



Ministry of
JUSTICE

Process evaluation of the Mental Health Court pilot

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Ministry of Justice Research Series 18/10
September 2010

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First Published 2010

ISBN: 978-1-84099-414-8

Acknowledgements

The authors would like to extend their thanks to the stakeholders who gave their views and especially to Mrs Gillian Ormston, Mr Glyn Thomas, Mr Kevin Ryan, Ms Catherine Elkington, Ms Jessica Haskins and Mr David Illingworth for their support. We would also like to thank operational staff at Brighton and Stratford Magistrates' Courts for sharing their views and experiences with us. In particular, we are grateful to the 14 service users who voluntarily gave up their time and openly discussed with us their experiences through the sentencing and supervision process.

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Abbreviations

CADS	Court, Assessment and Diversion Service
CJA	Criminal Justice Act
CJMHT	Criminal Justice Mental Health Team
CJS	Criminal Justice System
CPS	Crown Prosecution Service
DRR	Drug Rehabilitation Requirement
eCPA	Care Programme Approach (electronic)
FDR	Fast Delivery Report
HMCS	Her Majesty's Court Service
MHC	Mental Health Court
MHCP	Mental Health Court Practitioner
MHTR	Mental Health Treatment Requirement
NOMS	National Offender Management Service
NPS	National Probation Service
NSG	National Steering Group
NSPIS	National Strategy for Police Information Systems (database)
OASys	Offender Assessment System
PCT	Primary Care Trust
PER	Prisoner Escort Record
PNC	Police National Computer
PO	Probation Officer
PSO	Probation Service Officer
SDR	Standard Delivery Report

Glossary of terms specific to the Mental Health Court (MHC) pilot project

These terms are useful to understand before reading the report in full

Assessment

Assessment refers to the formal interview process to establish clinical mental health symptoms and needs. This is undertaken by a mental health professional. The outcome of assessment activities are used to inform the sentencing process and may be shared with other professionals to facilitate treatment and management arrangements.

Defendant

'Defendant' is a term used to describe an individual who is being prosecuted through the court for an alleged offence but who has not yet been, or may not be, proven guilty.

Offender

'Offender' is a term used to describe an individual who has been successfully prosecuted for an offence and who is serving his/her sentence either in the community or in prison.

Proactive screening

Screening refers to the proactive identification by mental health professionals of defendants who would benefit from an in depth mental health assessment. It often relies on electronic personal data such as is contained in police and/or health information systems. Screening may be indirect, i.e. when it relies on electronic or paper-based information, or direct when it involves face-to-face contact with the individual.

Section 178: Power to provide for court review of community orders

Section 178 powers are contained in the Criminal Justice Act (2003). These powers are given to certain courts by the Secretary of State to enable the judiciary to make an order allowing or requiring a court to review the progress of an offender under a community order. This involves the offender returning to the court at each review to discuss his/her progress with the judiciary. Under Section 178, the court also has the power to attach or remove a review provision from a Community Order, and regulate the timing of reviews.

Signposting and referral

Signposting refers to the activity of making offenders and defendants aware of suitable services by providing them with appropriate details and contacts. It is the responsibility of the offender or defendant to seek access to these services. Referral includes all further activities by court staff and other parties in the pilot which support and empower the defendant to access community or statutory provision to meet a wide range of complex social and health needs as well as addressing dynamic risk factors linked to the commission of the alleged or proven offence. In the MHC pilot this included making telephone calls, arranging appointments, transport, mentoring, support with paperwork, etc.

Tailor-made Community Order

Offenders sentenced to a Community Order (Criminal Justice Act 2003) serve their whole sentence in the community rather than prison. A Community Order is made up of one or more requirements. These may include supervision and/or specified activities and/or a Mental Health Treatment Requirement (MHTR). These can require the offender to address both their specific mental health issues as well as factors relating to offending behaviour. The MHC pilot refers to tailor-made community orders to reflect the individualised nature of the requirements and the co-ordinated approach to managing an order from first appearance at court to completion of the sentence.

Policy briefing

The Mental Health Court pilot facilitated identification and sentencing opportunities for offenders with mental health issues across two sites in 2009. Both sites operated within regular magistrates' court provisions, but with slightly different models. MHC Teams (made up of mental health and criminal justice professionals from the Government and the third sector) provided continuity of support for defendants and offenders in the pilot. Where appropriate, the model involved giving Community Orders¹ with requirements specifically tailored to address the mental health issues impacting on offenders' behaviour. These orders were regularly reviewed by the court or probation service.

Key learning points from the pilot were as follows.

- The MHC pilot yielded innovative multi-agency collaborations that addressed needs which probably would have gone unmet. A wider implementation of MHCs would require significant changes, supported at a national level, in the current patterns of multi-agency information sharing and data collection.
- The MHC benefited from early consultation at senior management level.
- The MHC excluded certain groups. Removing these exclusions should be investigated to allow wider access to services offered at the MHCs.

The core requirements for any new MHC would be:

- a Mental Health Court Practitioner (MHCP) available daily at court;
- multi-agency agreements put in place prior to the MHC for information exchange and to identify and address the priorities of collaborating agencies;
- comprehensive screening and assessment of defendants for mental health issues (through the MHCP and information sharing protocols);
- tailored use of community orders for offenders;
- court involvement in the processes to review whether Community Orders are being implemented effectively;
- involvement of the MHCP post-sentence;
- training and awareness events for practitioners and stakeholders.
- Identification of, and engagement with, local resources for signposting and referral of defendants to appropriate support services

¹ Offenders sentenced to a Community Order (Criminal Justice Act 2003) serve their whole sentence in the community rather than prison. A Community Order is made up of one or more requirements.

Summary

Context

The Mental Health Court (MHC) model was piloted at magistrates' courts in Stratford, East London, and Brighton, Sussex in 2009. The pilot aimed to:

- **develop a clear model**, which identified defendants and offenders with mental health issues, assessed the extent of those issues and ensured that (if convicted) the offender/defendant received the appropriate intervention(s);
- **identify the actual costs** that would be incurred across the Criminal Justice System (CJS) and Health Services as a result of implementing the model.

The key elements of the MHC model in both areas were to:

- identify defendants with mental health and/or learning disability issues through screening and assessments.
- provide the court with information on a defendant's mental health needs to enable the court to effectively case manage the proceedings;
- offer sentencers credible alternatives to custody to support an offender with mental health/learning disability needs by way of a Community Order with a supervision requirement or mental health treatment requirement;
- offer enhanced psychiatric services at court;
- implement regular reviews of orders; and
- signpost those individuals not suitable for the MHC community order² to mental health and other services that could appropriately address their needs.

This study set out to assess how the MHC pilot was implemented at Brighton and Stratford in order to draw out areas of best practice and areas for improvement and inform future decisions on the pilot.

Approach

Three methods of information gathering were used in the development of this Report.

- (a) Analysis of 547 cases from January 2009 and January 2010 and cost information for the same 12-month period.
- (b) Sixty-nine semi-structured interviews with a wide range of mental health and justice professionals. The interviews gave a flavour of the perceptions of those involved in the pilot.

2 This group includes those found not guilty and those convicted but where Community Orders were not considered appropriate.

- (c) Fourteen structured interviews with offenders who received Community Orders with regular reviews. Interviews with those who were solely signposted or received other sentences, and those who were offered intervention but declined to take part were outside the scope of this evaluation.

Findings

The key elements of the MHC model were delivered in both Brighton and Stratford, although in differing ways.

The MHC pilot was jointly delivered by criminal justice, health and third sector agencies. Both Brighton and Stratford operated within regular magistrate court provisions. Extensive multi-agency collaboration and data-sharing arrangements were achieved in both sites.

Both MHC Teams had an MHCP,³ an Offender Manager (Probation Officer) and a local coordinator who spent half the week working at each site. The presence of the MHCP five days per week at court was key to delivering a reliable and comprehensive service to the court and to service users.

Training and awareness around mental health issues were seen as key by professionals to support the aims of the MHC and promote multi-agency collaboration. Training was generally well attended, including joint practitioner events.

Between January 2009 and January 2010 over 4,000 defendants due to appear at Brighton or Stratford Magistrates' Court were proactively screened. The MHCP used paper-based evidence (e.g. medical information, custody risk assessments, etc.) to identify, without any face-to-face contact, the possibility that an individual may have a mental health issue.

From those proactively screened, 547 individuals were identified as requiring a formal mental health assessment, and a total of 394 were completed. Where assessments did not occur this was usually due to either unavailability of the MHCP or because the individual declined the opportunity for assessment.⁴ Of the 547 individuals screened, 181 (33%) were found to have no mental health needs.

Short-term mental health issues often involved anxiety and/or depression. Severe and enduring mental health issues often involved schizophrenia or psychotic issues. If there was a dual diagnosis⁵ of mental health and substance misuse issues, offenders were included

3 At Brighton this role was undertaken by a mental health professional employed within Sussex Partnership Trust. At Stratford the role was delivered by a Forensic Psychologist employed within 'Together: Working for Wellbeing', a third sector organisation.

4 Defendants' rights to decline a mental health assessment and/or to have their case dealt with through normal court procedures were not affected by the MHC pilot arrangements.

5 Dual diagnosis refers to co-occurrence of substance misuse and a clinically identifiable mental health need. Individuals were excluded from the MHC pilot if substance misuse was identified as the primary need.

in the pilot if mental health was the primary issue. Otherwise they would be signposted to the relevant services. Participating professionals expressed concern that individuals were excluded when substance misuse was identified as the primary need.

Signposting and referrals⁶ were available to all defendants and offenders. They typically involved re-establishing links with mental health services, liaison with services, referrals to substance misuse services, and encouragement to register with a General Practitioner (GP). The arrangements in Brighton and Stratford were different, reflecting local arrangements. In Brighton, the MHC referred and signposted to a wide range of non-statutory community services. The costs of these were carried by the probation area. In Stratford, the MHC channelled offenders and defendants into 'regular' statutory services, and negotiated with providers to ensure individuals received services to which they were entitled. In both areas, the costs of these services (including access) were sometimes felt by staff and offender/defendants to be prohibitive.

Following a conviction, inclusion in the pilot on a community order required that:

- the offender was suitable for a Community Order;
- he/she was aged 18 years or over;
- he/she had committed a summary or 'either way' offence which could be dealt with in the magistrates' court;⁷
- he/she lived in the immediate locality (i.e. the Local Justice Area);
- his/her mental health needs should be manageable on a Community Order, with no primary need regarding substance misuse; and
- he/she was registered with a GP in the locality (although homeless people could be included in the pilot).

In total 55 offenders were given Community Orders with mental health requirements. Of these, nine breached their orders. Both sites undertook regular reviews of those on Community Orders – a key part of the MHC model. The input of health professionals to the review process was seen as invaluable. Stratford MHC reviewed Community Orders by way of Section 178 powers⁸ (Criminal Justice Act, 2003). A district judge or magistrates presided over the reviews and the MHC Team also attended. In Brighton, probation practitioners led the reviews. At both sites, these reviews were in addition to the reviews conducted by probation in accordance with National Standards for the Management of Offenders (Ministry of Justice, 2007).

6 See 'signposting and referrals' in the glossary for further information.

7 'Either way' offences include theft, drugs offences and some offences involving violence against the person. These are triable either by a magistrates' court or by the Crown Court. The right of the magistrates' court to remit the sentencing of these offences to Crown Court or for the defendant to elect for trial in the crown court was not affected by the MHC pilot

8 See Glossary 'Section 178: Power to provide for court review of community orders'.

Supervision activities, such as regular meetings and referrals, were highly valued by offenders interviewed. The holistic support offered by the MHC team pre- and post-sentencing was one of the features repeatedly mentioned. Some offenders interviewed were not fully aware that they were supported by a specialist MHC team whilst at court. Defendants and offenders may need further explanation and information on the role of the MHC team. Some offenders praised the review process as it gave them a 'voice'.

The pilot cost was £401,440. Costs specific to the pilot included that of the evaluation and that of the local pilot co-ordinator. If these were removed in order to estimate the bare operational cost of both MHCs, the figure would fall below £300,000 for both courts.

Implications

Key learning points from the pilot were as follows.

- The MHC pilot yielded innovative multi-agency collaborations that addressed needs which probably would have gone unmet. A wider implementation of MHCs would require significant changes, supported at a national level, in the current patterns of multi-agency information sharing and data collection.
- The MHC benefited from early consultation at senior management level.
- The MHC excluded certain groups. It would be beneficial to investigate if current exclusions could be removed to allow for wider access to services offered at the MHCs.

The core requirements for any new MHC would be:

- a Mental Health Court Practitioner available daily at court;
- multi-agency agreements put in place prior to the MHC for information exchange and to identify and address the priorities of collaborating agencies;
- comprehensive screening and assessment of defendants for mental health issues (through the MHCP and information sharing protocols);
- tailored use of community orders for offenders;
- court involvement in the processes to review whether community orders are being implemented effectively;
- involvement of the MHCP post-sentence;
- training and awareness events for practitioners and stakeholders;
- identification of, and engagement with, local resources for signposting and referral of defendants to appropriate support services.

1 Context

1.1 Aims of the pilot and study

The MHC pilot was established to explore improvements in policy and practice to support offenders with mental health needs. The pilot sites for the MHCs were at Brighton Magistrates' Court, East Sussex and Stratford Magistrates' Court, situated in the London Borough of Newham.

The key elements of the MHC model in both areas were to:

- identify defendants with mental health and/or learning disability issues through screening and assessments;
- provide the court with information on a defendant's mental health needs to enable the court to effectively case manage the proceedings;
- offer sentencers credible alternatives to custody to support an offender with mental health/learning disability needs by way of a Community Order with a supervision requirement or mental health treatment requirement;
- offer enhanced psychiatric services at court;
- implement regular reviews of orders; and
- signpost those individuals not suitable for the MHC Community Order⁹ to mental health and other services that could appropriately address their needs.

The key aims of the pilots were:

- to develop a clear model, which identified defendants and offenders with mental health issues, assessed the extent of those issues, and ensured that the offender/defendant received the appropriate intervention(s);
- to identify the actual costs that would be incurred across the Criminal Justice System and Health Services as a result of implementing the model.

This supported the wider objectives of:

- reducing re-offending;
- reducing the perceived 'revolving door syndrome', where people have repeat contact with the Criminal Justice System over the course of their lives, by providing
- adequate support for mental health needs; and
- improving offender and defendant access to Mental Health Services.

⁹ This group includes those found not guilty and those convicted but where Community Orders were not considered appropriate.

The MHC pilot facilitated creative sentencing opportunities for offenders with mental health issues. It was jointly delivered by Criminal Justice, health, and third sector agencies. The arrangements involved tailor-made Community Orders to enable offenders to address the mental health issues impacting on their offending behaviour. At Stratford, a dedicated MHC sat one day per week to deal with sentencing and review of Community Orders with a mental health component within any of the available requirements. At Brighton, all cases were heard within normal court lists.

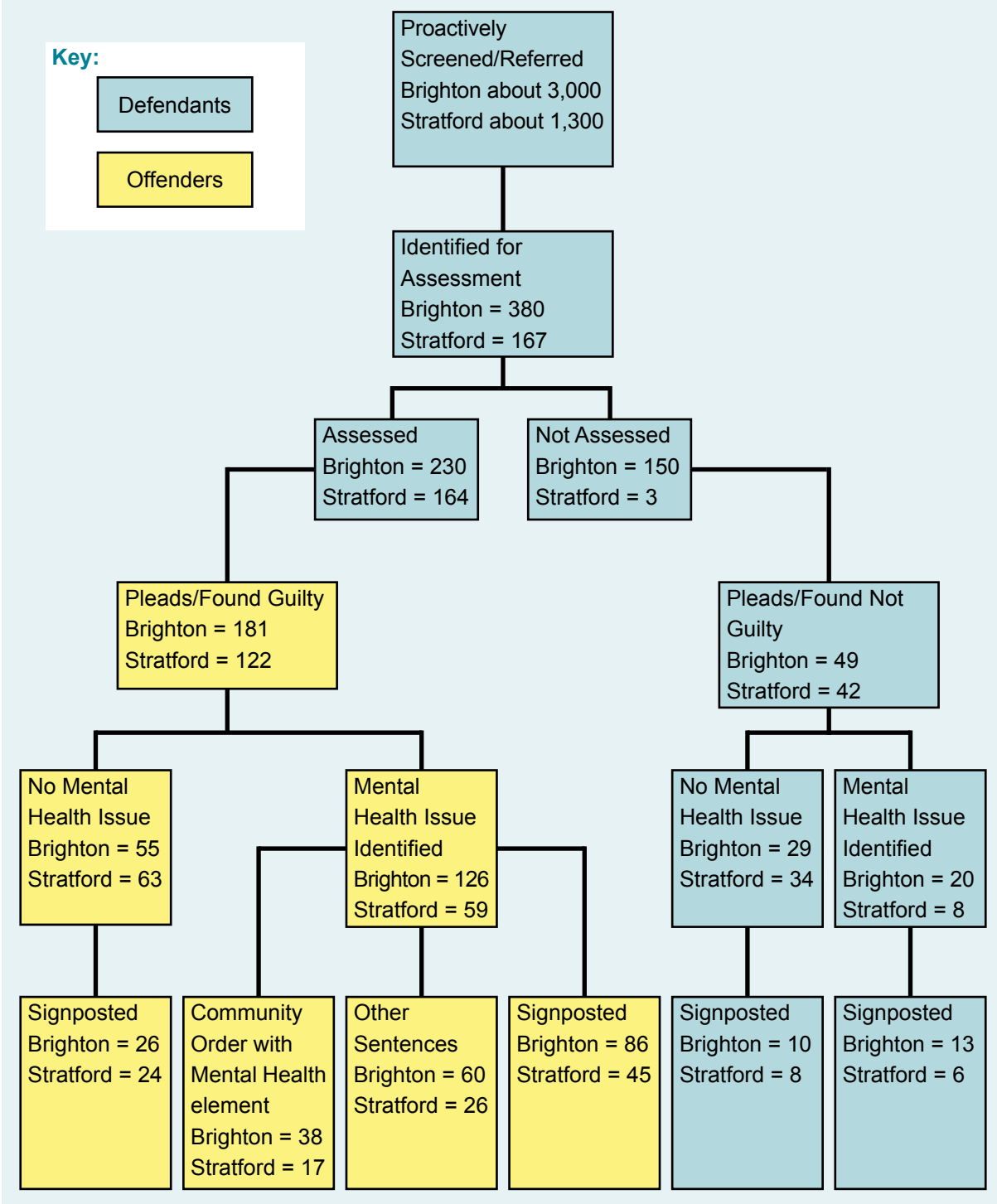
Inclusion in the pilot on a Community Order required that:

- the offender was suitable for a Community Order;
- he/she was aged 18 years or over;
- he/she had committed an offence which could be dealt with in the magistrates' court;
- he/she lived in the Local Justice Area;
- his/her mental health needs should be manageable on a community order, with no primary need regarding substance misuse; and,
- he/she was registered with a GP in the local magistrates' court area (although homeless people could be included in the pilot).

The Mental Health Court Practitioner was a pivotal figure in the pilot arrangements. At both Brighton and Stratford the MHCP was a mental health professional. At Brighton, the MHCP was a National Health Service (NHS) professional, a registered mental health nurse. At Stratford, the MHCP was a Forensic Mental Health Practitioner (the practitioner was also a trainee Forensic Psychologist) employed by Together: Working for Wellbeing, a third sector organisation. At both courts the MHCP was available five days per week to undertake screening and assessment activities. An important feature of the arrangements was that the MHCs were delivered jointly by Criminal Justice, health, and third sector bodies. A simplified process map of the MHC is shown in Figure 1, with details of the available pathways for both defendants and offenders.

Figure 1.1 Simplified process map of the MHCs

Throughput based on figures from January 2009 to January 2010



This study set out to assess how the MHC pilot was implemented at both Brighton and Stratford in order to draw out areas of best practice and areas for improvement. This would help with decisions on the future of the pilot and how to implement it at other sites in full or in part in the future.

The key research aims were as follows:

- to assess how well the two models were perceived to be implemented;
- to conduct a qualitative evaluation of the views of those affected by the processes that had been implemented; and
- to compare and contrast the models implemented at the two pilot sites.

The research questions which informed the outcomes addressed by the evaluation were as follows.

- a) How are offenders identified?
- b) How are the MHC pilots delivered?
- c) How are the review processes undertaken and what are the differences between them?
- d) What are the stakeholders' (including but not limited to court, probation, health service and offender) experiences of the court and subsequent review processes?
- e) How do the MHCs deal with cases?
- f) What are the costs incurred by implementing the new processes?
- g) What are the core requirements of a mental health court model capable of national roll-out?
- h) What is the appropriate geographical unit for the delivery of services in relation to court?
- i) To conduct a break-even analysis to establish the volume and costs of a national roll-out of MHCs.
- j) How would joint governance arrangements between the Ministry of Justice (MoJ) and NHS be configured?
- k) What are the roles of health, probation and the court in supervising mentally disordered offenders?

2 Approach

Three methods of information gathering were used in the development of this Report:

(a) case analysis; (b) semi-structured interviews with stakeholders/ professionals; and (c) structured interviews with service users.¹⁰ A wide range of documents was provided to the researchers by project management which informed the findings. These included protocols, minutes of meetings, policy papers etc.

2.1 Case analysis

The case analysis was based on analysis of data collected on the cases at Brighton and Stratford Magistrates' Courts in the twelve month pilot where there was contact by defendants with the MHC and/or supporting professionals. Its aim was to assess the workload of the MHC at both courts. It assessed key characteristics of the offenders involved, the sentences imposed and level of breach of orders. The data involved a large number of variables compiled by staff at both localities and entered onto a spreadsheet. The variables included demographic data, case details, mental health data, etc. (see Appendix 2). Information was not, however, consistently accessible across all the variables and therefore some could not be analysed as a result of missing/incomplete data. In addition, not all data collection directly relate to the research aims and questions. Relevant statistics are provided in the Findings section.

2.2 Interviews with stakeholders and professionals

Semi-structured interviews were used to gather information from stakeholders and professionals. This is an information gathering method where the interviewer is not constrained by a rigid set of questions. Instead, the interview is a structured conversation with a relevant agenda. The semi-structured interviews focused upon eliciting information regarding the performance of the MHCs, comparative strengths and weaknesses and the potential for informing future initiatives. The aim is to elicit a wide range of views and information from people with varied backgrounds and professional experience. This interview method allowed the interviewee to have a role in shaping the content and direction of the conversation. The analysis focused upon the identification of key themes, views and developments for all the research questions. Where these had been identified they were cross-checked with other sources. The researchers conducted interviews in accordance with the British Psychological Society Ethical Guidelines (2009). Interviewees included practitioners and management at the pilot sites, the project management team, MHC Team, magistrates, District Judges, local implementation group members, NSG members, court staff, psychiatrists, senior probation officers, NHS representatives, police and custody staff. In total, 69 individuals were interviewed, mostly individually although the interviewing of small groups (up to three people) did occur. On occasions, interviews via telephone took place.

¹⁰ Offenders subject to a Community Sentence imposed by the MHC.

2.3 Interviews with service users¹¹

A structured interview schedule follows a precise set of questions. The interviews were a blend of closed questions with a limited set of possible answers and open questions for clarification (see Appendix 1). In order to ensure confidentiality comments from the interviews included in this report have been anonymised. The researchers conducted interviews in accordance with the British Psychological Society Ethical Guidelines (2009). The aim was to elicit the views and experiences of those for whom the tailor-made Community Orders with a mental health component had been imposed. Interviews with those that were solely signposted or received other sentences, and those who were offered intervention but declined to take part were outside the scope of this evaluation.

Fourteen structured interviews were conducted with service users from the MHC pilot. The interviews were conducted part-way through their Community Order to provide service users with an opportunity to reflect upon their experience. All interviewees were given a letter of introduction which set out the purpose of the interview and confidentiality issues. This was also explained verbally by the interviewer. Each was asked whether he/she would like to be accompanied by a friend or professional of their choice, and three interviewees accepted this offer. It was explained to interviewees that they could terminate the interview at any time, withdraw a comment or choose not to answer a question without repercussion. A professional was always 'on hand' pre- and post-interview to support the interviewee if required.

2.4. Limitations

The limitations of this report are as follows.

- Although the datasets from Stratford and Brighton were of high quality there were gaps and discrepancies. The analysis excluded such instances where appropriate.
- The qualitative interviews were intended to give a flavour of the perceptions of those involved in the pilot. Interviewees generally self-selected. Therefore, the views presented should not be seen as representative of the wider population.
- The qualitative interviews with stakeholders and professionals investigated the MHC provision. Respondents were encouraged to 'speak their mind' and anonymity was guaranteed. Respondents could withdraw comments or speak off the record. It is acknowledged, however, that many of the interviewees had a vested interest in the service and worked hard on ensuring its success which may have led to bias in responses.
- Although the views from stakeholders from a variety of institutions and professions have been taken into account, the authors were not able to consult all stakeholders.

¹¹ Offenders subject to a Community Sentence imposed by the MHC.

- Every attempt was made to ensure that service users understood that their participation was voluntary and would have no impact upon their statutory supervision. However, demand characteristics, i.e. the possibility that service users provided responses that they thought were desirable rather than truthful, cannot be ruled out.
- Interviews with service users did not include defendants who only used the signposting service of the MHC Team and those who declined to take part. This could have provided valuable information but was outside the remit of this evaluation.

3 Findings

3.1 Overview of Brighton MHC

In addition to the local co-ordinator who spent half the week at Brighton, the MHC Team at Brighton Magistrates' Court was comprised of the following personnel:

- Mental Health Court Practitioner (MHCP)
- Probation Officer (PO)
- Probation Service Officer (PSO)

The arrangements at Brighton MHC were governed by the protocol for the delivery of an MHC Service to Brighton Magistrates' Court between Her Majesty's Court Service (HMCS), Brighton and Hove City Council, Sussex Partnership NHS Foundation Trust, Sussex Police, National Probation Service (NPS), Surrey and Sussex Probation Trust,¹² Crown Prosecution Service (CPS) and NHS Brighton and Hove Primary Care Trust (PCT). The number of parties to the agreement (eight) highlights the multi-agency nature of these arrangements.

There was a pre-existing provision operating five days a week at Brighton Magistrates' Court assessing those in custody known as the Court Assessment and Diversion Scheme (CADS). Prior to the MHC at Stratford there was an assessment and advisory Friday service for those in custody supported by a Forensic Psychiatrist. The focus of Stratford MHC on custody (the most vulnerable defendants) due to lack of such a service four days a week and Brighton MHC upon bail because there was an existing service which dealt with custody may have impacted upon service priorities, volumes of cases and, probably, the offending behaviour and mental health of the individuals assessed.

The initial screening process was multi-agency. All defendants were proactively screened at the charge stage. Information on all those charged and appearing at Brighton Magistrates' Court was drawn from the National Strategy for Police Information Systems database (NSPIS) and the Police National Computer (PNC). This was combined into a dedicated IT programme developed by Sussex Police especially for the purpose of collating different streams of data for use by the MHC. The information was forwarded electronically on a daily basis from the Police station to Brighton Magistrates' Court Police Officer to be made available to the MHCP. The MHCP also had access to NHS data such as the electronic Care Programme Approach database (eCPA)¹³ which contained clinical information on individuals so that the proactive screening could be both well informed and comprehensive. The eCPA was in use nationally at the time of writing.

¹² During the lifetime of the pilot, Sussex Probation Area merged with Surrey Probation Area to become Surrey and Sussex Probation Trust.

¹³ The electronic version of the Care Programme Approach (eCPA) should not to be confused with the Enhanced Care Programme Approach.

Defendants whose screening yielded evidence for possible mental health needs were assessed at court by the MHCP. This was essential in providing detailed information to the court to support case management and sentencing. Consultation and liaison between the MHC Team supported sentencing recommendations made by Probation. Those who failed to meet the MHC criteria were signposted out to appropriate services by the MHCP. Defendants identified as not having a mental health need proceeded through normal court processes without further intervention from the MHCP.

The MHC Team undertook all enquiries necessary for the completion of a Report to the court to support sentencing. These were in the form of an Oral Report, Fast Delivery Report (FDR), or Standard Delivery Report (SDR).¹⁴ Offenders who were sentenced to a Community Order which incorporated an element to address their mental health needs were reviewed by the MHC Team. The Offender Manager, a qualified PO, supported by the MHC Team, conducted the first review within ten days and at monthly intervals initially and then regular intervals, not longer than 12 weeks, after this, depending on assessed level of need. This was in addition to the review required by the national standards for the supervision of offenders. In addition, the MHC Team had identified a raft of community provisions and secured access to these services for their clients. This involved both signposting and referrals pre- and post-sentencing.

3.2 Overview of Stratford MHC

In addition to a local co-ordinator, the Stratford MHC Team was comprised of the following personnel:

- Mental Health Court Practitioner
- Probation Officer
- Case Manager (Administrative Officer)

At Stratford the listing of MHC defendants and the post-sentence review process was on a Friday afternoon. The court conducted reviews further to powers derived from s178 of the Criminal Justice Act (CJA) 2003. The sessions were presided over by a District Judge or by magistrates. In addition to the activities undertaken as described for the Brighton MHCP, the MHCP at Stratford, as Forensic Mental Health Practitioner to probation in Newham, had a role in offering consultation, advice and assessment with the wider supervised offender population in the Borough. She held a small caseload in order to deliver specialist interventions for those already sentenced to a Community Order with Supervision where mental health needs had been identified.

¹⁴ An Oral Report is a short assessment delivered orally to the court on the same day as the request. An FDR is a written report, typically provided on the same day as requested and involves fast track assessment of the offence and contributing factors. An SDR is a written Report from a Probation Officer provided to the court within 15 days of the request and based on a wide-ranging actuarial and clinical assessment of contributory factors which also addresses sentencing options.

Stratford was identified as a pilot site at a later stage than Brighton. This had an impact on funding streams and lead in time which meant that at the outset of the pilot the arrangements at the MHC in Stratford had fewer protocols in place than in Brighton. Screening and assessment were mainly undertaken on custodial remand defendants seen in the court cells. This resulted from the pre-existing Friday service and the view that defendants in custody were more vulnerable than those on bail. Information sharing arrangements were later agreed which supported the identification of police bail defendants.

At Stratford a clear distinction was drawn between signposting and referral. Signposting was defined by a process of information giving to offenders in terms of the community services available, including referral and access criteria, to meet identified needs following assessment. The expectation would be that offenders would then make contact with the services themselves. In contrast, the process of referral utilised by the MHC team would involve a number of additional activities to information giving – these could include direct consultation with community services to discuss access and criteria, completion of referral forms as required, sharing of assessment reports and other relevant information and securing first appointment times. At Brighton the distinction between these processes was not drawn out, with both considered to be signposting.

3.3 Case analysis

Overall throughput of Mental Health Courts

The data provided go well beyond what is typically recorded by Mental Health Liaison and Diversion Teams that operate at magistrates' courts (Winstone and Pakes, 2008). The data gathering was subject to a quality assurance process at the Ministry of Justice. A sample of 53 (9.7%) cases was reviewed as part of that exercise.

Across both sites, over 4,000 individuals were proactively screened for mental health issues. Most immediately screened negative for mental health needs and their cases could progress as normal. A total of 547 cases were deemed to require further mental health assessment and these were included in the dataset. Where missing data or duplications occurred cases have been excluded from the analysis where appropriate. Of the 547, 167 were from Stratford and 380 were from Brighton. Of these 143 were women (26.1%). There were 23 individuals that appeared more than once due to multiple offending over the course of the pilot and had more than one court appearance as a result. In their repeated offending no patterns of escalation can be detected and this did not involve individuals on an order imposed by the MHC. The monthly turnover is presented in Table 3.2.

Table 3.1 Monthly turnover of cases identified for formal assessments by both MHCs

Turnover	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan'10 ^a	Total
Brighton	18	23	34	33	18	34	48	35	38	34	29	34	2	380
Stratford	10	15	15	10	8	14	20	11	19	17	10	14	4	167
Total	28	38	49	43	26	48	68	46	57	51	39	48	6	547

a Data until 8 January 2010.

The data show that Brighton had the busier court with regard to screening and referral of individuals who might be in need of mental health support. The source of referrals highlights important differences in the identification of potential clients which help to account for the difference in turnover as documented above (see Table 2).

Table 3.2 Referrers of potential clients to Brighton and Stratford MHC

Referrer	Police	PER ^a	eCPA ^b	Probation	Bench	Solicitor	Other	Unknown	Total
Brighton	211	0	42	62	17	26	10	12	380
Stratford	13	69	0	48	12	6	16	3	167
Total	224	69	42	110	29	32	26	15	547

a Prisoner Escort Record Card (PER).

b eCPA was only available to the MHCP at Brighton because she was employed within Sussex Partnership Trust as a health professional.

The ethnic composition of the clients at the two MHCs is strikingly different. In Brighton, 309 (85.1%) of those who stated their ethnicity were reported to be White British. In Stratford, 55 (32.9%) were White British. This can be compared to the 2001 Census data for both Brighton and the more recent population estimates by the Office of National Statistics (ONS, 2007) for the London Borough of Newham in which Stratford Magistrates' Court is set. According to the 2001 Census, Brighton and Hove have a resident population of 247,817 of which 94.2% are White. The 2007 Office of National Statistics estimated population for Newham is 249,614 of which the ONS estimates that 29.2% are White. Thus, to a large extent the ethnic composition of the respective MHCs clientele is a reflection of the areas that they serve. An interpreter was required for 11 defendants. In total 240 (80% of cases where this information was available) defendants in Brighton and 128 (89.5%) of defendants at Stratford were not in employment or education.

Table 3.3 sets out the offence profile of all those identified for assessment. Whilst a wide range of offences were represented, this Table demonstrates that 'violence against the person' was the most frequent charge (28.9% of defendants in Brighton and 35.3% of defendants in Stratford). The second most frequent charge was that of 'theft and handling stolen goods' (14.7% in Brighton and 10.8% in Stratford).

Table 3.3 Offence profile of defendants assessed by the MHCP

Offence	Brighton MHC		Stratford MHC		Total	
	N	%	N	%	N	%
Arson	2	(0.5)	0	(0.0)	2	(0.4)
Breach matters	17	(4.5)	12	(7.2)	29	(5.3)
Burglary	6	(1.6)	4	(2.4)	10	(1.8)
Criminal damage	39	(10.3)	13	(7.8)	52	(9.5)
Driving without due care	1	(0.3)	2	(1.2)	3	(0.5)
Drug offences	27	(7.1)	9	(5.4)	36	(6.6)
Drunken driving	25	(6.6)	1	(0.6)	26	(4.8)
Fraud and forgery	19	(5.0)	4	(2.4)	23	(4.2)
Indictable motoring offences	0	(0.0)	1	(0.6)	1	(0.2)
Non-payment of fine	0	(0.0)	4	(2.4)	4	(0.7)
Other indictable offences	7	(1.8)	2	(1.2)	9	(1.6)
Other summary motoring offences	7	(1.8)	11	(6.6)	18	(3.3)
Public order offences	34	(9.0)	0	(0.0)	34	(6.2)
Review of DRR	1	(0.3)	0	(0.0)	1	(0.2)
Robbery	0	(0.0)	1	(0.6)	1	(0.2)
Sexual offences	8	(2.1)	6	(3.6)	14	(2.6)
Summary non-motoring offences	21	(5.5)	20	(12.0)	41	(7.5)
Theft and handling stolen goods	56	(14.7)	18	(10.8)	74	(13.5)
Violence against the person	110	(28.9)	59	(35.3)	169	(30.9)
Total	380	(100)	167	(100)	547	(100)

The mental health issues identified at assessment are set out in Table 3.4. In total, 394 (out of a possible 547) individuals were assessed. Thus, in 153 instances an indicated assessment failed to occur. Reasons given for non-assessment included a not guilty plea, a refusal to be assessed by defendant and/or their solicitor, case adjournments, the offence judged to be below a community sentence threshold and resources (prioritising of other defendants, annual leave, etc). In two cases the mental health complaint was unknown. Short-term mental health issues often involve anxiety and/or depression; severe and enduring mental health issues often involve psychotic issues and frequently a diagnosis of schizophrenia. The average age of defendants on the day of their assessment was 34.7 years; 34.1 years in Stratford and 35.2 years in Brighton.

Table 3.4 Mental health issues identified at assessment by MHCP

MHC Court	No MH issues identified	Developmental	Personality	Short term	Severe and enduring	Not assessed	Unknown	Total
Brighton	84	10	14	94	27	150	1	380
Stratford	97	2	3	32	30	3	0	167
Total	181	12	17	126	57	153	1	547

These data demonstrate a difference between the two sites regarding the identification of individuals who would benefit from a mental health assessment at court. At Brighton, the data suggest that more individuals were screened (n=380) than could be assessed (n=229) due to a variety of reasons (see above). At Stratford, 164 out of 167 identified individuals were assessed. This pattern may partly be attributed to the MHCP in Brighton having access to police and NHS data systems which enabled identification of these individuals prior to their court appearance. In Stratford, the MHCP did not have the same access to police and NHS data systems. With most of its clientele in custody, identification of potential clients tended to occur when these individuals were already held at court. Out of all those assessed at Brighton and Stratford, 181 (33%) were not identified as having mental health issues.

Signposting and referral activities

Case analysis demonstrated that of the 547 individuals initially referred or screened, 492 did not receive a Community Order with a mental health component. Signposting and referral activities were frequently not recorded for the data collection exercise and not always easy to decipher. It is, therefore, more appropriate to provide an overall impression rather than precise figures. Individuals who did not qualify for a Community Order could nevertheless be severely ill. Schizophrenia is often mentioned as a diagnosis and so are psychotic symptoms. Virtually all individuals with severe and enduring mental illness received a form of service. This frequently involved re-establishing links with mental health services, liaison with these services, referrals to drugs services or encouragement towards GP registration.

Cases sentenced through the MHC

Of the 547 individuals that were screened or referred to the MHC Team, 55 received a Community Order with a mental health component; 38 in Brighton and 17 in Stratford. Of these, 20 were women. The mental health issues of those on a Community Order are presented in Table 3.5. Although short-term mental health problems constituted the majority, Community Orders with a mental health component were regularly imposed on offenders judged to have severe and enduring mental health illness. Twelve defendants were identified as having a dual diagnosis which means that they had both mental health issues and substance misuse problems. They were suitable for the MHC pilot when it was assessed that the mental health problem constituted the primary need. Seventeen of these defendants reported current substance misuse problems.

Where substance misuse was identified as a primary issue, which excluded the individual from the pilot, a number of individuals were sentenced to Community Orders including Drug Rehabilitation Requirements or Alcohol Treatment Requirements. The MHCP signposted them to relevant services.

Table 3.5 Mental health problems of individuals sentenced through MHC arrangements and on a Community Order^a

	Developmental	Personality	Short-term	Severe and enduring	Total
Brighton	4	3	21	4	32
Stratford	1	1	6	5	13
Total	5	4	27	9	45 ^b

a Fifty-five orders were given, but information is only available on mental health problems for 45 of those orders.

b Information on the mental health problems of ten offenders was not clearly recorded in the dataset. They have been omitted from the table.

The case analysis demonstrated that for this group who were sentenced through the MHC arrangements the most common offences were violence against the person (16); theft and handling stolen goods (10) and breach matters (8). Others included drug offences (5) and criminal damage (4). These results demonstrate that neither violent offending nor severe and enduring mental illness are excluding factors in deciding suitability for a Community Order with a mental health component.

Of the 55 Orders made, four were Suspended Sentence Orders and the remainder were Community Orders with a mental health component. The Community Order with a Mental Health Treatment Requirement was imposed five times.¹⁵ Most frequent were Community Orders with a supervision requirement (36 out of 38 in Brighton and 16 out of 17 in Stratford). Additional requirements imposed were the Specified Activity Requirement (which requires the offender to take part in specified activities such as seeing a counsellor), Curfew (the requirement to, for instance, stay indoors at certain times), unpaid work, the Alcohol Treatment Requirement (involves a tailored treatment programme with the aim of reducing drink dependency) and an Exclusion Order which forbids the offender to enter a certain area (see CJA, 2003).

A small number of individuals, nine, breached the conditions of their Order. Caution must be exercised in drawing any conclusions on this due to the very small numbers involved. However, Solomon and Silvestri (2008) documented commonly higher breach rates among

¹⁵ The MHTR was introduced in April 2005. With the offender’s consent and where treatment is available, the court may direct the offender to undergo treatment by or under the direction of a medical practitioner and or psychologist with a view to the improvement of the offender’s mental condition. The order must be managed by an Offender Manager.

offender populations than those identified in this evaluation. Service user interviews suggest that they were strongly engaged with the content and style of the supervision arrangements which may account for the levels of compliance and engagement.

Interviewees mentioned frequently that the number of Orders with a mental health component imposed seemed relatively low, 38 in Brighton and 17 in Stratford. It is unclear why this is the case although several tentative reasons can be offered. The first is that many offenders who initially are judged to benefit from a mental health assessment do not suffer from mental health problems. For other offenders their offending is either too severe or not serious enough to warrant a community penalty. Finally the availability of the MHCP and their capacity to see clients is a constraint on the number of people that could be assessed. Whatever the reason, this meant that the MHC probation teams had a caseload lower than regular probation caseloads. The benefits of this are discussed in the analysis of the structured and semi-structured interviews.

It is important to appreciate the extent of the operational work that took place. Over 4,000 individuals were proactively screened for mental health problems. A total of 547 individuals screened positive and received some type of service through the pilot arrangements. In 55 cases, tailor-made sentencing took place and the MHC Team was involved in the implementation of the sentence. A great deal of referrals, signposting, liaison, and other work was undertaken on behalf of those who entered the Community Order part of the pilot as well as those who did not.

3.4 Interviews with stakeholders and professionals

This section addresses the criteria for inclusion, processes for identification of clients, assessment, signposting and referrals, multi-agency collaboration, professional roles and responsibilities and resourcing and training. Additionally the review process and post-sentence arrangements are discussed.

Identification, signposting and referral of offenders

Referrals to the MHCP were accepted from a number of sources including, but not limited, to police, defence solicitors, the court, probation and custody officers. Additionally self-referrals, referrals from friends and family, or anyone else involved with the defendant, could be made at the court. Proactive screening was undertaken to gather initial information was followed by a mental health assessment interview if required. The assessments undertaken by the MHCP also informed the court as to whether further specialist assessment was required, for example, a psychiatric assessment. This served the function of triaging potential court requests for psychiatric reports. This aimed to ensure that such assessments were only formally requested when deemed necessary, thus both avoiding unnecessary periods of adjournments, particularly for those on remand, and costs to the court.

The defendant was most likely to be assessed as suitable for the MHC if falling within either Tier 3 or 4 of the National Offender Management Service (NOMS) Offender Management Model. Tier 3 cases were those assessed through the Offender Assessment System (OASys) as medium to high risk cases of harm to self and others where the emphasis of intervention was upon changing behaviour. Tier 4 were those assessed through the use of OASys as being very high or high risk of harm cases where the emphasis was upon behaviour change and control. The complex needs of the offenders sentenced through the MHCs contributed to the OASys scores and the allocation to an Offender Management Tier which attracted resources for the management of multiple needs.

Where there was a dual diagnosis, mental health concerns had to be the primary need if an individual was to be identified as suitable for a Community Order within the pilot. The inclusion of dual diagnosis where the substance abuse is the equal or primary issue could lead to enhanced opportunities for the health and justice sector to work together. This would be in line with the ethos of the Bradley Report (2009), Ministry of Justice (2009) and the Health and Criminal Justice Programme Board (2009) to improve service through multi-agency collaboration in the case of dual diagnosis.

At the end of the evaluation period it was still the case that the criteria for initial assessment by the MHC Team were very wide compared to the criteria for suitability to be referred for sentencing in the MHC. From the perspective of case management at court, however, interviewees expressed their satisfaction that from the outset they were informed whether mental health issues were of concern. One interviewee commented "it is as important to know whether someone does not have a mental health issue as whether someone does".

It was always intended that the MHCs would expand their scope to include learning disability once other processes were embedded. Prior to implementation of this aspect, which took place after the conclusion of the evaluation, learning disability training was delivered to all of the practitioners in liaison with the Department of Health.

Access to police information was restricted as a result of multi-agency processes to identify police bail clients to the MHCP taking longer to establish than hoped for. Access to clinical information was also subject to restrictions. Unlike her counterpart at Brighton, who was an NHS employee and who therefore had direct access to the NHS data system, the MHCP at Stratford was not an NHS employee. She did however have a point of contact with the local Community Mental Health Team (CMHT). Both of these restrictions eased over the period of the MHC pilot but they had an inevitable impact on the identification of clients, particularly early in the pilot when those on police bail were less likely to be identified for assessment.

At both Brighton and Stratford the processes for early identification appeared to meet the requirements of the MHCs. The arrangements for early identification, including multi-agency

collaboration, took longer to establish in Stratford than in Brighton. This was partly attributable to existing protocols and key contacts already being in place prior to the MHC pilot in Brighton. That said, significant progress was made by the end of the pilot to ensure that the Stratford arrangements were more comparable to those at Brighton. For example, interviewees commented upon the “positive engagement” with police once a key contact had been identified and also upon the “*strides*” made in information exchange with the police thereafter. Credit should be given to professionals, stakeholders, project management and multi-agency partners for their sustained efforts to address this. Information sharing across agencies to support key activities to enhance service provision is renowned in the literature as posing hurdles to successful implementation. Without robust processes in place initiatives often struggle to realise their full potential (Stone, 2003; NACRO, 2005; Winstone and Pakes, 2009).

With regard to the signposting and referral activity, the screening for mental health problems in itself constituted a service, in particular as this is a group whose mental health problems may frequently go unrecognised or may be left untreated. Information from interviews, coupled with the case analysis, demonstrated that signposting and referral for those with short-term mental health problems was in the majority of cases to clinical support. This most often involved reconnecting individuals with services, encouragement to take medication and advice on what to do should their mental state deteriorate. The scope of signposting to address needs not necessarily requiring statutory input was wider and examples included referrals to Connexions, CRUSE bereavement care, women’s support, contraceptive advice, physical health advice, RU OK (self-help for teenagers in Brighton), Lewis2Brighton project, British Legion, and counselling for past physical abuse. Information from interviews and the case analysis confirmed that signposting for those with developmental problems mainly involved reconnecting with services and referral onwards. Finally, signposting regarding individuals with personality problems was characterised by onward referrals to community mental health provision.

Those with dual diagnosis were frequently signposted towards community drugs and/or alcohol services. Others were signposted to the Community Mental Health Team (CMHT) services or various forms of counselling. Where individuals were known to services, efforts were made to reconnect them. Other examples of support identified included the British Legion and the Samaritans. Individuals identified as having no mental health problems still benefited from the contact with the MHCP. This could, for example, result in referral to substance misuse services and getting information and advice in the areas of housing, education and personal relationships.

For those screened as having mental health concerns but not requiring a Psychiatric Report, the court could rely upon the information provided by the MHCP and the MHC Team. In order to avoid an adjournment, an evolving practice during the pilot was that some of these defendants would be dealt with by the court of the day. This supported the ethos of the pilot

to provide speedy and appropriate resolution of such cases. It may not have been what was intended at the outset of the pilot but it demonstrated the ways in which new practices could be successfully embedded into existing arrangements. As one MHCP commented:

“I will be called into court if the magistrate or other legal professionals have concerns. There is a short adjournment whilst I interview the defendant and then I write a short report which I make available to the court so that the case can continue”.

Interviews with the MHC Team confirmed that the approaches to signposting and referral post screening and assessment emerged differently at Brighton and Stratford.

Brighton MHC approach to signposting and referral

At Brighton MHC, the MHC Team were particularly effective at identifying a raft of non-statutory community provision. This included the British Legion (counselling and advice for post traumatic stress) and Mankind UK (counselling and advice for men who have been sexually abused). Latterly, the Brighton MHCP was working closely with a new scheme for women called INSPIRE, a women-centred support service funded by the Ministry of Justice. Most of the services identified operated a sliding scale of charges depending upon individual economic status. With the support of the MHC Team the provision was made accessible as the costs were carried by the Probation Area. However, it must be borne in mind that any charge for an offender (whether for travel or for sessions) no matter how small, may be perceived to be prohibitive. This may require incorporation into future budgets.

Stratford MHC approach to signposting and referral

Stratford MHC Team, in contrast, channelled offenders into ‘regular’ statutory services. This was a “*principled approach*”. The role of the MHC Team was interpreted as one of negotiating with catchment service providers to ensure that those identified as having a mental health need received the services they were entitled to. It is noteworthy that some of the activities of the MHCP and MHC Team signposting and referral function, especially at Brighton MHC, resulted in identifying local resources for offenders who previously may not have received this provision. The Stratford MHC Team tended to access statutory provision on behalf of offenders. This was primarily due to the numbers of offenders presenting with more serious mental health need assessed as requiring services from the local Community Mental Health Teams. Referrals to some organisations in Newham were viewed by the team as somewhat prohibitive due to charges made to receive the service. Only one counselling project, for example, offered a free service.

Conclusion on signposting and referral approaches

A definitive statement as to which approach to signposting, referral and assessment might be more successful underplays the importance of being responsive to local circumstances. Allowing the services to develop processes appropriate to local need and resourcing could

be seen as one of the strengths of piloting the two models. Both sets of arrangements appeared to achieve the aims of the pilot in relation to identification, assessment, signposting and onward referrals.

The review process

Stratford MHC review process

At Stratford MHC, a model of Bench review was adopted utilising s178 CJA 2003. The review process worked well with good collaboration between the relevant professionals to prepare the necessary information for the court. The review itself was reported to take between ten minutes and half an hour, whilst preparatory work (including, but not limited to, preparing written reports and making face-to-face contact) took additional time which was not accurately captured. It was originally intended that they would be held four-weekly, although the length of time between reviews is a judicial decision taken on a case-by-case basis and four weeks might not be a sufficient length of time for progress to be demonstrated. A number of interviewees commented that, unlike reviews for those on mandatory drug testing, offenders with mental health issues have ongoing difficulties and the support and progress they make should be considered as part of a range of long-term outcomes. A member of the judiciary commented:

“These Orders are a bit more difficult. You want to involve the offenders in setting goals: ‘what do you (offender) think is possible to achieve by next month?’ That is more difficult to do as it requires insight into their condition and the changes in that. It tends to involve no offending behaviour, meeting appointments (with probation, health or whoever they are directed to)...but there is no quantitative measure such as a negative drug test. When you ask ‘are you taking your medication’ they’ll always say yes. So you don’t review on the same quantitative, factual basis.”

It was reported that the reviews were mostly well managed in terms of the timeliness of the court availability to see the offender, the response of the court to the review process and the response of the offender. A member of the judiciary commented:

“Offenders are very communicative, very anxious to talk. Usually there is scope for a good dialogue.”

At Stratford MHC the MHCP had a mental health advisory role to the MHC Team and to Probation with ongoing clinical contact with offenders on a Community Order when required. Thus, referral and signposting could result in the MHCP working, post-sentence, with the offender to support the management of mental health needs. The lower number of defendants passing through the MHC at Stratford may have contributed to ensuring that the MHCP at Stratford was able to sustain the additional workload. This ongoing intervention was not part of the original pilot model, but arose as a result of fitting the model within the Together FMHP¹⁶ Service model which is delivered as part of a formal contract with London

¹⁶ Forensic Mental Health Practitioner.

Probation Trust.¹⁷ This provides a clear contrast between the post-sentence provisions at the two pilot sites. With regards to the MHCP employer, Together: Working for Wellbeing, the streamlining of the assessment and clinical role was part of their service model. With regard to the MHC it was, perhaps, an unintended outcome of the contract between Together: Working for Wellbeing and London Probation Trust and the way in which the MHC was resourced at Stratford. This arrangement was reported as highly satisfactory in providing continuity of expert support and was said to enhance service delivery and provision (see also Lewis, *et al.*, 2007). One interviewee commented:

“it works well, they see the MHCP at court, they see the same person at the probation office for specialised intervention, then they see her again at court for the review process. All the time the MHCP is liaising with the probation officers, so it really is an integrated package and the offender seems to engage really well with that”.

Brighton MHC review process

At Brighton MHC the review process faced fewer challenges than at Stratford. This was attributed to the fact that review activities were embedded as a process into Probation supervision, although the MHC review is an additional piece of work. It was reported that collaboration between the relevant parties to establish the information required to carry out the reviews was well supported. Complex cases required up to an hour for the actual review to be completed whilst others could be completed much more quickly. The reviews could be paper-based, attended by the MHC Team and probation management, or include a meeting with the offender.

At Brighton, and as intended in the arrangements for the MHC pilot, the role of the MHCP did not include ongoing work with the client post-sentencing but did include attendance at reviews. This was in keeping with the original intention to separate the assessment from the clinical treatment and intervention function to ensure that the workload for the MHCP did not become unmanageable.

Conclusion on review processes

All the offenders on community orders co-operated with the review process at Stratford and Brighton and in that respect served the aim of the MHC pilot to provide a tailor made service to manage complex offender needs. The arrangement to integrate court, supervision and review processes also appeared to result in positive outcomes, such as a small number of breaches.

Both courts demonstrated that the input of health professionals was invaluable. The difference between the two pilot sites led to the conclusion that direct electronic links to NHS data made identification of clients on police bail more readily accessible at Brighton. At Stratford the input of the health professional to support probation intervention post-sentence was perceived as maximising the benefits of multi-agency collaboration.

¹⁷ During the lifetime of the pilot London Probation gained trust status.

The learning from both these models could support future similar initiatives arising out of Integrated Offender Management and also health strategies to respond to the Bradley Report (2009). Particularly this refers to the use of experts in mental health to support the screening, assessment, sentencing and supervision process linked to joint working arrangements.

Joint working and governance arrangements (covering both Stratford and Brighton)

Governance arrangements were perceived to be key to the success of the pilot. A National Steering Group (NSG) chaired by the Senior Responsible Officer was situated at the top of a three tier structure that was designed to ensure the appropriate involvement of the various staff, judiciary, agencies and other organisations. The role of the NSG was to advise and support the Senior Responsible Officer to make sure the project met its objectives to time, cost and quality. Beneath the NSG were the Local Steering Groups for each pilot site, whose roles were to ensure the appropriate involvement of the various staff, judiciary, agencies and other organisations in the delivery of pilots. The HMCS Project Manager and team had responsibility for identification of pilot sites, delivery of the evaluation, and day-to-day running of the project. This involved working with local co-ordinators, steering groups and external services to ensure delivery of products in pilot sites to time, quality and within budget. At the pilot sites a local co-ordinator was responsible for implementation and support of the model and local steering groups at their site, input to the evaluation and reporting progress back to the central project team.

Interviewees indicated that the arrangements for joint working and governance at Brighton and Stratford both appeared to work. The project management team strove to enshrine multi-agency work in formal agreements and protocols. There was an impressive amount of work put into establishing these prior and during the MHC pilot. The strength of multi-agency collaboration was cited throughout the 12-month period of the evaluation as being one of the most impressive outcomes of the arrangements. Typical of this was the wide representation on the local Steering Groups from agencies supporting the MHC pilot. Other evidence (see for example, Rosenbaum, 2002) suggests that this supports collective ownership and overcomes differences in multi-agency philosophies and priorities. Multi-agency collaboration was further exemplified by management representation on the National and Local Steering Groups and Implementation Groups with a good level of attendance. This strategic framework has been demonstrated to secure the long-term interests of multi-agency mental health initiatives (Rosenbaum, 2002; Pakes and Winstone, 2009). Interviewees with experience of service provision to offenders with mental health needs prior to the MHC commented that to go back to the previous state of affairs would be “*unthinkable*”. Many of the arrangements for the MHC were positively commented upon as the following quotes illustrate:

“Good developments on the stakeholder engagement front.”

“Huge turn-around in terms of development of MHC Pilot – everyone hands on, involved staff really clear especially in the way they work with partnership arrangements.”

“Clarity now of roles, particularly with regard to how the Bench understands what each person does.”

“Good liaison and contact.”

“The way that professionals from different backgrounds and agencies work together in the MHC pilot is unique.”

Where tensions in multi-agency arrangements did exist it remained the case that these may have reflected the differences in philosophy between health and justice agencies. To a degree this may always remain the case. However, such differences can act as a spur to constructively challenge single-agency views. This can support creative solutions which serve both justice and health outcomes (see also Rosenbaum, 2002).

At the outset of the pilot, difficulties with access to office facilities at court were reported to hamper the work of the MHCP. Whilst progress was made towards resolving these issues, there remained difficulties with securing office space for the assessment of offenders at Stratford. Arrangements to resource these from the outset would have facilitated a more efficient working environment.

The need for training to support knowledge awareness and multi-agency provision was highlighted in the Bradley Report (2009). Training and awareness were noted throughout the evaluation as key to support the aims of the MHC and to promote multi-agency collaboration. Interviewees commented positively on their engagement with a number of training activities that were specifically supported the roles and responsibilities of the MHC. These included Joint Practitioners events. Training events supported by the MHC Team and project management included attendance from magistrates, legal advisers, Probation, Police and NHS staff. It was reported that these had been well attended. Those who attended these events and who also participated in the evaluation interviews unanimously stated that they had found the knowledge awareness valuable. They stated that it enhanced their understanding of the role and purpose of the MHC and how to use this to best effect during the sentencing and supervision process.

Interviews with Project Management covered the topic of a resource pack to support the dissemination of good practice identified in the evaluation of the pilot. This included a guide to training and awareness and draws upon the MHC pilot arrangements. This could contribute to the development of future similar initiatives. The resource pack will consider the core elements of MHCs in detail and address the following.

- Governance and key partnerships
- Information sharing and protocols
- Identification of cases
- Assessment
- Signposting and referrals
- Case management and sentencing
- Post-sentence and review processes
- Equality and diversity issues
- Performance management
- Court facilities
- Specialist support services
- Communication

It was felt by Project Management and by a number of the interviewees that the term ‘Mental Health Court’ failed to capture the range of professional activities embraced under this title.

Further, interviewees specifically mentioned that the term could be seen to be stigmatising. It is therefore suggested that another title be identified for future initiatives.

3.5 Interviews with service users

Profile of interviewees

A total of 14 service users (offenders) volunteered to be interviewed. They had all been sentenced through the MHC pilot arrangements. The interviewees were identified by the MHC Team probation officer in collaboration with the MHCP. Some were excluded on the grounds of being in an acute phase of mental ill health and therefore unable to give fully informed consent. There were also those for whom it was assessed that disruption to the pattern of their daily lives might cause further distress. All those who did not fall within these categories were invited by a member of the MHC Team to participate in the interviews. The 14 service users interviewed comprised four females and five males at Brighton MHC and five males from Stratford MHC. The ethnic profile of the interviewees is set out in Table 3.6.

Table 3.6 Ethnic profile of offender interviewees

Ethnicity	Number
White British	7
Asian Indian	2
African	2
Any other White	1
Asian Pakistani	1
Caribbean	1
Total	14

The youngest interviewee was aged 18 years and the oldest was aged over 60. All interviewees were Tier 3 (OASys). They were all were subject to Community Orders ranging from a five-month to 24-month supervision requirement. Individuals who had been signposted were outside the framework for structured interviews as they had no further involvement with the MHC and were therefore unavailable for interview. The sentences imposed were for offences which covered a range of behaviours which included acquisitive, violent and drug-related crime and minor sexual offences (exposure). Mental health problems ranged from traits of autism, anxiety, depression, personality disorder, learning difficulties, schizophrenia and paranoid schizophrenia.

Activities on Community Orders

Whilst on supervision the offenders were referred for various types of additional support appropriate to their needs. This included counselling (through the GP) and referral to community and statutory provision. In Brighton, contact was boosted by a mentoring scheme that had recently opened up for people on Community Orders which included counselling and advocacy on an informal basis. One interviewee commented “I am lonely, but they send round a mentor once a week to have tea with me”.

The experience of service users

The majority of interviewees reported that they had not been fully aware that they were being supported by a specialist MHC Team whilst they were going through the court process. This applied across both courts. One interviewee commented: “*the perception of the MHC is clouded by everything else that is going on*”. There was unanimous appreciation of the quality of time spent with the PO/PSO at Brighton and PO/PSO/MHCP at Stratford. One interviewee commented: “*When I was at court I had given up on myself but now I am glad that I didn't go to prison and I haven't given up on myself anymore*”. The process of conducting reviews, especially under the s178 arrangements, clearly made an impression upon the interviewees and many praised the process. One example of an individual comment on supervision and court reviews was: “*Great, especially Court Reviews. Before I wasn't even going to court when I was summonsed but doing this I have been staying out of trouble and attending*”. Another stated: “*This is more like helping people back into normality; it helps me to stay law-abiding.*” One interviewee commented that for the first time she felt that she “*has a voice*”.

There were eight questions scored by Traffic Lights as part of Question 4 of the service-user questionnaire (see Appendix 2). The responses are collated in Table 3.7.

Table 3.7 Service user responses to Questionnaire, Q.4^a

Questions	Yes	Some-what	No	Total
I understand how my case was being dealt with at court	8	4	2	14
I knew how to contact a member of the MHC Team at court	5	3	6	14
I know how to contact a member of the MHC Team now	14	0	0	14
I feel that I was listened to at court	9	2	3	14
I feel that I am listened to on a Community Order	14			14
My mental health needs were well looked after at Court	6	5	3	14
My mental health needs are well looked after on a Community Order	11	2	1	14
The court fully understands the mental health issues affecting me	7	4	3	14
The MHC Team fully understand the mental health issues affecting me	12	1	1	14
It was complicated to do the things that the court asked	4	3	7	14
It is complicated for me to do the things the MHC Team asks	4	3	7	14
I have other problems that the court/MHC Team cannot help me with	3	3	8	14
I would rather go/have gone to prison	0	0	14	14

a No interviewee responded “don’t know/no answer” to any of the questions.

Six of the fourteen interviewees were uncertain to some extent about how their case was being dealt with at court and how their mental health needs were being supported. This suggests that defendants need further explanation and information about the purpose and role of the MHC Team and MHC when they are at court.

All 14 of the interviewees stated that now they were on a Community Order they knew how to contact a member of the MHC Team. In total, 11 felt that their mental health needs were well looked after on a Community Order and benefitted from the supervision process:

“It was really about money and aggression and now I am listening and asking for help and I am being listened to”.

One individual, however, reported his experience as negative. He cited *“too many assessments but nothing else happens”* as one reason for this, but also that the Team had put barriers in his way to *“moving to Sweden and starting a business”*.

Six individuals reported that they had other problems that neither the court nor the MHC Team could help them with. This was commonly related to issues of loneliness, isolation, lack of employment and shortage of money. All fourteen interviewed reported that they would not have preferred to go to prison.

Ten of the interviewees reported some difficulty in doing what the court and MHC Team asked them to. Typical reasons given for this were: using public transport with a broken leg in plaster; the number of activities leading to some difficulty in keeping track of when and what

these were; and one individual who found it difficult to leave the house because she was the sole carer of a young adult with mental health difficulties.

Caution must be exercised in drawing conclusions from the interviews of service users given the small numbers and self-selection. The findings suggest that whilst it may not have been entirely clear to defendants as to how they were benefiting from being part of an MHC during the court proceedings, this is outweighed by the positive experience they report of being supported by the MHC Team post-sentencing. Typical comments were as follows.

"I have done nothing but benefit from the scheme. It has got me in touch with professionals who know more about my issues than my doctor would and I feel very grateful for it."

"The Mental Health Court Team needs to continue, if not to grow. It's helped and is helping me still. It's a bit of a light in the dark when people start understanding you."

"It makes me very happy – there is somebody to talk to once a week."

"They've been wonderful for me; they've been flipping lovely."

"Its given me the support I need, I have never been so much further down the line; I'm not sure quite what I want from my future but I know now what I don't want."

"When you attend the appointments you find out how caring they can be and it's a different environment when you are a law-abiding citizen and attending your appointments. It makes me realise all those years I wasted getting arrested all the time."

"They are really working hard to help us; it's a very good service."

"It's been a fantastic experience, I have been really well treated, they are approachable, easy to talk to, I felt really comfortable with them and always happy to go to probation as its actually helped me and when I was really ill the support felt like being wrapped up in cotton wool for a bit. Now that its coming to an end I know that I don't have to do those things anymore and I know where to go to for help."

The range of needs that the MHC Team identified and provided a service to meet was impressive. Activities which remain largely unmeasured, such as addressing loneliness and isolation and helping someone find the right telephone number to phone the council or fill out a form, are what seemed to draw the interviewees into a trusting relationship with the MHC Team. One interviewee commented *"I can't let her down (PO), not after all she has done for me"*, another stated *"they have been absolutely marvellous, I can't fault them, they have been there for me when I have been down"*. The researchers concluded that the enhanced response to individual need seemed to co-occur with good levels of compliance with the

requirements of the Community Order. This is a learning point for any supervision activity which requires the co-operation of a vulnerable individual and a finding which is in keeping with the other evidence (see for example Rex, 1999).

3.4 Identification of costs

The cost of the pilot can be summarised as follows.

Table 3.8 Cost data (12 months)

Activity	Cost (£)
Salaries of all operational staff and local co-ordinator	279,513
Stakeholder Management plus training and awareness	11,500
Travel and subsistence	3,500
IT costs	4,000
Building works	5,000
Evaluation including peer review and economists' costs	82,927
Total	401,440

The cost of salaries is included in costs. The costs for IT and building works were one-off start-up costs that took place at one of the two sites (Brighton). Travel and subsistence mainly involved the travelling of the local pilot co-ordinator between the two sites. Hidden costs include the salaries of those involved with project management, the costs incurred by service providers and by service users where there was a charge for non-statutory provision, and goodwill resourcing by probation to fund offenders' attendance at appointments. Whilst all planned and unplanned absences from key posts at both MHCs were covered, many of these arrangements were not formalised within the funding provision but delivered on a good will basis. Should the MHCs or similar initiatives be more widely implemented these could impact upon the framework of arrangements and have resourcing implications.

To evaluate the costs of the pilot in light of what has been achieved is not an easy task. Costs specific to the pilot included that of the evaluation and that of the local pilot co-ordinator. If these were removed in order to estimate the bare operational cost of both MHCs, the figure would fall below £300,000 for both courts.

It was not possible to provide a break-even analysis (see research question i) as an adequate assessment of the mental health support in terms of reducing reoffending would be problematic. The key obstacle would be to devise a credible comparison group of offenders from a comparable area since no information on mental health status is available from likely candidate comparison areas. Additionally, comparing to the whole offender population in a comparable area is also unlikely to provide meaningful results, since the schemes in both Brighton and Stratford are highly selective (roughly 10% of offenders were selected) and, thus, it could not be guaranteed that the comparison would be credible.

4 Conclusion

During interviews there were extensive discussions as to the essential components of MHCs. Based on this information, this evaluation has identified the core requirements of the MHC as:

- MHCP available daily at court;
- comprehensive, pro-active screening and assessment;
- multi-agency agreements for information exchange;
- creative use of Community Orders;
- court review processes;
- involvement of the MHCP post sentence.

The pilot demonstrated that these key components worked well and could be considered to constitute best practice. They may well be suited to wider implementation and a resource pack has been produced by Project Management to support the dissemination of the MHC arrangements. Rather than conceptualising MHCs as a self-contained package it makes sense to regard the suitability of its components to meet local needs; some of which may well be worth advocating to commissioners.

Other examples of best practice of the MHC pilot have been identified and are summarised as follows.

- Protocols to support multi-agency information sharing.
- Identification and engagement with local resources.
- Comparable data collection activities across the two sites.
- Flexibility to embrace new areas of practice such as learning disability or dual diagnosis with substance misuse as the primary need.
- High involvement of service users which promoted engagement and compliance from this hard-to-reach group.
- High level of stakeholder engagement.
- The proactive approach of project management to addressing operational issues.
- Joint training and awareness events for practitioners and stakeholders.

Several initial weaknesses were identified and addressed early in the pilot. These included the clarification of the eligibility criteria, boundaries of the role of the MHCP and the nature and purpose of the court review process. An important issue that remained was the relatively low supervision caseload. The low supervision caseload was in part a result of the complexity of cases and that a significant amount of work and time was required from each case to support offenders holistically. From the point of view of probation this may call into question the necessity of a separate MHC entity. The stated desire to include features of the MHC activity into regular practice is therefore consistent with this. In addition, it would be beneficial

if the outcomes of signposting and referrals were recorded in order to objectively establish effectiveness. Finally, one of the strengths of the pilot may be perceived a weakness in relation to wider dissemination, this being, the active and involved nature of project management. The financial cost of project management has fallen outside the pilot costs but their activities may well have been an important contributory factor in its success. Future initiatives need to consider how strategic oversight and operational problem-solving capacity could be fostered in its absence.

The collaboration proposed between health and justice in providing a presence to support mental health needs is detailed in the document *Improving Health and Supporting Justice* (2009). Regardless of multi-agency work to support sentences, it is the responsibility of criminal justice agencies to enforce a Court Order. This is not so for health workers who are usually guided by an ethos of voluntary participation. Their professional background and occupational culture may not sit easily with taking decisions that may lead to a breach and could ultimately lead to imprisonment for their client. An MHCP with limited but clearly defined onward responsibilities post-sentencing could go some way towards addressing this.

The activities of the pilot also moved in the direction of the recommendations of the Bradley Report (2009) that Criminal Justice Mental Health Teams (CJMHTs) be established in every magistrates' court. The proposal was that these CJMHTs become a 'hub' of liaison and information sharing for those sentenced with mental health concerns. Locking the practice of the MHCP into the Integrated Offender Management Model and specifying the links with Community Mental Health provision would further this aim.

The cost of the pilot was established at £401,440 and the bare operational cost of both MHCs is estimated to be less than £150,000 per MHC. It is difficult to decide what these costs mean in the absence of benchmark data. Firm data on the cost of diversion, assessment and liaison teams are not readily available and cost data cannot be linked to long-term health or criminal justice outcomes. Therefore, caution should be exercised in drawing conclusions from these figures in isolation.

Further development of the MHC model needs to be mindful of implementation pathways of the Improving Health Supporting Justice (Health and Criminal Justice Programme Board, 2009) delivery plan, the Government's response to the Bradley Report (2009). Although the Bradley Report did not wholly endorse MHCs, they may be part of local innovations. Therefore, strategic alignment with the Improving Health Supporting Justice (2009) recommendations remains essential. That said, the title of 'Mental Health Court' did not fully reflect the nature of the multi-agency collaboration or range of professional activities which clearly fall within the ethos of the Improving Health Supporting Justice delivery plan. The name also carries the potential for stigmatisation. It is therefore suggested that this name should not be used in the future.

The level of multi-agency protocol development, commitment, collaboration and training at both pilot sites has allowed for the identification of areas of best practice which could be further developed should the pilots continue locally. One interviewee stated that to revert to arrangements prior to the MHC pilot was “*unthinkable*”, a sentiment that was expressed by numerous others who were interviewed. The pilot also focused minds. Many agencies became involved in order to create solutions to long-standing problems, such as information sharing to support sentencing which had formally created barriers to identification and provision. The authors suggest that it would be advisable for the outcomes of the pilot to be shared with commissioning bodies and for the resource pack to be made widely available.

5 Implications and further research

Utilising the creative sentencing and review process for offenders with mental health issues were innovative aspects of the MHC activity. Building upon these to manage offenders with mental health and primary drug misuse issues could be a valuable addition to the management of dual diagnosis. Throughout the pilot concerns were expressed regarding whether the eligibility criteria were sufficiently inclusive. The researchers concluded that just as the multi-agency arrangements were expanded toward the end of the pilot to consider the inclusion of those with learning disability, they could be further extended to include dual diagnosis. This would optimise professional resources and expertise and provide the continuity of contact demonstrated to motivate and engage clients (Lewis, Maguire, Raynor, Vanstone and Vennard, 2007).

Whilst good progress was made in securing access to health and police data for the MHCP at both courts (in particular at Brighton) a wider implementation of MHC arrangements would require significant changes nationally in the current patterns of multi-agency information sharing and data collection. A point of learning was that early consultation at senior management level benefited new multi-agency initiatives by identifying and addressing the priorities of collaborating agencies. This included constraints which could impact upon the arrangements and information sharing at all phases of the process. Future similar initiatives should plan for these to be put in place during the early stages of implementation.

In summary, the core requirements for any new MHC would be:

- a Mental Health Court Practitioner available daily at court;
- multi-agency agreements put in place prior to the MHC for information exchange and to identify and address the priorities of collaborating agencies;
- comprehensive screening and assessment of defendants for mental health issues (through the MHCP and information sharing protocols);
- tailored use of community orders for offenders;
- court involvement in the processes to review whether Community Orders are being implemented effectively;
- involvement of the MHCP post-sentence;
- training and awareness events for practitioners and stakeholders;
- identification of, and engagement with, local resources for signposting and referral of defendants to appropriate support services

The MHC pilot had much to contribute to the debates of best practice and how mental health provision could be improved for those passing through the CJS. The protocols developed comprised a unique framework to inform future multi-agency collaborations. These facilitated pro-active screening, assessment and signposting which resulted in identifying and addressing needs which would likely have gone unmet. The presence of the MHCP five days per week at court was key to delivering a reliable and comprehensive service to the court and to service users. With only nine breaches of order over the period of the pilot, a fruitful area for further research would be to explore whether and what combination of MHC arrangements contributed to this. However, to establish best practice that identifies what reduces reoffending rates and produces better health outcomes further research would need to be undertaken. Further research would also be needed to identify the appropriate geographical unit for the delivery of services in relation to court. A pilot conducted in two places (Brighton and Stratford) could not generate sufficient breadth and detail of information to draw conclusions regarding this. To address the diversity of population and economic and social profiles across rural and urban settings would require a national breakdown and analysis of local structures, local commissioning practices and demographic profiles.

Such further research could be inclusive of signposting activities and those who decline interventions offered by specialist provision. These groups could be followed up to establish the rate of uptake of the suggested support and the associated benefits to service users. It could examine the differences in characteristics of those who take up community support and those who do not. It could also examine the characteristics of those who breach their orders versus those who do not. Interviews with operational staff and service users could provide further insight into effective aspects of professional activity. A cost analysis which took account of longer-term health and justice outcomes would also support this. For further information on possibilities relating to cost-benefit analysis and impact analysis please see *Feasibility of conducting an impact evaluation of the mental health court pilot* (MoJ, 2010).

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Appendix 1 Semi-structured interview schedule for service users

Interviewers:.....

Date:.....

Participant identification number:.....

- 1) Letter of Introduction and brief verbal description of purpose of interview
- 2) Tell us about your experience at the Mental Health Court [allow for a wide ranging answer bearing in mind question 4, below]
- 3) Tell us about what sort of things you have been doing on your Community Order
- 4) We would now like to ask you a number of specific questions. For each question, can you indicate whether the answer is 'yes', 'somewhat' or 'no'? If you do not know, or do not want to answer, that is fine, just say so

4a) I understand how my case was being dealt with at court

			
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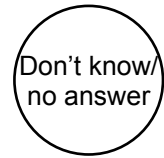
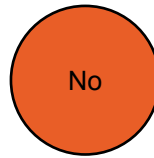
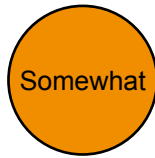
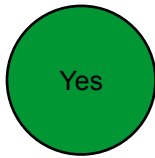
4b) I know how to contact a member of the mental health team at the court/on a Community Order

			
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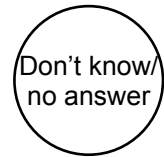
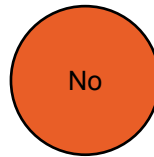
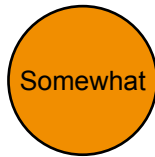
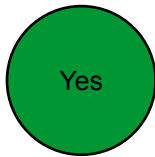
4c) I feel that I am listened to at the court/on a Community Order

			
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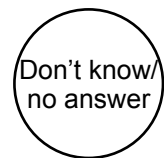
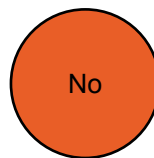
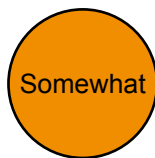
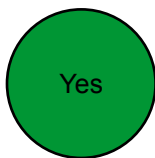
4d) My mental health needs are well looked after at the court/on a Community Order



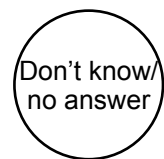
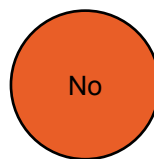
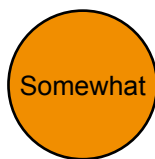
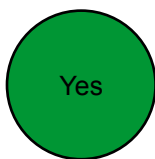
4e) The court/MHC Team fully understand the mental health issues affecting me



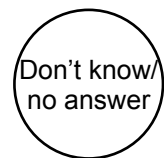
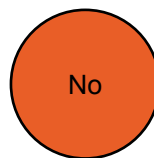
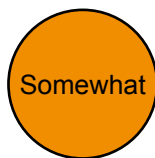
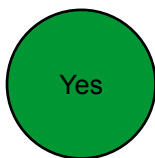
4f) It is complicated to do the things that the court/MHC Team ask me to do



4g) I have other problems that the court/MHC Team cannot help me with



4h) I'd rather go to prison (at the time? now?)



5) Tell us about the Review process

6) Interviewee is asked whether he/she would like to provide a summary of their experience of court and supervision supported by the MHC Team which might be quoted in the evaluation report.

7) Interviewee is thanked for his/her participation and advised of the professional to contact if the interview has raised any concerns for them.

Appendix 2 Data collection variables

Defendant data	Referral/assessment data
Month PNC ID Name Date of birth Gender Ethnicity Language (spoken) if not English Interpreter Postcode Employment status Employment type Educational qualifications Accommodation status Benefit type Mental health categories Diagnosed condition Dual diagnosis Current substance misuse issues Substances misused Number of previous convictions Main type of previous convictions Date of offence Offence types Police station	Referrer Referral date Assessment date Assessment location Suitable for scheme If not suitable for scheme, give reasons and any action taken Case adjourned to MHC HMCS case number
Court and sentencing data	Review data
Plea Plea date First court date Outcome/reason for adjournment Second court date Outcome/reason for adjournment Third court date Outcome/reason for adjournment Fourth court date Outcome/reason for adjournment Fifth court date Outcome/reason for adjournment Sixth court date Outcome/reason for adjournment Type of sentencing document Date report requested Working days taken to complete report Sentence/disposal/outcome Sentence start Sentence end Current supervision	First review date First review outcome Probation Health Defendant present? Second review date Second review outcome Probation Health Third review date Third review outcome Probation Health Additional comments Has order been breached? Comments

Appendix 3 Membership of Steering and Implementation Groups¹⁸

National HMCS Representatives

- Mental Health Pilot Co-ordinator and MHCP Project Manager

Court

- Chair of Local Bench (or nominated representative)
- District Judge (or nominated representative)
- Justices' Clerk/ Director of Legal Services (or nominated representative and HMCS Project team member when required)

External Agencies

- Probation
- CPS
- Police
- Criminal Justice Mental Health Unit (Access units in Brighton)
- NHS Trust
- PCT Commissioners
- Health and Social Care Criminal Justice Group
- Local Authority Housing
- Current Liaison and Diversion Scheme representatives
- Nominated representative from local Psychiatrists

¹⁸ This list is inclusive of all those participating in national and local strategic and operational groups to support the MHC pilot at both sites. The Local Implementation Groups has an operational focus; the Steering Groups were strategically orientated.

Ministry of Justice Research Series 18/10

Process evaluation of the Mental Health Court pilot

The aim of this study was to assess how the Mental Health Court pilot was implemented at Brighton and Stratford magistrates' courts. This was in order to draw out areas of best practice and areas for improvement and inform future decisions on the pilot. Interviews with staff, stakeholders and offenders investigated perceptions of how well processes were embedded and gave insight into what worked well. Analysis of data from the courts in the first year of the pilot (January 2009 to January 2010) enabled assessment of the workloads at the courts, and provided some demographic information on offenders. The study found that the key elements of the model were delivered at both sites, but in different ways. The pilot yielded innovative multi-agency collaborations. A wider implementation of Mental Health Courts would require significant changes in the current patterns of multi-agency information sharing and data collection, and early consultation at senior management level..

ISBN 978 1 84099 414 8

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