



Diversion of mentally disordered people from the criminal justice system in England and Wales: An overview

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ABSTRACT

The form that diversion mechanisms take in a given jurisdiction will be influenced both by mental health law and sentencing policies, and by the structure of criminal justice and health care systems. In England and Wales, treatment in hospital in lieu of any other sentence is available as a disposal option following a finding of guilt. In addition, there is a National Health Service, free at the point of delivery, the existence of which creates the potential for a co-ordinated nationwide response to mental disorder within the criminal justice system. In recent years, the National Health Service has taken over the delivery of health care in prisons, including psychiatric services, with the principle being one of equivalence between the quality of health provision provided in the community and that provided in prisons. However, problems within the system dictate that an important place remains for add-on diversion initiatives at courts and police stations, which aim to circumvent some of the delays in dealing with mentally disordered people or to prevent them entering the criminal justice system in the first place. It has been demonstrated that such mechanisms can be highly effective, and a government-sponsored review in 1992 recommended their general adoption. A lack of central co-ordination determined that progress was very slow. A new government-commissioned report in 2009 set out detailed recommendations for reform throughout the system. It laid emphasis on a co-ordinated response at all levels and between all agencies, and placed importance on linking initiatives with community services and with preventative measures, including attention to the effects of social exclusion. Some grounds for optimism exist, although there are particular problems in implementing change at a time of financial austerity.

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1. Introduction

Services for mentally disordered offenders in England and Wales have recently been subject to thorough government-sponsored review for the second time in twenty years (Bradley, 2009a; Reed, 1992). Whereas successive governments have broadly welcomed the recommendations of these reviews, their implementation has thus far been impaired by financial issues and by a lack of central co-ordination. Current systems for the diversion of mentally disordered offenders will be described below, and then the proposals of the latest review will be summarised and related to the underlying problems.

The concept of diversion in the United Kingdom (UK) has been summarised as follows: "... a process of decision making, which results in mentally disordered offenders being diverted away from the criminal justice system to the health and social care sectors. Diversion may occur at any stage of the criminal justice process: before arrest, after proceedings have been initiated, in place of prosecution, or when a case is being considered by the courts." (Bradley, 2009a p. 16). If diversion is taken in this wider sense to mean the transfer to psychiatric care of people at any stage of the 'offender pathway', then there are three

main elements to be considered: the structural interaction between criminal justice and health care systems, as determined by mental health legislation and sentencing policies; arrangements for health care within the prison system and the manner in which this impacts on pathways through it; and the development of 'add-on' initiatives, which provide additional links in the system to fast-track cases, avoid bottlenecks or accelerate individuals out of the system altogether. Each of these will be considered in turn. Although there is a strong case for diversion efforts to include intervention before offences are committed, the account below will concentrate on the three sites in which diversionary effort is generally concentrated: the police station, the court and the remand prison (jail).

The UK is split into three main legal jurisdictions: England and Wales (54 million inhabitants: 88.5% of the UK total), Scotland (5 million) and Northern Ireland (1.8 million). Legal differences are greatest between the first two. Only the provisions in England and Wales will be considered here.

2. The court: diversion and mental health law

The scope of diversion and the mechanisms used to achieve it vary between different jurisdictions. In the UK, the concept of the diversion of mentally disordered people from the criminal justice system is

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more deeply embedded in the legal process than in many other countries (James, 2005). The UK differs in that legal concepts of criminal responsibility in adults are irrelevant in the disposal of mentally disordered offenders by the courts, other than in cases of homicide. In consequence, people with mental illness who are found guilty of a criminal offence and who meet the criteria for treatment in NHS hospitals under the Mental Health Act 1983 (as revised by the Mental Health Act 2007) are sent to hospital by the courts in lieu of any other form of disposal, and all links between the convicted person and the criminal justice system are thereby severed. Treatment outside the criminal justice system therefore constitutes the sentence of the court in most cases of serious mental illness, and this is independent of concepts of insanity or fitness to plead. It is also non-contentious and not a matter for dispute between defence and prosecution, such disputes rather being limited to the area of special psychiatric defences.

The main psychiatric disposal used by the courts in England and Wales is a treatment order under section 37 of the Mental Health Act 1983 (as amended in 2007), which is applicable where a defendant has been found guilty of any criminal offence for which the law would potentially allow a custodial sentence. For such an order to be imposed, the court must be satisfied, on the written or oral evidence of two medical practitioners (of whom at least one must be a psychiatrist) that:

- 1) "the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and (appropriate medical treatment is available for him)"... and;
- 2) "the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section."...and
- 3) that, on the evidence of the psychiatrist who will be treating the patient or of any other representative of the hospital management, that the hospital in question agrees to treat the patient and will offer a bed within 28 days.

Compared with many other jurisdictions, the criteria for hospital disposal can be seen as almost wholly medical in nature. "Once the offender is admitted to hospital pursuant to a hospital order....without restriction on discharge, his position is exactly the same as if he were a civil patient. In effect he passes out of the penal system and into the hospital regime. Neither the court nor the Secretary of State has any say in his disposal..... A hospital order is not a punishment.... Questions of retribution or deterrence are immaterial. The sole purpose of the order is to ensure that the offender receives the medical care and attention which he needs in the hope and expectation that the result will be to avoid the commission by the offender of further criminal acts" (R. v. Birch, 1989: 11 Cr. App. R.(S.) 202, 210).

For most people put on such an order, their position becomes almost exactly the same as if they were a patient detained under a civil order of the Mental Health Act. The courts retain no powers of any kind. Leave is the decision of the treating psychiatrist alone. The psychiatrist may discharge the patient at any time, as may the managers of the hospital. The patient may only be detained for six months, unless the order is renewed by the treating psychiatrist. This can only be done if certain conditions, which resemble those which were satisfied when he was admitted, are fulfilled. After detention for six months, the patient/offender may appeal to an independent Mental Health Review Tribunal, constituted under Part V of the 1983 Mental Health Act, which has the power to discharge from hospital against the advice of the supervising psychiatrist.

A further difference from many jurisdictions is that there is no strict separation between psychiatric units that cater for the general

public and those that specialise in the treatment of offenders. General hospitals may admit patients from the courts and prisons, and forensic units can admit people detained under the civil provisions of the Mental Health Act. Placement is determined by the clinical and security needs of the individual.

However, where a person has been convicted of a serious offence, the sentencing judge in a Crown court has the power to add to a treatment order under section 37 a so-called 'restriction order' under section 41 of the Mental Health Act. This has the effect of removing from the treating psychiatrist the power to release the patient from hospital. Release is determined by the Justice Ministry, or by an independent Mental Health Review Tribunal. The decisions of the Tribunal concern whether cases meet strictly defined criteria set out within the Mental Health Act. There is no concept of 'tariff', or the patient remaining in hospital for longer the more serious the offence.

In order for the Court to impose a restriction order, it must be the judgement of the court that the imposition of the order is necessary "for the protection of the public from serious harm", this being "having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large". This is therefore a provision based primarily upon considerations of public safety. The decision to impose a restriction order is not based on the gravity of the offence as such, but upon a judgement as to dangerousness and prognosis, based in part upon the defendant's previous record, both in terms of offending and in terms of co-operation with treatment. It remains possible (and indeed not unusual) both for patients to be released from hospital after a relatively short period, despite having committed a very serious offence; and also for patients to be kept in hospital for longer periods than they would have served, if they had been given a prison sentence. This is because discharge is determined principally by medical outcome and related issues of risk.

The imposition of a restriction order also has two further consequences. Firstly, it deprives the psychiatrist of the power to give a patient leave in the community without the approval of the Ministry of Justice. Secondly, it provides for the conditional discharge of patients. This means that patients have to comply with conditions imposed either by the Ministry of Justice or by an independent Mental Health Appeal Tribunal, depending which granted the provisional release. Failure to comply with the conditions imposed may result in recall to hospital, if there is any deterioration in mental state, this being capable of wide interpretation. The most common conditions to be imposed are attendance at a psychiatric clinic and the taking of medication; keeping in contact with a social worker; and residing at a specific address. A conditional discharge from a restriction order in effect constitutes a strict form of compulsory treatment in the community. The necessity for such an after-care provision in a given case is a common reason for a psychiatrist to recommend to a court that a restriction order be imposed.

The Mental Health Act contains various other provisions for the transfer of both remand and sentenced prisoners to National Health Service psychiatric hospitals for treatment. Those sentenced to prison terms who are subsequently found to be suffering from serious mental illness and transferred to hospitals may be returned to prison when they improve, but many will complete their sentences in NHS hospitals, often for pragmatic reasons. Compulsory treatment is not permitted in prisons under the Mental Health Act 1983, because there are no hospitals in prisons. Prisons contain 'health care wings', but these are not designated as hospitals and there are no psychiatric 'wards' within the prison system.

The Mental Health Act 1983 also allowed admission to hospital from the courts and prisons for those with learning difficulties and personality disorders, which were (like mental illness) defined within the body of the Act. Persons with such disorders could, however, only be admitted if their conditions were deemed 'treatable'. The Mental Health Act 2007 removes both the definitions of types of mental

disorder and the ‘treatability test’. “While clinical judgement remains paramount in decisions to detain and treat, the Act establishes the principle that personality disorder, as a mental disorder, is now a mainstream condition requiring equal and appropriate consideration for assessment and treatment” (Bradley, 2009a p. 11). This is, of course, far from the clinical reality.

The concepts of fitness to plead and insanity are retained in the Criminal Procedure [Insanity and Fitness to Plead] Act, 1991. The insanity defence is rarely used, because psychiatric disposal options are no different to those available when someone is found guilty. Fitness to plead remains a central concept. However, most cases will be transferred to NHS hospitals for treatment under the Mental Health Act in order to render them fit before trial, rather than being dealt with under the specific legislation. When someone is found unfit under the Act, there is not necessarily an expectation that they will be returned to court for trial once they do become fit. In practice, it is difficult to try to arrange such an outcome, as the system is resistant.

3. The prison: diversion and mental health care provision in prisons

The care of the mentally disordered in prisons falls into two parts: first, the identification of serious mental disorder and the implementation of mechanisms to transfer prisoners out of the prison system; and second efforts to offer treatment for less serious mental illness, personality difficulties and substance abuse problems within the prison estate. An appreciation of the problems involved in providing appropriate care and diversion requires an understanding of the way in which the prison health service has developed.

At the inception of the National Health Service in 1948, prison health care remained outside the new arrangements and was financed through the Home Office (Interior Ministry). In effect, the prison service had its own primary care system, and any assessments from secondary psychiatric services were requested from NHS hospitals and paid on an item of service basis. For hospital treatment, transfer to NHS facilities outside the prison system was necessary. However, standards in the prison health care service gradually fell far behind those in the NHS. In terms of mental health, the position became particularly concerning, given the high level of psychiatric morbidity within the prison population (e.g. Brooke, Taylor, Gunn, & Maden, 1996; Singleton, Meltzer, & Gatward, 1998). Approximately 90% of prisoners have either a psychosis, a neurosis, a personality disorder, or a substance misuse problem. The prevalence of psychosis was estimated at 9% in male remand prisoners and 4% in male sentenced prisoners. The equivalent proportions for females were 21% and 10% (Singleton et al., 1998). Smaller recent studies suggest that the position has changed little in the last decade (HM Inspectorate of Prisons, 2007; Stewart, 2008).

During the 1990s, a number of influential reports on prison health care were published. The government adopted the principle of ‘equivalence of care’ (HM Prison Service, & NHS Executive, 1999; Home Office, 1990;1991). Prisoners should receive the same level of health care as they would were they not in prison – equivalent in terms of policy, standards and delivery (Health Advisory Committee for the Prison Service, 1997). It was eventually accepted that the principle of equivalence was not attainable whilst the prison health service remained separate from the National Health Service, and the transfer of budgetary responsibility for health care from the Prison Service to the National Health Service was completed in April 2006. From that point, health care in the prisons has been the responsibility of the NHS – or, to express the situation more formally, the commissioning of health services for prisons in England and Wales has become the responsibility of the Primary Care Trusts, the purchasing organisations at local level that commission health care provision for their areas on behalf of the NHS.

According to this approach, the prison is to be seen simply as another section of the general community, and the medical services

provided to it are to be the equivalent in availability and quality to those available to anyone in the population. This is reflected in the structure of the services supplied. The first level of care is ‘primary care’, meaning general practitioners (family doctors). Most prisons have their own primary care doctors, who are now trained general practitioners. Secondary care involves the equivalent of hospital outpatient appointments and hospital inpatient care. Consultants from a number of specialities attend prisons to conduct outpatients’ clinics. For others, prisoners must be taken to clinics outside hospitals. The third tier involves hospitals. There are no hospitals in prisons. Any condition requiring acute hospital care results in a transfer to an outside NHS facility.

The prison health service has been undergoing the most ambitious re-organisation in its history. However, the manner in which this has occurred, as far as mental health is concerned, was initially beset with problems, and this has impaired the ability of the system to achieve the aims of change. Problems have been summarised as follows (James, 2009). The fact that different PCTs are responsible for different prisons means that there has been no uniformity of services across the country, and services are in consequence fragmented. The psychiatric service responsible for a given prisoner is that which serves the area in which he previously resided. It is policy to disperse many prisoners around the country, meaning that they are often imprisoned away from their home areas. This leads to difficulties in liaising with the relevant psychiatric services – either to arrange transfer, or in order to hand over cases at the end of sentence. Few prisoners remain in one prison for the duration of their sentence. Therefore, treatment approaches to psychological problems in one prison are interrupted or discontinued every time that the prisoner is moved. PCTs in many areas chose to purchase different parts of their ‘in-reach’ services from different organisations. General psychiatry, forensic psychiatry, and drug/alcohol treatments were often commissioned separately. This meant a lack of co-ordination and coherence in attempts to provide comprehensive care. Local general adult psychiatry services have in many areas been pressed reluctantly to provide services in an environment which is alien to them, to a population with which they have little sympathy. Whereas forensic psychiatry services might broadly be typed as seeking out mentally ill people to transfer to hospital, the general adult services have always tended to the opposite stand-point – looking for reasons not to transfer to hospital. There is a conflict in ethos. There is also a shortage of beds in NHS psychiatric hospitals into which prisoners can be transferred. This applies both to forensic units and to general adult units. With the latter in particular, there is an appreciable tendency to alter diagnosis according to bed availability – for instance from schizophrenia to personality disorder or drug abuse. Dual diagnosis (i.e. drug problems combined with mental illness) in itself is sometimes put forward as an exclusion criterion to hospital transfer. There is very little treatment available for people with personality disorders, either in prison or outside. There are few services for those with non-psychotic mental disorders. The custodial environment of prisons makes attempts to introduce defensible standards of care into prisons extremely difficult. Those attempting to provide in-reach services within prisons have been hampered by attempting to work within a culture where security is the predominant factor. The clash of cultures has hampered health care. Chronic over-crowding in the system has made the internal functioning of prisons difficult. It is reported that appointments with psychiatrists in some prison clinics show a 35% default rate, as there are insufficient staff available to move prisoners across the prisons to the clinics (Rickford, & Edgar, 2006). Each prison governor has been left with the power to interfere with the form and details of the mental health service being introduced into their prison. The mental health input is therefore subject to the whim or personal interests of each prison governor.

The prison population in England and Wales has increased by 60% since 1995 and there are indications that it will continue to increase

(Ministry of Justice, 2009). By May 2010, the number of prisoners stood at a record 84,982. With the prisons full and a large national budget deficit, it is far from clear that the goal of equivalence of care between the community and the prisons is currently attainable. A further issue is whether equivalence is in itself a sufficiently ambitious aim. The needs of the prison population are greater than those of the general population in terms of mental health care. The services available to the community would, even if adequate to the community itself, prove inadequate to the prison population. And it is currently quite apparent that the services available to the community are inadequate across the board. This relates not only to the shortage of beds and of after-care services. The National Health Service is currently transferring the care of all psychiatric problems other than acute psychosis to general practitioners, who have neither the time nor the expertise to take on this task. There are few services for people with personality disorders, who are generally simply excluded from care. Those with non-psychotic disorders find themselves with limited access to services. In addition, the health care system is currently being subjected to covert privatisation, with accompanying compulsory “efficiency savings” (i.e. cuts). All these problems determine that, despite the emphasis on diversion in mental health law, there is an important place for the development of initiatives to circumvent blocks in the system or to prevent mentally disordered individuals entering it in the first place.

4. The police station: police station diversion and liaison in England and Wales

4.1. Diversion by the police

If a policeman finds someone in a public place and deems them to be “in need of care or control”, he has the power under section 136 of the Mental Health Act to take them to a psychiatric hospital where they may be detained for up to 72 hours to allow them to be assessed for detention under the civil sections of the Mental Health Act. This applies whether or not the person has committed a criminal offence. Alternatively, a policeman may take someone on a voluntary basis to a hospital for assessment.

When mentally disordered persons are arrested and taken to the police station custody suite, sufficient resources are, in theory, available to ensure assessment and transfer to health care facilities where appropriate. Under Code C of the Police and Criminal Evidence Act 1984, the custody sergeant, if he suspects a person might be mentally disordered, is obliged to seek the services of an ‘appropriate adult’ to represent the subject’s best interests. The forensic medical examiner (FME), a doctor on call to the police station, is also called to examine the prisoner. Where the FME considers that admission to hospital may be appropriate, he or she may advise the custody sergeant to contact an Approved Mental Health Professional (in effect a mental health social worker) to arrange an assessment under the Mental Health Act. Such an assessment can lead to compulsory admission under civil powers, or indeed to voluntary admission. The police may decide to take no further action, to caution, to charge and bail, all of which will permit hospital admission to proceed. If detention in custody is inevitable, (for instance due to the seriousness of the charges), the police can make sure that the prisoner is accompanied by a form providing notification about mental health concerns when he goes to court.

In practice, this system rarely worked. The main decisions are taken by the custody sergeant, who has limited knowledge about mental disorder. His primary concern is with legal matters about the person’s detention and to ‘dispose’ of those arriving in custody as quickly as possible. The role of the FME tends to be narrowed, in a brief interview, to making judgements about fitness to be detained and fitness to be interviewed, rather than conducting a full mental state examination. And the delays in acquiring the services of an

AMHP act as a disincentive to initiating assessments under the Mental Health Act. Two police station surveys in London in the 1990s, based on records or observational study, suggested that 1.2 to 1.6% of those arrested showed signs of serious mental illness (Revolving Doors, 1994; Robertson, Pearson, & Gibb, 1995; Robertson, Pearson, & Gibb, 1996). Yet, “the opportunity to put people in contact with health and social services was not taken” (Revolving Doors, 1994), and “the grossly psychotic beggar who persistently begs in central London now stands less chance than he used to, even of receiving temporary relief from his symptoms” (Robertson et al., 1995, p. viii). In effect, minor offenders with mental disorder were diverted away from care and back onto the streets.

4.2. Police station diversion and liaison schemes

A solution adopted in several large cities (Chung, Cumella, Wensley, & Easthope, 1998; James, 2000; Riordan, Wix, Kenny-Herbert, & Humphreys, 2000) has been the introduction of police station schemes, in which psychiatric nurses from the NHS are attached to police station custody suites. Their role is to improve the identification of mental disorder; to take a detailed history and conduct a mental health examination; to acquire details of health records from psychiatric services where appropriate; to decide upon an appropriate intervention and to arrange this, including arranging assessments under the Mental Health Act; to prepare typed reports and to follow cases through, informing relevant agencies as to developments (James, 2000). One scheme in London assessed 1.1% of all custody cases at three police stations over a 31-month period, this being a similar proportion to those given in the observational studies for severe mental illness in custody cases. A need for admission was identified in 34% of referrals and was achieved in 31%. In addition, community referrals to a range of health and social agencies were made in another 32% of cases. The outcome was immediate, in that 91% of admissions were accomplished on the day of assessment (James, 2000). In effect, the nurses played a co-ordinating role, catalysing the effective involvement of existing services and ensuring the sharing of knowledge between agencies where appropriate.

Psychiatric diversion schemes at police stations should not be seen in isolation, but rather as part of an integrated spectrum of services at police stations courts and prisons. There are few areas in which this ideal has been properly established. There remain some similarities between UK police diversion schemes and pre-booking schemes systems in the US, in which mentally ill people who commit minor offences are directed towards care, rather than being charged (Steadman et al., 2001).

5. The court: court diversion schemes in England and Wales

5.1. The model

The first court diversion in England and Wales began in 1989 in central London. There are 650 courts in England and Wales, of which 400 are magistrates’ (lower) courts. That is where court diversion schemes are located, other than for one pilot scheme at a Crown (higher) court. The logic of this is that magistrates’ courts each serve a number of police stations and concentrate cases from a given area, thus constituting an efficient place in the system to which to commit resources. In some cities where there are many magistrates’ courts, the court diversion schemes are centred at one central court, to which the other courts can cross-remand cases for assessment, so resulting in a further improvement in efficiency.

There is little data on the current level of psychiatric morbidity amongst those passing through such courts. At one inner-city court, 6.6% of custody cases were found to be suffering from serious mental illness (i.e. psychosis or major depression): 1.3% of those bailed by police to appear at court were similarly afflicted (Shaw, Creed, Price,

Huxley, & Tomenson, 1999; Steadman et al., 2001). Two sorts of system have grown up, depending on the number of mentally ill defendants passing through a given court. A low referral rate or need for admission leads to the development of 'liaison schemes', which are generally run by nurses and function by linking cases in to local psychiatric services, with an emphasis on those based in the community. Where the need is greater, 'diversion schemes' are developed with the aim of admitting people into hospital from the court. The most developed of these are consultant-led, with several psychiatrists, nurses, social workers and an administrator, working out of dedicated and well-equipped offices in the cell areas at court, with their own interview facilities.

The aims of diversion schemes are to assess, at court, people in custody and admit them to hospital where indicated, using either the forensic provisions of the Mental Health Act 1983 (amended in 2007) or the civil provisions where the offences are less serious. Minor offenders will be admitted to general psychiatry units, those committing serious acts of violence to forensic units. With charges that can be dealt with at the magistrates' court, admission to hospital is likely to be as a sentence after a finding of guilt or the discontinuance of a charge. In serious offences, which are destined for the higher Crown Court, admission to hospital will be organised pending trial after assessment by court schemes, often through Ministry of Justice warrants, rather than through court powers.

In effect, the schemes have two purposes: to increase the recognition of mental illness at the courts, and to accelerate admission into hospital. Where no scheme is present, the magistrate has to remand cases to prison for reports. The prison health care staff has to identify the responsible NHS sector consultant and arrange for him or her to visit the (often distant) remand prison. Once there, the patient will be seen without the benefit of access to prosecution papers or past medical history. If a recommendation is signed for a hospital disposal, there will then be a further delay until the person's next court appearance. It is much more efficient to short-circuit this system by having the psychiatrist examine the accused at the originating court. At court, the psychiatrist will have access to the prosecution papers. Any past psychiatric reports will be gathered from hospitals, general practitioners and social services by fax or direct computer link. The referred person will be interviewed, a detailed typed report prepared, and admission to hospital arranged. The psychiatrist will be available to appear in court to resolve any queries or procedural problems, and the social worker will negotiate transport (James, 1999).

Quality standards for court diversion schemes and for their audit have been developed and published (Mental Health Foundation, 1997; Pakes, & Winstone, 2008). In practice, the system works best when the staff running the schemes are from the psychiatric service local to the court, and have direct admission rights to psychiatric beds, including secure facilities (James, 1999; James et al., 2002). A weakness in current systems concerns case selection. In some schemes, there is a screening procedure for all custody cases at court, generally based on examination of files (Chung et al., 1998; Rowlands, Inch, Rodger, & Soliman, 1996). There is evidence that the use of questionnaires may improve detection rates (Shaw et al., 1999), but most schemes depend on referral procedures, which rely on the question of mental disorder being raised by non-medical personnel. Another disadvantage of current schemes is that many only operate on certain days of the week. This results in some referrals requiring remand into custody until the day on which the court scheme operates: this may act as a disincentive to the referral of appropriate cases.

5.2. Comparison with other models of court psychiatric system

Other models, familiar from the USA, are court psychiatric clinics and mental health courts. The first formal court psychiatric clinic in

the USA, known as the Psychopathic Laboratory, started up in the Municipal Court of Chicago on the 1st of May 1914 (Kegel, 1930). A service in Baltimore soon followed (Oliver, 1929). By 1962, 27 court psychiatric clinics had opened (Guttmacher, 1966), and in 1989, it was estimated that court psychiatric clinics numbered "probably higher than 100 and closer to 250 – the approximate number of metropolitan areas in the United States" (Keilitz, 1989, p. 34). Court psychiatric clinics, in a competency and insanity jurisdiction, aim at full psychiatric evaluation of offenders in a setting that avoids hospital admission. A secondary aim, initiating and enforcing treatment procedures with the threat of legal sanction, was a small part of their function, and concerned minor offenders, and often involved juveniles, family court issues or drug and alcohol problems (Selling, 1946). This is a function which has since been assumed by the system of mental health courts. The first mental health court was set up in Broward County in Florida in 1997 (Mikhail, & Akinkunmi, 2001). Their number increased rapidly to nearly 100 in 2004 (Steadman, Redlich, Griffin, Petrila, & Monahan, 2005). Their structure and function has been extensively described (Goldkamp, & Irons-Guynn, 2000; Watson, Hanrahan, Luchins, Heyrman, & Lurigio, 2001; Watson, Luchins, Hanrahan, Heyrman, & Lurigio, 2000). Mental health courts follow the "therapeutic court" model of the drug courts. Based upon ideas of therapeutic jurisprudence, they use various creative methods to enforce compliance to treatment in the community: "pre-adjudication suspension of prosecution of charges; post-plea strategies that suspend sentencing; and probation" (Griffin, Steadman, & Petrila, 2002, p.1285). The mental health court is dedicated to the processing of people with mental illness. The court has a 'mental health judge' with a particular interest in the area and cases are referred across from other courts, if there is 'voluntary' agreement of the accused to participate. The court will liaise with mental health agencies and mandate participation in treatment programmes, mainly in the community. The court retains control and monitors the progress of the case. If the person fails to comply, the court can apply sanctions, either by continuing with the prosecution in cases where the process has been suspended at the pre-adjudication stage, or by adopting another form of sentence in post-plea cases, including custodial sentences.

There are major differences in ethos between the three types of court diversion system (James, 2006). Those working for court psychiatric clinics function as servants of the court: mental health courts are courts, and their functioning is heavily influenced by ideas of restorative justice and therapeutic jurisprudence; the focus of court diversion is upon the health of the patient. Court diversion schemes serve a triage function, with the most ill cases admitted, the less ill linked to community provisions and the remainder not offered any psychiatric input. Mental health courts practice a form of 'voluntary' coercion, whereas the other two forms of provision are more openly coercive. Court psychiatric clinics are different from the other two in that the majority are located in higher courts, rather than lower courts. They deal with serious offending, whereas mental health courts deal with minor offending only, and court diversion schemes may deal with both serious and minor offending. Court diversion schemes aim to admit people to hospital, whereas court psychiatric clinics aim at avoiding admission to hospital for assessment where possible. Mental health courts are mainly concerned with treatment in the community and can be seen as a creative way of enforcing compulsory treatment in the community in states where there is no legislative provision for this.

Although the three systems are very different, the factors that have been found to be important in making them successful are very similar. The most important elements are a firm funding base; adequate staffing for the intended function; 'ownership' of the project by all the agencies involved; and good outcome data and quality control. For court diversion schemes, direct admission rights to hospital beds, particularly on general psychiatry wards, are the key to ensuring efficacy.

5.3. Efficacy of court diversion in England and Wales: Process

There has been extensive examination of the efficacy of court diversion schemes in terms of process. There are indications that such schemes can increase the identification rates for mental disorder. There was a four-fold increase in compulsory admissions from one court after the introduction of a diversion scheme (James, & Hamilton, 1991). Of those compulsorily admitted through another court scheme after a period in remand prison, 39% had not been recognised as ill at the remand prison (Hudson, James, & Harlow, 1995). A common finding is that time from arrest to admission is reduced from an average of seven weeks to one week (James, & Hamilton, 1991; Joseph, & Potter, 1993; Pierzchniak, Purchase, & Kennedy, 1997). Court schemes have proved able to deal with serious offenders as well as minor offenders: in one area, there was no difference in seriousness of offending between admissions through court schemes and those through prison assessment (James, Cripps, Gilluley, & Harlow, 1997). The mechanism proved so powerful that, in one year, one court diversion scheme in London (and its two psychiatrists) were responsible for 12% of all the unrestricted section 37 hospital orders in England and Wales (James, & Harlow, 2000). More details of these findings can be found elsewhere (James, 1999). However, no estimates are available as to the efficacy of court diversion schemes in England and Wales overall, as data collection in many is poor. In the year 2008–9, there were 2138 compulsory admissions from courts and prisons in England and Wales. This was an increase of 12% on the previous year and it represented 8% of all compulsory admissions under the Mental Health Act (NHS Information Centre, 2009). But this figure does not include people diverted from magistrates' courts and police stations under civil orders of the Mental Health Act, nor voluntary admissions from those sources. Nor is it possible to ascertain what proportion of such admissions were instigated by court diversion exercises.

5.4. Efficacy of court diversion in England and Wales: outcome

Although the efficacy of the court diversion process appeared to have been demonstrated, concerns about the effects of such services on general psychiatry units were initially expressed. Deahl, and Turner (1997) suggested that those admitted through the schemes constituted a new population of patient, previously hidden in the criminal justice system and unknown to psychiatric services, and that, as such, their transfer to health services should have been accompanied by a dowry. Marshall (1997) asked: "Could there be a link between London having pioneered court diversion schemes and the level of violence on its acute wards?" Joseph (1992), who pioneered early schemes in London, questioned whether admitting cases into general psychiatry wards accomplished anything in the long run, given the standard of care that they provided: "There is a danger that court psychiatrists, whilst improving the quality of life of the magistrates before whom they appear, will do little for their patients, simply leading them out of the 'revolving door' and up a blind alley" (p.219).

A comprehensive case-control study, funded by the Home Office, examined outcomes of those admitted through court diversion schemes, comparing a sample of 214 such cases with 214 compulsory admissions from the community under the civil provisions of the Mental Health Act, matched for hospital and month of admission (James et al., 2002). The main findings were that court diversion admissions, when compared with civil community admissions: were no less likely to complete their admissions; had similar lengths of stay; were no more likely to be violent or to abuse substances in hospital; were less likely to use intensive nursing resources (i.e. 'specialising'); achieved a similar improvement in mental state by the time of discharge; and were not readmitted any more quickly. The court admissions were more likely to be reconvicted in the two years

at liberty following discharge. However, there were highly significant reductions in numbers of convictions in the two years at liberty following discharge from hospital compared with the two years before admission. In addition, the reconviction rate for the court diversion admissions in two years at liberty following discharge was only 28%. This compares with two-year reconviction rates in national cohorts of similar composition of 56% for discharged prisoners and 58% for those placed on community penalties (Home Office, 1999). The authors concluded that the court admissions were a similar population to the civil admissions and that admission through the courts probably represented a different style of accessing psychiatric care, analogous to the manner in which some people habitually access physical care through emergency departments, rather than general practice clinics. They suggested that there was no evidence that court admissions caused more problems to general psychiatry wards than civil admissions, and that admission appeared to have an effect in reducing offending. The reduction in offending concerned mainly theft and similar offences. The hypothesis was put forward that any reduction in offending might be a consequence of people being housed, linked into social security benefits and thereby receiving social care and support as a result of their admissions.

5.5. Scope and coverage of court diversion schemes

In 1999, there were said to be 150 court diversion or liaison schemes operating in England and Wales. Annual surveys of the schemes, organised by the National Association for the Care and Resettlement of Offenders (NACRO), suggest that their number has declined and that many of the schemes are insufficiently staffed and financed to carry out their function effectively. In the 2004 survey (NACRO, 2005), 78% of schemes surveyed were unable to collect statistics describing their function. 50% had no input from a psychiatrist and 72% cited a lack of beds as a barrier to their scheme operating effectively. Twenty-five per cent of schemes had seen a decrease in their staffing in the past year. A more recent survey for the Bradley Review concluded that, of the 100 or so schemes in operation at courts and/or police stations, only 13 regularly secured excellent scores on a set of performance criteria. It was concluded that schemes had developed "despite the lack of national drive and investment" and that "many schemes owe their existence to the enthusiasm and dedication of individual members of staff" and that this is no basis for such an important service to rely upon (Bradley, 2009a p. 87). Other than court diversion schemes, there have been trials of special drug courts and courts for domestic violence. However, the mental health court model is unlikely to find a place in the UK, as UK mental health law and diversion mechanisms enable more directly interventionist solutions to be adopted.

6. A new model of joint police-health care units: the Fixated Threat Assessment Centre (FTAC)

A new form of diversion mechanism arose out of a government-financed research project to examine how to assess and manage threat to public figures from lone individuals with intense, pathological fixations (the 'fixated'), the majority of whom are mentally ill (James et al., 2007; James et al., 2009; James et al., 2008). The project discovered that inappropriate attention to public figures was a powerful new tool for identifying seriously ill people in the community who had fallen through the care net. It was apparent that the interests of public health substantially overlapped with those of the protection services, in that, if the healthcare needs of the individuals were attended to, any risk that was posed to public figures would be diminished. In effect, this constituted a form of population approach to the issue of risk. Rather than conducting large numbers of assessments looking for risk factors in individuals, a risk factor could be attended to in the population as a whole. If psychosis were treated, then risk would be reduced without

the need to attempt to predict which individuals might go on to engage in severely disruptive or violent behaviour (Mullen et al., 2009). The result was the establishment of the first joint police–NHS unit in the UK, a significant innovation. By joint unit is not meant co-operation or joint-working between two organisations. FTAC's unique feature is the working together of police and mental health workers in one team to research cases referred by police or the offices of protected persons, to assess risk and to effect interventions. The case-workers have access to standard policing information resources. In addition, the mental health staff has access to NHS databases. Because of their status as health workers, they are able to acquire detailed medical information without infringing confidentiality restrictions. The combination of police and health information permits a rapid and thorough assessment and risk evaluation, which allows the formulation of a management plan. This may sometimes involve arrest, but in most cases involves catalysing rapid mental health intervention by services in the relevant area, together with liaison with local police. The presence of psychiatric staff in the team overcomes the barriers which police would normally face in such circumstances, cutting straight through inter-agency red tape. Cases are then followed up, often by visits to case conferences all over the UK, until the risk is deemed low. Of the first 100 cases in which FTAC intervened, 85 were taken on by psychiatric services, 55 through compulsory admission (James, Kerrigan, Forfar, Farnham, & Preston, 2010).

FTAC won an Association of Chief Police Officers' Excellence in Policing Award in 2009. It is considered by those involved with FTAC that the joint police–NHS model has wider possible applications. A logical further development would be the modification of the role of NHS police–liaison psychiatric nurses, so that they become embedded in police responses at borough or county level in order to perform an enabling role, to the benefit of individual patients and of public protection. The joint-working approach in fact plays a wider role in educating police officers about mental health issues. It enables the police to gain further understanding of the psychological issues involved in their cases. It enables more efficient and effective risk assessment and management between agencies. It helps the police to understand where psychiatric intervention is indicated and aids them to navigate the complex system for obtaining psychiatric care in people with whom they deal.

7. Blueprints for change: recommendations from government-commissioned reports

7.1. The Reed report

The Reed review, which was jointly established by the Department of Health and Home Office, reported in 1992. A particularly thorough exercise, it set out a blueprint for the improvement of services for mentally disorder offenders. Whilst its conclusions were broadly accepted by government, there was little impetus or new funding to encourage the developments which the report had recommended. The result was that there were few immediate changes as a result of its recommendations. However, the general acceptance of its conclusions led to a consensus as to what should be done; and some of its more important recommendations were eventually put into place, notably the incorporation of prison health services within the NHS and the expansion of the sub-speciality of forensic psychiatry. However, its recommendation that there should be nationwide provision of court diversion schemes is no nearer to realisation now than it was in 1992. This is primarily due to the lack of central direction, resulting from a policy of leaving local services to develop their own initiatives according to local need – in effect a recipe for inaction.

7.2. The Bradley Report

The Bradley Report, published in April 2009, identifies ways in which services could be improved to aid diversion at all stages of the offender pathway. Its recommendations include: improved identifi-

cation of mental health problems in children and young adults through schools and primary care staff; neighbourhood policing teams should have a focus on identifying people with mental health problems; youth offending teams should incorporate mental health workers; diversion schemes should be available at all police stations and magistrates' courts; medical services to police stations should be provided by the NHS, not purchased by police authorities; the Crown Prosecution Service should investigate the use of conditional cautions for people with mental health problems; all probation staff, the judiciary and all prison officers should receive mental health awareness training; adequate provision of services for dual diagnosis cases should be standard; an improvement in reception screening in prisons; a refocusing of mental health prison in-reach teams on severe mental illness; a minimum delay of 14 days for transferring people from prisons to NHS psychiatric hospitals; continuity of care under the Care Programme Approach for mentally ill people entering prison from the community, and ensuring continuity of care when they leave prison.

A main emphasis of the Report is that services at all levels of the system should be co-ordinated and integrated. "One of the main problems with previous policy development has been the piecemeal approach that it has taken: government departments, agencies and organisations working independently of one another, developing policies and practice in isolation, addressing one problem or one part of the system at a time." (Bradley, 2009b p. 21). The review highlighted the importance of a single focus of accountability for the whole system of dealing with mentally disordered offenders and suggested the setting up of a National Programme Board to oversee the matters. It advocated the commissioning within the National Health Service in all areas of 'Criminal Justice Mental Health Teams' to deal with every stage of interaction between mentally disordered people and the criminal justice system, including community services.

There is an emphasis on intervening as early as possible, including before offences have been committed, and a realisation of the importance of the social exclusion agenda. The nine key factors identified in the report by the Social Exclusion Unit (2002, *Reducing offending by ex-prisoners*) as influencing offending and re-offending were: education, employment, drug and alcohol misuse, mental and physical health, attitudes and self-control, institutionalisation and life skills, housing, financial support and debt, and family networks. The report commented: "The failure of mainstream agencies to deal with these aspects of social exclusion means that the Prison and Probation Service are in many cases being asked to put right a lifetime of service failure" (p.18). Socially excluded groups are poor at accessing services, including mental health services. Attention to social issues and deprivation are emphasised as an important part of the prevention aspect of diversion.

8. Conclusion

The combination of diversion-oriented sentencing policy, flexible mental health law and a National Health Service creates fertile conditions in which to create good services and effective diversion mechanisms for mentally disordered people who become embroiled in the criminal justice system in England and Wales. Two thorough government-sponsored reviews have set out comprehensive plans for future service development. A lack of firm direction by central government has led to patchy and slow advances in achieving agreed goals. The latest review comes at a time when the mood has been moving towards stricter central planning in this field. However, it remains to be seen whether the Bradley review will fare better than the Reed review, given current political change and financial deficits.

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