Figure 9: Distribution of responses to statement ““With mentally ill offenders, treatment should take priority over punishm

Table 11g: Distributions of responses to statement ““With mentally ill offenders, treatment should take priority over punis

		Frequency	Percent
	strongly agree	149	
	2.00	190	
	3.00	97	
	4.00	28	
	strongly disagree	4	
	Total	468	
	Missing	11	
Total		479	

CHARACTERISTICS OF DEFENDANT

Respondents believed that defendants often disposed of without sufficient advice because of the behaviour/characteristics of the defendants themselves. The characteristics of the defendant or their behaviour may also reduce the likelihood of advice/assessment being sought out. Issues include:

- the defendants denial of a mental health issue,
- the crime not being severe enough for a mental health illness to be suspected/considered
- the mental illness not being severe/obvious enough for assessment
- the defendant not being known by any service that might raise the issue on their behalf.
- The defendant being diverted to drug and alcohol services without mental health being addressed first
- Mental health being complex and difficult to diagnose
- Youth offending 16/17 nor being provided.

The lack of defendant being disposed of appropriately also links to the knowledge and feelings of efficacy of the court worker:

FEELINGS OF EFFICACY

Themes from the qualitative data suggested that feelings of efficacy in working with mental ill defendants had an impact on the provision of advice/assessment.

Respondents report a LACK OF AWARENESS or ability to recognise a mental illness in a defendant. They report being denied access to adequate information on the defendant's mental state. This means that these conditions are often not identified during the court process, particularly less severe conditions such as depression. Some respondents suggest general awareness is improving and that newsletters from mental health teams in the court can improve this awareness.

Respondents' inability to recognise mental illness is often related to mental illness being MASKED BY OTHER CONDITIONS specifically:

- drug and alcohol abuse
- learning difficulties of the defendant
- dementia

Respondents find it difficult to differentiate between alcohol/drug abuse and presence of mental illness, especially difficult in younger defendants. They discuss causality, asking whether substance misuse is the

cause of mental illness or the reverse, i.e. does mental illness predispose defendants to drug and alcohol abuse. Although there is some disagreement about the direction of this relationship, and which condition should take priority in treatment, respondents agree that that one exacerbates the other

Respondents' lack of knowledge on the presence and nature of the illness of the defendant is particular cogent when it comes to deciding an adequate DISPOSAL. They report a lack of ability to assess the mental illness, its impact on the defendant, the relationship with culpability and the balance then between treatment, punishment and public safety. They are unsure of the potential impact of the sentence on the defendant and/or the ability of the defendant to comply with disposal if a community order is issued.

Some respondents indicated that custodial sentences were inappropriate, but that enforced are also. They feel there is a lack of sufficient disposal options especially of defendants with less severe conditions. Although they identify sentencing as problematic in these cases, a LACK OF BEDS to which defendants can be referred as part of their disposal, is equally problematic.

Respondents call for advice on appropriate means of disposal and for more options available to them

Ability to identify a defendant with a mental health issue

The above themes were confirmed in more quantitative parts of the survey. Respondents were asked to rate their ability to identify a defendant with a mental health issue on a scale of 1 (very high) to 5 (very low). There was some variation in how people rate their abilities to identify a defendant with mental health issues (figure 10 and Table 12). A median of 3 suggests workers are not fully confident in their abilities to identify a defendant although unwilling to suggest they are totally unable to do so. There is a significant relationship between the role of the court worker and their confidence in their ability to identify defendants with mental health problems (X^2 (8; N=470); 21.113 $p<0.01$) (Table 13). Defence lawyers; 63.6%; n=33), Judges (57.1%; n=14) and probation officers were the most confident (41.7%; n=24) rating their abilities as high (rating 2) or very high (rating 1). Legal advisors and magistrates were the least confident with only 20.8% (n=24) and 35.2% (n=375) reporting high and very high ability respectively.

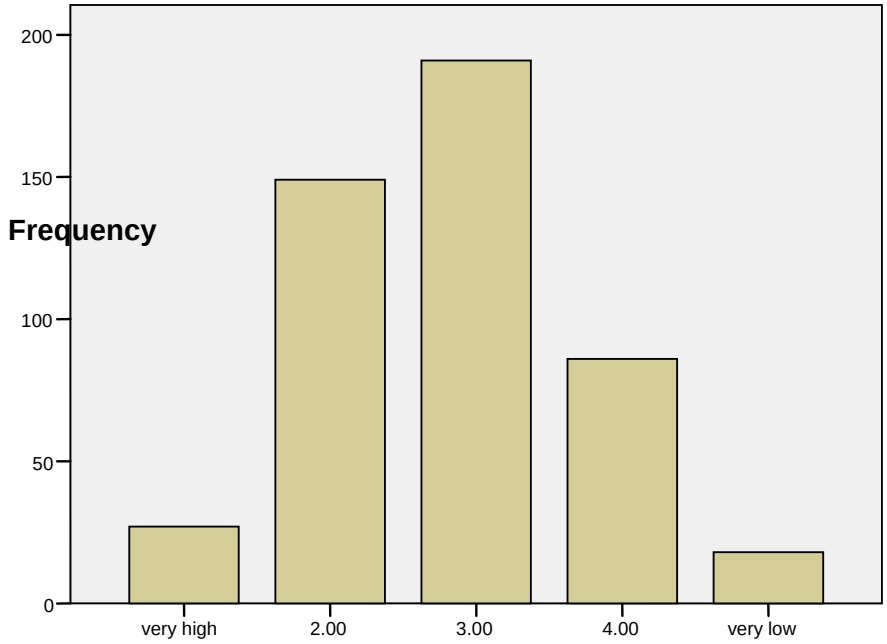

Figure 10: Distribution of ratings of ability to identify a defendant with a mental health issue

Table 12: Ratings of ability to identify a defendant with a mental health issue

		Frequency	Percent
	Very high	27	5.6
	2.00	149	31.1
	3.00	191	39.9
	4.00	86	18.0
	Very low	18	3.8
	Total	471	98.3
	Missing	8	1.7
Total		479	100.0

Table 13: Cross tabulation of professional role versus ratings of ability to identify a defendant with a mental health issue

							Total
		probation officer	**legal advisor**	**Judge**	**defence lawyer**	**Magistrate**	
	Very high and high	10	5	8	21	132	176
		41.7%	20.8%	57.1%	63.6%	35.2%	37.4%
	Neutral	12	13	5	10	150	190
		50.0%	54.2%	35.7%	30.3%	40.0%	40.4%
	Low and very low	2	6	1	2	93	104
		8.3%	25.0%	7.1%	6.1%	24.8%	22.1%
Total		24	24	14	33	375	470
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Their ability to look for external assistance

In addition to rating their own ability to identify a mental health issue, court workers were asked to rate (on a scale of 1-extensive to 5 Limited) their ability to look for external assistance on the mental health of a defendant through their knowledge of how to go about getting an external assessment.

Overall, respondents were unsure of their knowledge of how to get an assessment (median=3), neither rating themselves as overly confident nor lacking any knowledge at all (Figure 11 and Table 14). There is a significant relationship (X2 (8;n=469) 24.080; $p<0.01$) (Table 15) between role and confidence in obtaining an assessment for a defendant. Although probation rated themselves relatively high in terms of ability to identify a mental health issue in a defendant, they are, after magistrates, the least likely to rate their knowledge of how to go about organising an assessment (30.7% n=374 and 37.5%; n=24 of magistrates and probation officers respectively, gave themselves a rating of either 1 or 2). In contrast, legal advisors (52.2%; n=23), judges (66.7%; n=15) and defence lawyers (51.5%; n=33) are more confident in their knowledge of how to go about doing this.

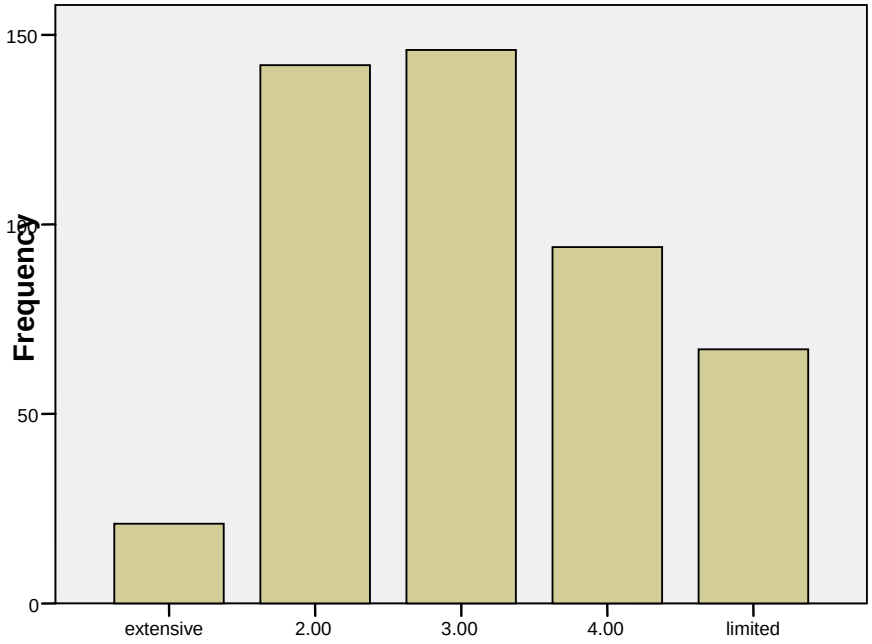

Figure 11: Distribution of ratings of knowledge of how to get an assessment for a defendant with a mental health issue

Table 14: Ratings of knowledge of how to get an assessment for a defendant with a mental health issue

		Frequency	Percent
	Extensive	21	4.4
	2.00	142	29.6
	3.00	146	30.5
	4.00	94	19.6
	Limited	67	14.0
	Total	470	98.1
Missing	System	9	1.9
Total		479	100.0

Table 15: Cross tabulation of knowledge of how to go about getting and assessment with professional role

							Total
		probation officer	**legal advisor**	**judge**	**defence lawyer**	**magistrate**	
	Extensive (ratings 1 or 2)_	9	12	10	17	115	163
		37.5%	52.2%	66.7%	51.5%	30.7%	34.8%
	Neutral (ratings 3)	11	7	4	9	114	145
		45.8%	30.4%	26.7%	27.3%	30.5%	30.9%
	Limited (ratings 5 or 4)	4	4	1	7	145	161
		16.7%	17.4%	6.7%	21.2%	38.8%	34.3%
Total		24	23	15	33	374	469
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Unsure of which health service to approach for mental health advice on a defendant.

Respondents were asked how frequently (on a scale of 1 (very frequently) to 5 (very seldom or never) they were unsure of which health service to approach for mental health advice on a defendant. Responses varied but more than a quarter of the sample indicated that this occurred very frequently or frequently (30.9%) (Table 16).

Table 16: Responses to how often respondents felt the need for mental health advice about a defendant but were unsure whom to approach

		Frequency	Percent
Valid	very frequently	31	6.5
	2.00	117	24.4
	3.00	131	27.3
	4.00	110	23.0
	very seldom or never	79	16.5
	6.00	1	.2
	Total	469	97.9
Missing	System	10	2.1
Total		479	100.0

Table 17: Responses to " Are you aware of any service available to you from which you are able to receive advice on a defendant with a mental health issue?"

		Frequency	Percent
Valid	Yes	261	54.5
	No	204	42.6
	Total	465	97.1
Missing	System	14	2.9
Total		479	100.0

Respondents were subsequently asked whether they were aware of any service they could approach for advice. 42.6% of the sample (Table 17) were not being aware of a service available to them. This does not necessarily point to a deficit in the system, however, as workers may be happy about receiving advice from a court intermediary: the defence lawyer or other court worker and not to receive information directly from the mental health service directly.

Training

In the open ended questions in the survey, training in the mental health issues of defendants was an identified theme. Respondents perceived court officials, magistrates, lawyers to have a lack of knowledge in being able to deal with defendants with mental health issues and call for training in the area. Respondents feel that the lack of the latter leads to decisions on how to deal with defendants being ill informed or a reliance on advice being received from those unqualified to make these judgments. They call for magistrates to have training on

- interpreting reports,
- of the services available that offer advice and when and how to access them.
- the nature of mental illness, the impact on defendant and the appropriate means of disposal to deal with these types of cases.

Quantitative data showed that the majority of the sample (78.9%; n=479) (Table 18) have never received training on how to deal with offenders/defendants with mental health issues.

There is a significant relationship between role and training in mental health issues of defendants. X2 (4; n=470) 16.845; $p<0.05$). Table 19 suggests that probation officers are more likely to report having had training (although more than half still indicate they have not (54.2%; n=470). Magistrates report the least training (83.2% answering negatively; n=470).

Table 18: Frequency distribution of training of court workers on how to deal with offenders/defendants with mental health issues?

		Frequency	Percent
Valid	yes	93	19.4
	no	378	78.9
	Total	471	98.3
Missing	System	8	1.7
Total		479	100.0

Table 19: Cross tabulation of professional role versus training on how to deal with offenders/defendants with mental health issues

	Current role in court					Total
	probation officer	legal advisor	judge	Defence lawyer	magistrate	
yes	11	6	6	7	63	93
	45.8%	26.1%	40.0%	21.2%	16.8%	19.8%
no	13	17	9	26	312	377
	54.2%	73.9%	60.0%	78.8%	83.2%	80.2%
	24	23	15	33	375	470
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

COST OF REPORTS

The cost and funds available to the court to obtaining a report is a central theme. Consensus is that money available to pay for assessment is too low. Under funding for reports means that the courts are loathe to request reports even when necessary. Legal services commission takes similar perspective. This may mean that some defendants slip through CJS without the required assessment.

Money dictates whether liaison officer can be employed in the court or not.

Psychiatrists may be loathe to provide the reports if requested as the fee paid for the report is seen as too low to be financially worth their while. As reports are so difficult to attain, some respondents feel psychiatrist consultant have the courts over a barrel and can charge more than guidelines suggest.

Some respondents believe that sending defendant to prison is the cheaper often rather than obtaining a report

It is sometimes unclear which service should pay for the report. Limited budget of court for assessment means court refuse often refuse responsibility for finding psychiatrist to make report. They encourage payment for assessment from alternative agencies if assessment required. Occasionally this is picked up

by legal aid but cuts here too means that legal aid wont pick up these costs either MENDOS reports are seen as cheaper but not as effective.

Respondents recommend that:

- extra funds to payments for reports are made so are reports are requested if and when necessary.
- more legal aid be provided to defendant.
- More attractive fee offered for writing a report
- funds be provided for both report and appropriate treatment

Respondents made recommendations as to how delays might be resolved. These included:

- A fast track system where reports could be provided on the day or the week. This could be achieved through short/brief reports or verbal reports
- Similar timescales being used similar to those imposed on probation service reports
- Professionals other than the psychiatrist providing reports
- Providing workers on site

Time taken could be differentiated from timeliness, i.e. when assessments took place along the time line of court proceedings.

DELAY OF REPORTS

One of the strongest themes raised by respondents was the time it took for reports to be produced. The vast majority of respondents believed reports to take unacceptably long periods to be produced. Psychiatric reports and reports from GPs were particularly identified as problematic, although sometimes it was felt that the latter were more readily available. Some defendants need more rapid assessment than others including young defendants and those with severe mental illness.

Many respondents made only a general reference to the long time it took to obtain an assessment report. Other respondents spoke of the reasons behind delays. Delays were caused by:

- A lack of resources, services, staff available to perform assessment
- The intermediary making contact with the mental health service.
- A mismatch between expected timescales in court and those followed in mental health services
- Professionals in the mental health services not meeting required deadlines
- Multi agency working
- Defendants not attending assessment
- Systems not being in place whereby assessment was readily available if required
- The defendant not being known to service

Respondents described the impact of these delays. These included:

- Lengthy and multiple adjournments
- Delays in court proceedings
- Delay in time to sentencing
- Court personnel being discouraged from requesting reports
- Cases continuing and sentencing occurring without appropriate information on defendants' mental health

- Risk to the public if the defendant on bail and the possibility that the defendant will reoffend during this time
- Impact on the defendant that result in:
    - Their failure to be assessed at all
    - Their being placed in remand inappropriately when should be receiving treatment
    - A compromise of their need for treatment
    - Defendants being in remand longer than a sentence commensurate with their offence
    - Their being placed under unnecessary stress when waiting outcome

Quantitative data supporting this theme was presented in the interim report 1.

CONTENT OF REPORTS

Respondents discussed the content of the reports they received and there is wide variation in their perceived quality. This may reflect the variation in quality in reports themselves. Some respondents find the reports very useful, others less so.

Characteristics of the report

- Clarity
    - Language

Some reports are seen as being clear and well written in lay language. Others find reports complex, long winded and difficult to understand using medical terminology that is hard to interpret. Access to the report writer or having the report writer on site is recommended as it allows court personnel to clarify the content of the report if necessary.

    - Clear recommendation

It is also clear that some court personnel want clear and concrete recommendations in the report. Some recognize that this may not be realistic .“We need a black/white answer in an area where there invariably shades of grey” C318.

Although this is sometimes achieved, reports are often seen as being vague, inconclusive, offering no concrete or practical advice that the court would see as relevant or useful as how best to proceed with the defendant.

- Depth

There is disagreement in the perceived comprehensiveness of reports. Many see psychiatric reports as very through. Other reports, especially shorter and GP reports, were seen as superficial, little more than a statement that a mental health issue was present. This lead some respondents to question whether these reports were of any added value to what was already known about the defendant by the court. However, others see psychiatric reports as longwinded and confusing and call for briefer, clearer reports in their stead.

- Impartiality, Professionalism and perceived conflict

Respondents appreciate the report as an expert, professional and impartial assessment of the defendant and feel confident in the assessment they contain. However, they sometime perceive the assessments of reports and professionals to be conflicting.

- Content of the report

Respondents vary in the perceived usefulness of the content itself of the report. They recognize the usefulness of the report in identifying that a mental health issue exists in the defendant and perceive them as helpful in differentiating mental illness from related issues such as drug and alcohol misuse. Respondents see reports as important to improve their understanding of:

- the case and defendant in general
- an up to date account of the defendant's history, previous and current treatment
- the relationship between the defendant's criminal behaviour and mental illness-culpability
- the risk posed by the defendant
- the treatment required for the defendant and the effect treatment would have on future offending

The content of reports does not always contain sufficient information for the above to be achieved. This understanding is essential when probation, magistrates and judges consider the appropriate sentence required. Although some see the reports as useful in this regard, others find reports of little use and call for clearer recommendations for sentencing to be included within them. Some respondents call for reports that more closely address the exact requirements of the court

Usefulness Of Reports

Overall reports are seen as useful. Of the sample, 59.3% rated verbal reports a 1 or 2 on a rating scale of 1 (very useful) to 5 (not very useful at all) Table 20) (Figure 12). and 74.6% of the sample rated written reports at this same high level (Table 21 (Figure 13

Table 20: Usefulness of verbal reports

		Frequency	Percent
Valid	very useful	146	30.5
	2.00	138	28.8
	3.00	90	18.8
	4.00	32	6.7
	not useful at all	27	5.6
	Total	433	90.4
Missing	6.00	7	1.5
	System	39	8.1
	Total	46	9.6
Total		479	100.0

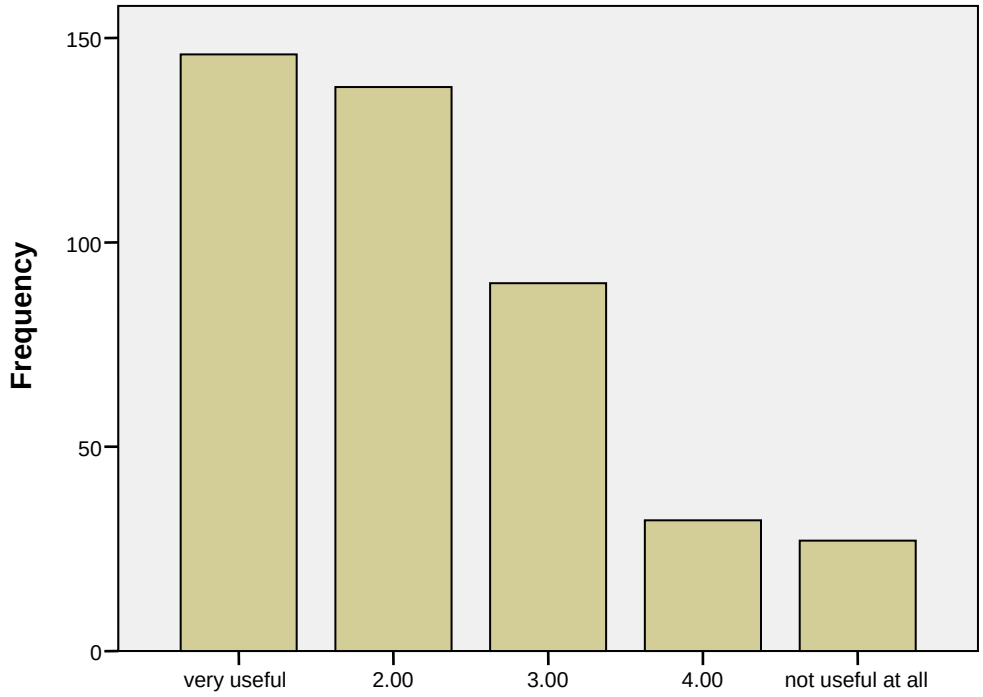

Figure 12: Distribution of responses to usefulness of verbal reports

Table 21 : Usefulness of written reports

	Frequency	Percent
very useful	191	39.9
2.00	166	34.7
3.00	75	15.7
4.00	14	2.9
not useful at all	9	1.9
Total	455	95.0
not applicable	4	.8
System	20	4.2
Total	24	5.0
Total	479	100.0

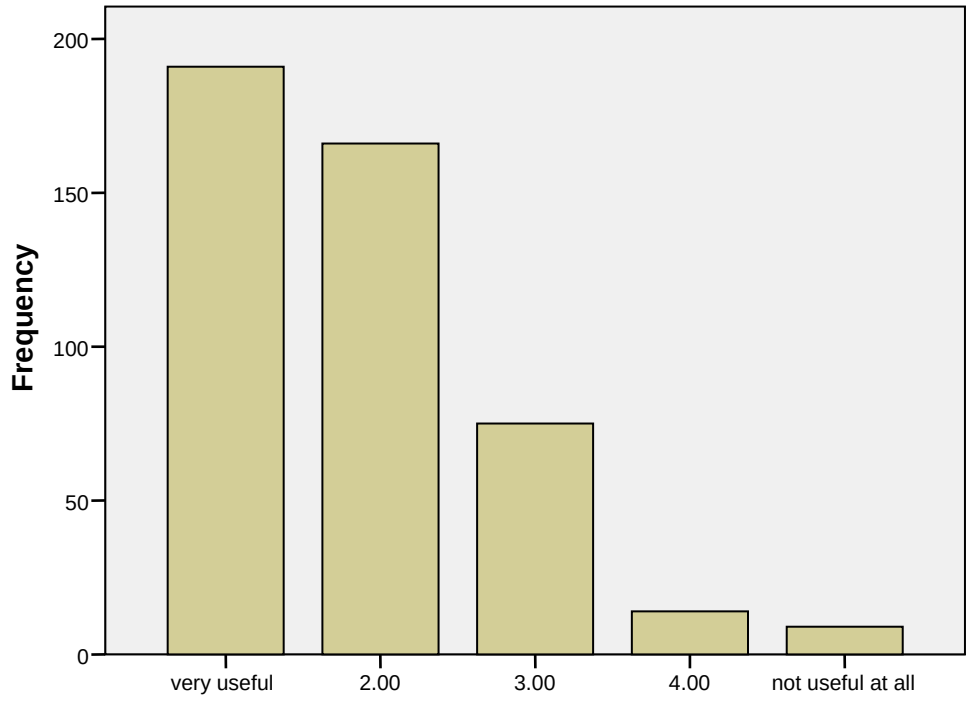

Figure 13: Distribution of responses to usefulness of written reports

AVAILABILITY OF SERVICES AND ADVICE

The availability /accessibility of advise is a key issue for respondents rising from the more qualitative data collected from respondents. Here key themes of ease of contact/accessibility pertained to:

- the availability of reports
- The availability of services
- The availability of a mental health worker/liaison service based in the court

Respondents commented on the AVAILABILITY OF REPORTS AND SERVICES TO PROVIDE ADVICE. They indicated that reports are often not readily available and the services that provide them are hard to access or are of insufficient variety to tackle the complexities of the problem. The lack of report availability may be due to:

- the cost and delay associated with obtaining a report
- the service not having previous contact with defendant
- Lack of apparent willingness of mental health services to conduct report
- Mobility of prisoner within prison system makes getting a report difficult
- the service having no contractual obligation to act on behalf of the court.

- Court workers not knowing/being aware of how to access a service or assessment effectively
- Poor information sharing across agencies. Respondents recommend that legislation be put in place that would facilitate information sharing across the mental health services and court services but also between individuals with the court service itself.
- Reports only being readily available for certain cases (in cases of fitness to plead; when a hospital order is anticipated) but less available if the issue relates to mitigation.

Recommend an increased awareness of services available to direct access to professionals offering advice

Many respondents associate improved availability of reports and advice with the presence of a MENTAL HEALTH WORKER IN COURT. Specific services are mentioned, namely MENDOS workers, CARS workers and/or members of a mental health service that accompany and support the defendant during trial. Respondents that have the liaison service in their courts see the benefits of these workers in terms of:

- the support they provide to the defendant;
- the immediacy or reduction in delay in waiting for advice on a mental health issue
- the opportunity of having someone readily available with whom to discuss and clarify the mental health issues at hand,
- the support in deciding the nature of disposal
- a liaison with external health services
- an up to date advise on defendant's current condition
- an abbreviated report replacing the need for a psychiatric report in all but the most serious cases

Respondents recommend that the liaison services be expanded to cover all courts in the region rather than at only a few sites
Some respondents perceive the liaison service in Bristol to be a new initiative and some know little about it. They recommend promoting an increased awareness of the service.

It is evident that not all courts have access to a liaison service or that liaison services when in place (MENDOS) are not evenly active across the county. When liaison services are available there are further requests for more personnel to be available to cover all courts, annual leave requirements and to be more frequently available either daily or at least at times when mentally ill defendants appear in court. Some call for liaison workers to have increased powers within the court and to be available in the police station as well as court. The longetivity and sustainability of the liaison services are raised. The advice from service is sometimes accused of being superficial

<u>Availability of service</u>

The availability of advice was measured quantitatively through respondents' ratings of the "ease of contact" with each of the services with whom they come in contact when seeking mental health advice on a defendant. Overall, ratings are fairly evenly distributed, although the most popular response is a neutral rating of 3 (15.9%) (Table 22)
.

Table 22: The ease with which respondents find making contact with members of the mental health service for advice/assessment of defendants with mental health issues

		Frequency	Percent
	very easy	47	9.8
	2.00	63	13.2
	3.00	76	15.9
	4.00	64	13.4
	very difficult	35	7.3
	Total	285	59.5
	Missing	194	40.5
Total		479	100.0

The cross tabulation in Table 23 suggests that the liaison services (MENDOS and CARS) are the most easy to access. However, the difference between the different sources of advice was not a significant one (X212; 176)=10.172; n.s.).

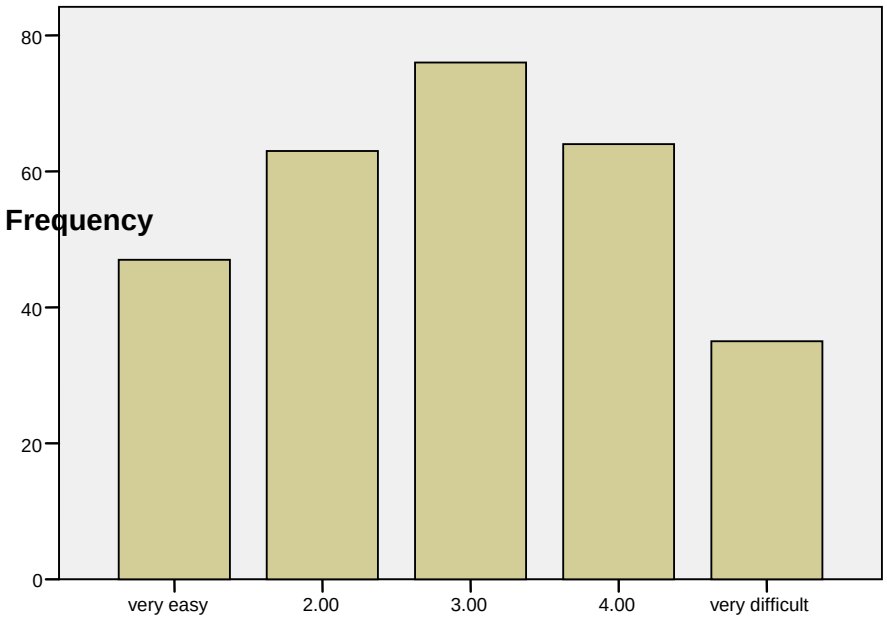

Figure 14: Distribution of responses to ease of contact with mental health service

Table 23 : Cross tabulation of ease of contact with type of service providing advice/ assessment

		liaison service	probation	other mental health service/worker	other court service/worker	
very easy		23	10	7	4	44
		31.5%	17.2%	22.6%	28.6%	25.0%
2.00		22	12	8	4	46
		30.1%	20.7%	25.8%	28.6%	26.1%
3.00		16	18	7	3	44
		21.9%	31.0%	22.6%	21.4%	25.0%
4.00		8	11	6	3	28
		11.0%	19.0%	19.4%	21.4%	15.9%
very difficult		4	7	3	0	14
		5.5%	12.1%	9.7%	.0%	8.0%
Total		73	58	31	14	176
		100.0%	100.0%	100.0%	100.0%	100.0%

The liaison services are rated as most easy to make contact with (Table 23), Probation as least accessible. The community mental health services are not rated as easily accessible.

Relationship with service

Looking at how easy contact with each of these services has been; the level of relationship with these services and level of satisfaction in providing advice, overall, ratings are fairly evenly distributed.

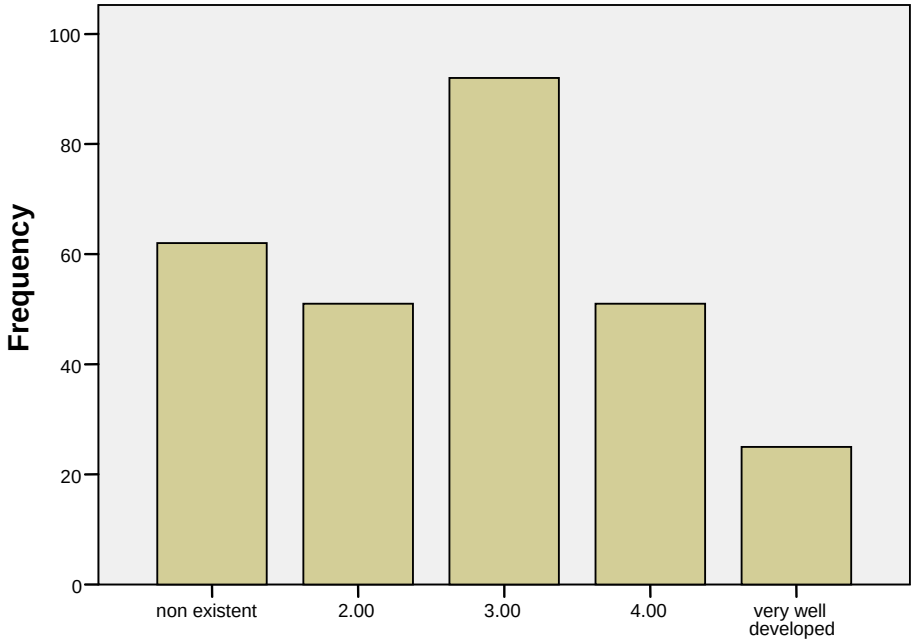

Figure: How would you describe the nature of your relationship with members of the mental health services

Table : Cross tabulation of relationship with service and type of service providing advice/assessment

	the most frequent service code variable collapsed				Total
	liaison service	probation	other mental health service/worker	other court service/worker	
non existent	9	15	5	1	30
	12.2%	25.4%	15.6%	8.3%	16.9%
2.00	10	7	3	5	25
	13.5%	11.9%	9.4%	41.7%	14.1%
3.00	23	21	9	2	55
	31.1%	35.6%	28.1%	16.7%	31.1%
4.00	22	9	11	2	44
	29.7%	15.3%	34.4%	16.7%	24.9%
very well developed	10	7	4	2	23
	13.5%	11.9%	12.5%	16.7%	13.0%
Total	74	59	32	12	177
	100.0%	100.0%	100.0%	100.0%	100.0%

General indication that relationships are existent between the court services and mental health services (43.2% and 46.9% of sample rate their level of development of relationship with liaison services and other mental health respectively as 5 or 4 on a scale of 1 to 5). Less well developed relationships exist with probation and other court services in this respect in comparison (27.2% and 33.4% of the sample rated the level of development of their relationship with probation and other court workers respectively as 5 or 4 on a scale of 1 to 5). However the relationship is not a significant one (X^2 (12, 177)=17.116; n.s.)

COMMUNICATION

Table : Who brings mental health issues to your attention

	very frequently		2.00		3.00		4.00		seldom or never		not applicable	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Liaison schemes	23	5.0%	55	12.1%	70	15.4%	66	14.5%	224	49.1%	18	3.9%
Security services	4	.9%	38	8.4%	45	9.9%	77	16.9%	267	58.7%	24	5.3%
Defence solicitors	140	29.9%	197	42.0%	87	18.6%	19	4.1%	11	2.3%	15	3.2%
prosecutors	26	5.5%	102	21.7%	134	28.6%	108	23.0%	95	20.3%	4	.9%
Court ushers	10	2.2%	51	11.0%	80	17.3%	91	19.7%	213	46.0%	18	3.9%
Mental health workers	28	6.0%	82	17.6%	111	23.8%	72	15.5%	164	35.2%	9	1.9%
Probation officers	64	13.6%	191	40.6%	117	24.9%	50	10.6%	38	8.1%	10	2.1%
Police/custody sergeants	7	1.5%	30	6.4%	52	11.2%	69	14.8%	259	55.6%	49	10.5%
Forensic medical examiner or custody nurse	7	1.5%	14	3.0%	22	4.7%	42	9.1%	304	65.5%	75	16.2%
Appropriate adult	15	3.2%	60	12.9%	101	21.7%	125	26.9%	146	31.4%	18	3.9%
Defendant	17	3.6%	96	20.6%	116	24.8%	115	24.6%	119	25.5%	4	.9%
Own observation	51	10.9%	128	27.4%	152	32.5%	94	20.1%	38	8.1%	4	.9%
Other	10	3.5%	13	4.5%	11	3.8%	5	1.7%	105	36.6%	142	49.5%

Respondents were asked to indicate how frequently a range of sources brought the mental health of the defendant to the attention of the court worker. Data showed (Table x) that the defence solicitor, the probation officer and one's own observation of the defendant's behaviour were the three most frequent means by which a mental health issue in a defendant is raised in court.

Prosecutors, the defendant themselves, an appropriate adult, and court ushers are used to some degree, as are the liaison or mental health worker but this is much less frequent .

Communications between the police station and the court on this subject are least well developed as shown by the low frequencies with which Police/ custody sergeants, Security services and Forensic medical examiner/custody nurse bring mental health issues of the defendant to the attention of the mental health worker.

Table: Most frequently used service

		Frequency	Percent
	CARS	23	4.8
	Probation	60	12.5
	independent psychiatrist	2	.4
	Defence	3	.6
	legal advisor	6	1.3
	no direct contact	15	3.1
	GP	3	.6
	CAMHS	2	.4
	CMHT	4	.8
	mendos	48	10.0
	youth offending team	6	1.3
	other	13	2.7
	Secure unit (Ravenswood)	2	.4
	liaison team unspecified	3	.6
	doctor unspecified	3	.6
	psychiatrists unspecified	5	1.0
	prison in reach teams	1	.2
	two mentioned	12	2.5
	Total	211	44.1
Missing	System	268	55.9
Total		479	100.0

Respondents were asked to identify the service with whom they were in most frequent contact. Responses show that court workers make most frequent contact with liaison workers situated in the court (15.4% of sample)

There a range of other services that are accessed to lesser degrees which include the CMHT, CAMHS prison in reach teams.

Some of the sample indicated they do not obtain advice directly from a health service but that a court worker acts as an intermediary between them and the service. Probation are the most frequent intermediary (12.5% of sample), although the legal advisor/court clerk and defence lawyer also play this role.

Despite this endorsement, issues of their cost, content and time required to produce them need to be addressed as illustrated by the following themes:

TIME 2: MONITORING RECORDS

Chief outcome is the production of valid data if compared to time 1. There was no data available from CARS at time 1.

DEMAND

On average 40 people are being seen a month. The majority of cases come from Bristol magistrates court (71.4%), followed by Bath magistrates court (20.6%) and the remainder are form Bristol Crown court (8.0%)

NATURE OF CLIENT

The average age of offenders is 33.9 years but ranged from 17.8 to 76 years. The majority are male (78.9% of sample; n=199) and white British (78.4%). Defendants are in a range of accommodation types the most common being with family and friends (19.6%), NFA (13.1%) and council housing (11.1%);

Depression (22.6%), psychosis (17.1%) and dual diagnosis (12.1%) are the most commonly diagnosed conditions in defendants recorded. The majority are perceived as being of risk to themselves or others (62.8%). The vast majority have been involved with the health services previously or currently (75.4%) (in contradiction to what was reported in phase 1).

The most frequently recorded offence is assault (20.1%) followed by theft (15.1%) and criminal damage (8%)The most common means of disposal for this group is a community order of some form (33.2%) with a custodial sentence (20.6%) being the next most frequent. There was only one recorded hospital order, received by a psychotic defendant, recorded as being arrested for not producing a specimen.

SOURCE OF REFERRAL

The majority of referrals come form MHIS checks (32.7% of sample); probation (12.6%) and legal advisors.

Screening reports

The majority of screening reports are completed on the day of referral, i.e. for those cases for which dates had been recorded (n=156), 89.7% (140; n=156) were completed on the day. For the few that were reported as not having been completed on the day, there are delays of 2 to 32 days. No apparent relationship was identified between the presence of a delay and the source of referral although referrals from probation showed a slightly higher level of delay.

The vast majority of screening reports lead to no recommendations being made (179; n=199; 89.9%); 5% (10; n=199) lead to a HSC report and 1.5% (3; n=199) lead to a psychiatric report being recommended. In terms of the action taken to deal with the defendant's mental illness, only 10 cases (5%; n=199) proved to require no further action. For the remaining cases some form of liaison with external services was required. Although in most cases the service with whom liaison took place was not specified by the mental health worker (112; n=199; 56.3%), liaison with prison in reach (19; n=199; 9.5%) and local CMHTS (13; n=199; 6.4%)were the most commonly accessed services.

Psychiatric reports

Records indicated that of all defendants that were screened, CARS felt that 6.5% (13 reports in the 5 month period) required a psychiatric report. Of these only 4% (8 reports) were requested by CARS. Of

these 8, information was recorded for 5 of the reports. Reports took between 30 and 84 days to complete with an average of 67 days. This is comparable to the time taken to return reports in the time 1 study.

HSC reports

11 HSC reports were done over the 5 month period. HSC reports were completed by take 11 to 21 days to complete. Similar or slightly longer than HSC reports in Hants (see Time 1). Of the 6 for which a recommendation had been recorded, only 1 required a full psychiatric report.

DISCUSSION POINTS

- The frequency of contact of defendants with mental health issues with full time court workers is sufficient to suggest there is a demand for mental health advice on a defendant. The relatively high level of belief that defendants are disposed of without adequate advice and the range of satisfaction levels suggests that the level/nature of advice is not optimum. The data also suggests that liaison services are seen as particularly useful in addressing this challenge
- Magistrates need to be targeted to help them understand firstly to identify a mental health issue in a defendant and then the protocol of how to go about gaining an assessment. Probation may need some support on how to access mental health services for their clients.
- Attitudes: A personal declaration of attitudes towards the mentally by the respondents suggests that this is not a factor that might adversely impact on the advice received on and assessment received by the defendant. However qualitative themes that arose from the survey suggested that respondents felt that others in the court do indeed hold negative attitudes that may impact negatively on advice/assessment provision.
- Ability to identify a MH condition and to ask for advice/obtain and assessment: Defence lawyers and judges reported being the most confident in identifying mental health problems as well as obtaining advice/assessment. Magistrates appear to be the least confident in either. It is therefore recommended that training and efforts to reinforce the working of the SLA be targeted at this group.
- Suggestion is that whilst SLA is not be improving the time it takes for a psychiatric report to be returned, the limited number of psychiatric reports and HSC reports requested suggests the need for psychiatric/HSC reports is low. If the majority of CARS assessment

only go as far as screening reports and the vast majority of these are completed on the day, then it appears that the SLA protocol will lead to a reduction in delays related to advice/assessment overall by removing the need for psychiatric and HSC reports

- Data on request for reports etc is incomplete and inaccurate.

- Main conclusion: screening reports completed on day. Very few progress to a HSC report and even few to a full psychiatric reports.

- Cars workers have a better handle of the link between MHS and CJS than those that exist in one service or the other. CARS is the gate keeper between the services