

Diversions and Networks

**An overview of Diversion,
Community Support Schemes
and Prison Provision for
Mentally Disordered
Offenders in the Thames
Valley**

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December 2000



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In The Thames Valley**

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for
The Thames Valley Partnership
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Foreword

The intention of the Thames Valley Partnership in commissioning this report was to obtain an overview of the current position on services for mentally disordered offenders within the Thames Valley area. Much of the work undertaken has followed on from the high level of national policy making activity which took place in the early nineties – notably the Reed Report and the Home Office Circulars 66/90 and 12/95 which urged local agencies to pilot criminal justice ‘diversion’ initiatives.

Ten years on the wider context is changing with the restructuring of the Probation Service, the introduction of Youth Offending Teams, the development of a statutory framework for community safety and the introduction of NHS priorities which include the development of mental health services. In due course there will be a new Mental Health Act, likely to create new boundaries and definitions on access to treatment and compulsory treatment.

Ten years on our perception of the position ‘on the ground’ has also changed. The projects described in this report have helped to change the services available within the Thames Valley, but the complex needs of those who have both mental disorder and problems with drugs or drink still emerge as major challenges in planning future services.

Our wish therefore was to have an overview, which charted the development of the main Thames Valley initiatives and identified strengths and opportunities, but also examined how agencies had responded to the changing context. The Report demonstrates that a number of different approaches have successfully developed, but notes that across the Thames Valley as a whole there are significant gaps. It goes on to comment on the position in prisons and the emerging strategies for dual diagnosis treatment. The Report concludes with an attempt to describe the components, which would make up a comprehensive interagency service for mentally disordered offenders.

It is time, ten years after the Reed Report, for a new strategic lead both within the Thames Valley and nationally. We hope that the Report and initiatives flowing from it can contribute to that process.

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Executive Summary

This report is concerned with the services available in the Thames Valley for a group of people with mental health problems and complex needs who come into contact with the Criminal Justice System. Members of this group are often described as “hard to place” and they often fall through the net of existing services. Many have both mental health problems and problems with drug and/or alcohol use (usually referred to as a “dual diagnosis”). This group of people frequently has problems in accessing services, they may be homeless or vulnerably housed, and may be excluded from available help in the community because of their difficult behaviour.

There are a number of initiatives in the Thames Valley area, which seek to divert mentally disordered offenders where possible, from the Criminal Justice System. Some also seek to support the “hard to place” group within the community.

This report includes an overview of diversion and community support schemes currently operating in the Thames Valley and demonstrates that a number of different approaches to the needs of people with mental health problems have developed successfully in the area. The report highlights the need to develop some common practice across the Thames Valley and fills in some of the gaps. The report also reviews current mental health provision within four prison/young offender establishments. It refers to the link with dual diagnosis issues and the need for improved services. The report makes recommendations for improvements in multi-agency working and concludes with the suggested components of a comprehensive service for mentally disordered offenders in the Thames Valley.

Diversion and Community Support Schemes

The five diversion and/or community support schemes within the Thames Valley examined are Divert’, Reading and West Berkshire, the Elmore Community Support team based in Oxford, the ‘Revolving Doors’ Agency High Wycombe and South Bucks, the Multi-agency Panel Milton Keynes and the Aylesbury Court Diversion Scheme. The services they offer are compared and some of the current issues facing them are described.

Mental Health Issues in Prison

Bullington Prison, Woodhill Prison, Aylesbury Young Offender Institution and Reading YOI and Remand Centre were visited. The current political and policy context for work with mentally disordered prisoners is outlined, and current concerns and initiatives within the specific prisons described.

Dual Diagnosis Issues and the Perspectives of the Thames Valley Area DAT Co-ordinators

A definition of Dual Diagnosis is offered and the extent of the problem examined. Possible models of treatment and management are described, as is the impact of the new Drug Treatment and Testing Orders (DTTOs). Views from the Drug Action Teams (DATs) are included.

Key Conclusions:

- In no part of the Thames Valley does a comprehensive service exist but there are areas of good practice
- There is limited evidence of systematic inter-agency working. Where inter-agency forums do exist priorities are easier to identify and auditing of services becomes more possible
- Services are particularly limited outside main population areas
- There is little sharing of good practice, a lack of resource manuals
- There is a lack of standardised implementation e.g. in the application of Section 136 policy
- Many agencies, both statutory and non-statutory provide services that either exclude or work unsuccessfully with the group of mentally disordered offenders with multiple needs
- More systematic evaluative work is needed on projects and initiatives with mentally disordered offenders, which should have clear objectives and performance targets
- There is a lack of information available about what local systems and provision exist
- A wider range of accommodation is needed for mentally disordered offenders with support where appropriate
- The new Thames Valley Probation Service needs to develop a policy with regard to the role of Probation staff and a review of partnership arrangements
- Youth Offending Teams (YOTs) need to consider how to meet the needs of mentally disordered young offenders with multiple problems
- There are some examples of imaginative work but more contact is needed between Prison Service staff working with mentally disordered offenders and outside agencies
- Police, Prison and Probation staff all need more training

- Protocols are needed between substance misuse and other agencies about how to manage dual diagnosis work. A strategic approach and leadership at a senior level are required
- Deficiencies exist generally in services for substance abusers throughout the area which impacts on availability for people with dual diagnosis
- There are some serious concerns about the identification, assessment and treatment options open to black people with mental disorder
- More systems of user consultation in mental health services are needed
- More resources are needed generally if a comprehensive service for Mentally disordered offenders is to be achieved
- Clearer links are needed between Community Safety practitioners and services for Mentally disordered offenders
- Research on the Revolving Doors initiative shows that preventative interventions can be done with mentally disordered clients with little or no impact on the overall cost of services. The cost of services used by clients can be shifted away from expensive crisis services (police, accident and emergency departments and temporary housing) towards primary care, community mental health services and stable tenancies

Components of a Comprehensive Service for Mentally Disordered Offenders

This section makes some recommendations about what is needed to achieve a comprehensive pattern of services for mentally disordered offenders including those with multiple needs, within the Thames Valley

Following Arrest

- A Thames Valley Police generic policy on Section 136 should be introduced across the whole Area to ensure consistency and fairness in local arrangements.
- Training of custody and other Police staff should be on the basis of a rolling programme
- Alternative places of Safety should be available to Police throughout the Thames Valley
- In addition to established medical assessment procedures there should be a system of referral to other appropriate agencies

Pre-Prosecution and Court

- There should be a Panel system along the lines of the Milton Keynes scheme in each Police area. The work should be supported either by a Steering Committee or the proposed local MDO Forum
- Further work should be done on into the implications of panel work for the management of Community Safety cases
- Each Court or group of Courts should have a Court assessment scheme. The scheme should have a sufficient level of CPN cover to allow liaison and referral work. Sessional Psychiatrist input should be targeted on formal assessment and available at an agreed time each week.
- When custody follows Court appearance there should be a clear Thames Valley-wide agreement on the nature and timing of information to be sent to the prison

Treatment

- There should be an extension of the Link Worker model, piloted by Revolving Doors throughout the Thames Valley initially in the main areas of population, for those identified as having multiple needs.
- Health Authorities and Trusts should undertake an audit of CMHTs to establish where there are gaps in the service and examine whether they might contribute further on their own or in partnership to work with mentally disordered offenders
- A coherent strategy needs to be in place in each area for the development of dual diagnosis services with clear arrangements as to lead agency and service specification
- Managing Dual Diagnosis issues needs to be part of the role of DATS and joint commissioning authorities should be set up in each area to commission relevant services
- Substance misuse services, as a whole should be further developed in the Thames Valley
- Particular priorities are the needs of young people, faster response to crisis and the lack of provision outside main centres of population
- More suitable supported housing options need to be developed
- The Probation service needs to develop a Thames Valley wide policy on the role of its staff that is clearly communicated to the other agencies

Prisons

- Priority should be given to the development of the Health Care outreach approach in prisons
- Consideration should be given to the introduction of a Bed Manager to expedite prison/hospital transfers
- Priority should be given to the training needs of Prison Officers on mental disorder
- Every effort should be made to involve prisons in local mental health groupings
- Prisons should seek opportunities to extend further their partnership work on mental health

Local Structures

- Every area or group of areas should have a standing MDO Forum on the lines of successful existing models
- At a local level there should be clear links with Community Safety Partnerships including local authorities, housing departments and Drug Action Teams

Introduction

The Thames Valley Partnership has for some time sought to strengthen networks and co-operation in the improvement of services for Mentally Disordered Offenders. The last decade has seen many national research and policy initiatives, and these have been responded to in a variety of ways within the Thames Valley. During 1998 the Partnership researched and published work on confidentiality and information sharing. That document, as well as addressing good practice issues, made clear the significance of a co-ordinated approach to Mentally Disordered Offenders for the wider Community Safety agenda. The establishment of a Thames Valley Mentally Disordered Offenders Forum has been a further step towards the sharing of common policy concerns and improved planning.

The origin of this study was the awareness that a range of approaches have been developing within the Thames Valley to deal with vulnerable individuals who have complex needs and mental health problems at the point of arrest or contact with the Criminal Justice system. While the different projects are based on an assessment of local need, and have in some cases been the subject of considerable evaluation, there has been no overview of the different models of operation, and the way they fit into a pattern of local services. Similarly there has been no overview of the position in the area's prisons. This Report aims to provide an overall picture of these fields and the connections between them. Section 1 attempts to provide a description of key community based initiatives, including some comparative observations between the different models. Section 2 is a description and analysis of the main issues emerging from visits to four Thames Valley prisons. Section 3 describes some current developments in dual diagnosis policy and incorporates issues raised by the three (at present) Drug Action Team Co-ordinators in the Thames Valley. Section 4 summarises the main findings and attempts to describe basic levels of provision which would need to be in place in each area to achieve a comprehensive system of intervention.

The overview of community based initiatives is based primarily on an examination of four major schemes within the Thames Valley. They are as follows:

- Divert, covering Reading and West Berkshire
- The Elmore Team based in Oxford
- The Revolving Doors Project based in High Wycombe
- The Multi-Agency Panel covering Milton Keynes

In each case I have visited and met with workers directly involved in the schemes. I have also consulted with managers and practitioners in other agencies who were able to provide a wider context for the work being undertaken. I have read descriptive material and research

or evaluative material relevant to an understanding of each scheme. A full list of those consulted is given in the Appendix at the end of the Report. I did not make use of a questionnaire format for interviews, not least because the range of work being undertaken seemed to call for wider discussion, but I did base my questions a number of common themes, and the scheme descriptions reflect this pattern. All those involved were helpful in their willingness to share information, and there was a general recognition of the need for both an overview and more information sharing between areas. Inevitably given the purpose of this work and the time constraints I will not have met with all those who could have been consulted, but I have attempted to obtain a fair picture and I hope that this is reflected both in the descriptions and analysis.

Similarly, this Report is not an exhaustive study of all current initiatives; notably the Court based psychiatric assessment scheme at Aylesbury that was not operational at the time of my fieldwork. I have, however met with the Psychiatrist responsible for taking this scheme forward and have therefore made some reference to it in this final Report. While the four main schemes studied do cover a comprehensive range of models any subsequent work will need to take the wider field into account.

A characteristic of the Thames Valley is its mix of large urban centres, smaller towns and rural areas. Whatever gaps are acknowledged in this Report about service provision in the main centres, the gaps are much more serious elsewhere and the design of a suitable service to deal with smaller numbers in a range of places emerges as a particular challenge.

It is clear also that after the many changes in public service infrastructure and local authorities in recent times there are further major changes on the way. These include the establishment of the unified Thames Valley Probation Service in the spring of 2001 and changes resulting from the recent Prison Service regrouping of areas. Though the Thames Valley is not the natural reference point for a number of relevant services coterminosity between Police and Probation boundaries, will have substantial implications for the future. At a national level Government policy on NHS priorities that include Mental Health, and a new structure for the management of Prison Service Health Care provide an important context for the Review. Behind everything else is the consultation process on proposed changes to Mental Health legislation. Though a detailed examination of those proposals is beyond the scope of this study they have major implications around definition, compulsion and the relationship between Community Safety and Mental Health.

Ann James noted in her 1996 Report, 'Life on the Edge', a major study of policy and provision of diversion, for the Mental Health Foundation, that the debate on diversion needed to move on. As she says:

'Often misrepresented as a process to keep people with mental health problems out of the criminal justice system, diversion is not, as the term suggests, a departure from mainstream process, but rather a way of accessing those services which should rightly be available to all

citizens.... It would be more constructive and effective to move away from the concept of diversion altogether and focus attention on arranging services to meet need. To achieve this in practice requires the integration of the special needs of mentally disordered offenders into mainstream commissioning, purchasing and provision of services. It requires careful listening to users' views of service, a process that has largely gone unrecorded in this area of work. It requires the development of multi-agency skills and work practices, a development acknowledged in principle but as yet not fully realised. And it requires the effective re-targeting of interagency resources on identified individuals with very complex needs, and on points of individuals transferring between services.' (1),

How the different schemes are grappling with those challenges, in their different circumstances and approaches is the central subject matter of this report, at a time when the rise of dual diagnosis work presents new demands on assessment skills, and the wider community safety agenda is requiring agencies to co-operate in new settings within the terms of the Crime and Disorder Act.

Finally, in introducing this work, I must acknowledge the issues of language and definition. In an evolving field with differing approaches there are inevitably arguments about definition, and when these are important in terms of understanding the focus and philosophy underpinning schemes I have tried to make this clear.

As a general approach however I will use the term Mentally Disordered Offender (MDO) because of its common usage. In defining this I am using the broad based definition used by Ann James, including her caveat at the end.

The term 'mentally disordered offender' is used here to refer to those people perceived as suffering from a mental illness, personality disorder, and/or learning disability while having committed or suspected of or likely to commit an offence against the law. This definition incorporates that of section 1 of the Mental Health Act 1983 that includes mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind, and the wider NACRO definition of 'mentally disturbed offender' as follows:

'those offenders who may be acutely or chronically mentally ill; those with neuroses, behavioural and/or personality disorders; those with learning disabilities; some alcohol and substance misusers; and any who are suspected of falling into one or another of these groups. It also includes offenders where a degree of mental disturbance is recognised even though that may not be severe enough to bring them within the criteria laid down by the Mental Health Act. It also applies to those offenders who, even though they may not fall easily within this definition- for example some sex offenders and some abnormally aggressive offenders- may benefit from psychological treatments.'

The term (MDO) is used reluctantly in the absence of a more appropriate descriptor and in acknowledgement of its legal bias. ‘ (2)

A second definition that I will use concerns dual diagnosis, an increasing area of concern. In this Report I will use the definition suggested by Jeremy Spafford in his work on the City of Oxford (3).

‘Dual diagnosis describes a condition whereby a person has a mental health problem and a substance misuse problem and, if one were to be resolved, the other would still cause concern’

There are other forms of dual diagnosis but this definition is a helpful in thinking about the needs of a widely defined Mentally Disordered Offender group. As Jeremy Spafford indicates the term becomes useful when the duality of diagnosis prevents agencies from being able to offer an adequate service.

NOTES/REFERENCES:

- 1) *Life on the Edge, Diversion and the Mentally Disordered Offender. Ann James, Mental Health Foundation 1996, Volume 2 p6*
- 2) *Ditto p9.*
- 3) *Reflections on dual diagnosis in the City of Oxford. Elmore Community Support Team, Oxford. April 1999.*

Section 1

The Description of the Schemes

1. DIVERT- Reading and West Berkshire

Background History and General Description

Divert is the longest established initiative in the Thames Valley. Concern from Magistrates and the Probation Service about the number of Mentally Disordered Offenders appearing in Court, and the lack of provision for them led to an inter-agency seminar in September 1989. A presentation of the pioneering Hertfordshire Panel Assessment scheme was given and a Steering Committee was established to plan a local scheme. The project was launched in April 1990 and was called DIVERT to reflect the designated aims of diverting offenders from entering the Criminal Justice system, and failing that, to divert them from prison by offering treatment plans using resources in the community.

A panel system was not adopted, and instead a small team was established capable of intervening both in the Police Station and at the Magistrates Court. Despite financial pressures affecting all the funders concerned the scheme has continued and is an accepted feature of the local Criminal Justice provision. The Probation Service is a substantial funder, providing premises, administrative support, a full time Probation Officer who co-ordinates the scheme's work, and part of the time of a Senior Probation Officer who holds management responsibility. The Health Service contributes Consultant Psychiatrist sessions for court assessment and half the costs of a full time CPN. Social Services contribute the other half of those costs.

Some points of note are that until recently psychiatric provision came from the Regional Forensic Service. This worked well both in terms of continuity and a useful crossover with work at Bullingdon Prison, but on the basis that 70% of the work has a general adult psychiatry content the arrangement recently changed, and cover is now provided from the mainstream psychiatric service. There was some concern about this change and a wish to retain some links with the Forensic Service. So far as Probation input is concerned, the Probation Officer has been in place from the beginning and has clearly played a major role in sustaining and promoting the scheme.

DIVERT currently deals with some 300 people per year though if initial screenings at the Police Station are taken into account the figure is higher. It is planned shortly to extend DIVERT to cover the three Unitary Authorities in East Berkshire (Slough, Windsor & Maidenhead and Bracknell). This will either be on the basis of remitting cases to the established provision at Reading, or, as seems more likely, by establishing separate psychiatric assessment sessions at Slough. There were some concerns expressed about this in terms of the stretching of the role of the Probation Officer, and the fact that the extension of

the scheme is being undertaken without an evaluation of the current project. A number of those interviewed felt that the scheme had achieved a great deal but was significantly under researched given its size and significance.

Of the four initiatives studied DIVERT represents a model strongly tied to diversion, committed to intervention at court as well as at the Police Station. It has clearly defined staff roles and relies substantially on formal psychiatric and CPN contributions.

Work at the Police Station

The CPN sees those who have been arrested, and who present concerns, every weekday morning. In the CPN's absence the Probation officer will do this work. Referrals will normally come from the Custody Sergeant and frequency of contact means that good shared understandings have built up. There has in the past been a co-ordinating contact but not at the moment. There is no doubt that maintenance of these working relationships is crucial and, after a period when there was no cover because of sickness, referrals had to be built up again.

The CPN will in practice see a wide range of people including sex offenders, serious violence cases and anyone known to the Community Mental Health Team. Drug and alcohol cases are also seen and the CPN uses clinical judgement to assess whether to give the person referral advice or follow through herself. All cases referred are followed through as quickly as possible, including those cases where there is release without charge.

DIVERT is not normally involved in Section 136 work, but cases which lead to Court rather than diversion are likely to be picked up at Court.

At Court

Intervention can come at any stage in court proceedings and both the Probation officer and CPN may be involved in the identification of cases. This can impact on bail decisions, referrals to other agencies, and information sharing with other agencies. Contacts with defence solicitors and CPS staff are well developed. Where formal psychiatric assessment is required cases are remitted to the regular Thursday Court where four slots are available and the Psychiatrist has an Approved Social Worker available. Diversion may take place at this stage, but the point was made to me that with the increasing emphasis on public protection remands to custody are sometimes proposed.

A particular issue relating to bail is the problem of accommodation, given the high levels of housing difficulty and the frequent need for a reasonably high level of care, especially for cases where longer assessment is needed. DIVERT refers regularly to local hostel provision and also the Berkshire Approved Hostels. In common with other Thames Valley Approved Hostels they are now accustomed to taking some Mentally Disordered Offenders but

availability will depend on management considerations, and Elliott House in the West Midlands remains the only specialist provision for those with substantial Mental Disorder. Establishment of more local specialist Approved provision was an early objective of DIVERT. Though this has not happened it was suggested to me that a significant unmet need still exists, and that this idea should be looked at again in a wider Thames Valley context, and the imminent establishment of the Thames Valley Probation Service.

Referrals and Interagency Networking

DIVERT does not undertake ongoing work with individual cases, though it may work with people on a time limited basis if there are referral problems or delays in putting treatment packages together. Having identified cases, assessed need and influenced criminal justice process its task as with all diversion schemes is to ensure that the offender/service user gains prompt access to appropriate sources of help. All studies of Mentally Disordered Offenders show a high level of multiple need, and that people are most vulnerable at the point of transfer between services.

There is no formal machinery for liaison and inter-agency working, nor a panel system for case planning. Responsibility for referral of individual cases and regular liaison rests with the DIVERT workers. This operates regularly with Social Services and the CMHT. Working relationships were described as good, including the interchange of information. DIVERT work at the Police Station can feed in helpfully to the management of Section 136 assessments. As with other schemes there are inevitably issues about the willingness of the CMHT team to take on new cases given resource pressures and differing priorities, but the continuity of staffing at DIVERT, and the scheme's reputation help considerably.

DIVERT is regularly in contact with the local Drugs and Alcohol Services, (Neutral Zone and CAS respectively).

There does seem to be clarity about referral arrangements, but there are some concerns, particularly with drug users about willingness to share information with DIVERT. This will become a more substantial issue with the development of arrest referral, and concern about dual diagnosis. This latter question is discussed later.

The lack of suitable accommodation was described as a major concern, accentuated by the very limited availability of in-patient beds, though this may be helped in the longer term by the Regional Forensic Service's development of a pre-discharge unit and long term secure ward. Concern about accommodation is shared by the manager of Berkshire Probation's CHASE Unit that deals with partnerships and specialist provision.

The working relationship between DIVERT and the Probation Service has inevitably changed, given the shift in national priorities and the emphasis on seriousness of offending as the main indicator for Probation intervention. Clearly one of the main functions of

DIVERT is to ensure that alternative main stream options are available for offenders, but the limited options available can make this difficult, and it was suggested to me that DIVERT had become more isolated from mainstream Probation as these trends have developed. There was also a feeling that Probation Officers may need more training on mental health issues than they currently receive.

The scheme's founding Probation Officer felt that ideally a multi-agency team should be established to undertake work with hard to place cases, arguing that this might appear an expensive model, but actually prove more effective in cost benefit terms, including community safety gains. This would be a very different approach to the 'mainstreaming' agenda outlined in 'On the Edge', and may be unlikely to happen in the current climate, but both the Oxford and High Wycombe projects described later both hold cases for longer periods, and it is clear that accessing services for hard to place people can take considerable time and perseverance whichever model is followed.

Training and Information

The main training issues identified were the need for Probation staff training, mentioned earlier, and a more regular arrangement for training Police staff. On the Police side I am aware that training models have been developed elsewhere in the Thames Valley, an example being the work carried out at Oxford. It would seem sensible to use a standard model for the Force as a whole, but at present arrangements are left locally. A similar approach should become possible in the context of a Thames Valley Probation Service. It must be remembered that training on these issues needs to concentrate on awareness raising and identification. Because of the numbers of staff involved it also needs to be part of a rolling programme.

Another identified concern was the need for an inter-agency referral and resource manual, an issue also raised in later prison visits. My impression is that at present a great deal of expertise and knowledge rests with the specialists involved.

Dual Diagnosis Issues

At the time of my initial fieldwork dual diagnosis was not seen as a major issue. Since then the picture has changed with the publication of research conducted in Berkshire and a strategy for development of local services has been developed. This is described more fully in section 3 of this Report, and the implementation of these plans will have significant implications for DIVERT. The development of arrest referral work throughout the Thames Valley is already disclosing more cases and DIVERT may well need to review its responses and referral practice.

Management Structure

As is indicated earlier, the Probation Service provides management time from a Senior Probation Officer and until relatively recently the scheme had a Steering Group with representatives from different agencies and interest groups. This worked effectively for liaison issues but was less well equipped to manage strategy. Accordingly a Management Committee was set up, mainly representing funders. This appears to be working well, but the Police are not currently involved.

Summary

DIVERT works as a well established and effective diversion project based on work at the Police Station and Court. It has considerable psychiatric back up, and experienced specialist staff. It has so far lacked a full-scale appraisal of its impact and working methods, and there are some concerns that the expansion to East Berkshire will take place without this having happened. The expansion, together with the forthcoming change in psychiatric provision, will be substantial challenges over the next year. The scheme may be more effective at identification and assessment than networking, and the lack of suitable initiatives in accommodation was identified as a serious gap. Similarly concerns over local provision for dual diagnosis cases are likely to increase.

2. The Elmore Community Support Team - Oxford

Background History and General Description

The Elmore Committee is an independent agency and Registered Charity, established some 30 years ago. It has been involved with a range of projects over the years but during the last 11 years the Committee's main work has been the establishment and management of the Community Support Team that now constitutes Elmore's sole activity. A succinct definition of the Team's function is given in Elmore's 1998 Annual Report.

'We provide community support for people with complex multiple problems who do not fit easily into other agencies, incorporating street outreach work to rough sleepers-all of this in Oxford City.'(4)

This working definition is backed up by the Team's Mission statement, and this is so central to an understanding of the Team's model that it is worth quoting in full:

'The Mission of the Team is with those people whose needs are towards the margins of agency based provision in the health care, social care, accommodation or criminal justice systems. Agencies, either singly or within a network of care, perceive such individuals as 'difficult to place' because their problems are multiple, chronic or presented in bizarre or disorderly ways. They therefore require intervention to enable them to make optimal use of the services the agencies ordinarily provide. The Elmore Committee believes this is done most effectively and efficiently when a team having specialist experience of these problems works in an integrated fashion with both the persons and the agencies concerned until such time as those individuals' needs can be absorbed into the agencies' core functions. Such individuals presenting within the City of Oxford will thus be eligible to the services of the Elmore Team.'(5)

Elmore has three main funders, the Oxfordshire Health Authority, the County Council and the Probation Service, but also receives grants from the City Council as well as small amounts from other Oxfordshire District Councils.

The Project has a Co-ordinator, two part time support staff and four Support Workers who undertake the range of work with the Project's clients. The workers all carry the range of Elmore's workload from outreach through to assertive advocacy and networking. One of the workers is a CPN but the aim is to share and mix skills. Team working and a common approach are seen as central to the operation of this model.

The Community Team has during its life played a major part in campaigning for services to Mentally Disordered Offenders, and was the host agency for the action research project funded by the Mental Health Foundation which reported in 1995. This project was one of 13 nationally chosen studies described in 'On the Edge' (6), and the full local Report, 'People

with mental health problems arrested in Oxford' by Matt Berkley (7) reviews local provision as well as making a wide range of specific recommendations.

There have been a number of developments since that time and the purpose of this overview is to assess the current overall levels of provision and the contribution which Elmore with its very specific model is able to make.

Work at the Police Station

Elmore workers are called to the Police Station in respect of their own clients and possible new referrals who are seen as fitting the agency's brief. In this way Elmore does contribute to diversion work but within the context of its wider responsibilities. Since this contrasts with the exclusively criminal justice focus of both DIVERT and Revolving Doors at High Wycombe it is important to examine how Police Station work does operate in Oxford. This was certainly an area of concern identified by Matt Berkley who noted in the 1995 Report the lack of a clear local Section 136 Policy, poor conditions, the lack of an alternative Place of Safety option and poor inter-agency co-operation.

There have in fact been considerable improvements and all those I spoke to acknowledged these. Better Police identification seems to have flowed from three main factors: training provided during the operation of the short lived Court Diversion Scheme which is described later; the establishment of Force standards on section 136; the development of good working links with the CMHT's; and the personal commitment of the Police Partnership Inspector, an active member of the City MDO Strategy Group. This mixture of strategy, structure and management level commitment does seem to have had a significant impact, and the Elmore Team was able to contribute to this thinking.

Additional helpful factors have been the staffing continuity within the Custody Department and the focus that the Berkley Research provided. There is said to have been significant progress on a diversionary approach not only post but pre-arrest. Conditions have improved, and a hospital bed at the Ashurst Clinic was made available for a pilot period as an alternative Place of Safety. Recently this has been confirmed as a permanent arrangement. It would be valuable to assess these overall improvements in more detail, not only to quantify their impact but also to examine how they might be best sustained. It might well be appropriate to compare this approach with the results from both DIVERT and Revolving Doors where systematic specialist screening takes place at the Police Station by an outside agency.

Court Based Work

In order to understand the current role of the Elmore Team in respect of Court work it is necessary to examine the history of Court assessment in Oxfordshire. The Berkley research noted that a 6-week pilot scheme offering a psychiatric service in the City Magistrates Court

had suggested the regular appearance of mentally disordered people there. An Oxfordshire Court Diversion Scheme funded by the Home Office and sponsored by a multi-agency forum was established in 1995. A CPN was available at the Court on four mornings each week but the worker could also be called to other Oxfordshire courts. A psychiatrist attended each Thursday morning for Mental Health Act assessments. A good deal of training work was undertaken with key staff, but subsequently Home Office funding was withdrawn on the basis of low referral numbers. For a time the Mental Health Trust incorporated the work within a CMHT but the departure of the Consultant and continuing low numbers meant the scheme was discontinued.

Since that time an Elmore worker has continued to be available at the Court's request, sometimes in collaboration with the Probation Service. This provision is not funded specifically, though it is plainly valued by Court staff and Magistrates. The worker is able to undertake assessment and advise the Court. Where formal assessment is necessary the Elmore worker can facilitate arrangements. In a discussion which I attended between Elmore's CPN, Court staff and Magistrates it was suggested that the numbers referred had reduced in recent times. There seemed to be a strong consensus about this and if true it raises some important issues, particularly as the Reading scheme continues to have consistent and sustained demand. Either there are significant numbers of cases going unrecognised or the Police and the well established Network of local agencies are having a significant impact on pre-court diversion and crime prevention. A further assessment would be necessary to confirm what exactly is going on, and a Reading/Oxford comparative study might be particularly valuable. At present there seems little enthusiasm for a new Diversion scheme, and it was suggested to me that a better model might be a system of Court availability within the City CMHT's though this would not fit easily with their current priorities.

Whatever the situation in Oxford City the fact remains that there is no formal provision in the other Oxfordshire Courts. The numbers are undoubtedly very low and occasional need is hard to meet in an organised way, but this remains a serious deficiency.

Referrals and Inter-Agency Networks

Elmore's 1998 Annual Report indicates that it dealt with 117 clients in the year of whom 41 (35%) had offending as a known client need. 59 (50%) had a known offending history, but only 22 (approximately 19% of all referrals) had current offences of which half were serious offences. These figures do understate Elmore's involvement with Mentally Disordered since significant assistance is provided to the Bail Hostel as well support and advice to Probation Officers. Moreover, given the agency's brief those worked with are hard to place. By definition they are both challenging and vulnerable with complex needs, and the increasing importance of Elmore's work with rough sleepers is widely acknowledged.

Elmore sustains longer-term work with some clients, and a City CMHT Consultant Psychiatrist stressed that however effectively onward referral works there remains a

significant minority of hard to reach clients who respond better to this approach from an independent agency.

Elmore belongs to the Oxford Network, described in its 1998 Directory as a loose structure of agencies from the statutory and voluntary sector who work with vulnerable, single people in Oxford. The Network is not a planning group but a co-operative liaison group. Network agencies include housing and hostel providers, day care resources, and community services. Oxford has an unusually well developed range of services that do work closely together. Clearly the presence of such facilities as the Luther Street Health Centre for homeless people and the Night Shelter make their own distinctive contribution to work with Mentally Disordered Offenders and any fuller study of diversion and treatment would need to evaluate the impact of the different agencies. An evaluation of the Elmore Team is planned, and I would hope that inter agency working can be examined alongside the wider cost benefit advantages of Elmore. There seem on the face of it to be significant community safety implications as well as a diversionary impact.

Elmore's working relationships with the City CMHT's seem to be strong. As well as referrals between the CMHT's and Elmore there is some joint working. The shortage of assessment beds is seen as a problem, particularly in dual diagnosis cases.

A number of improvements have flowed from the operation of the Oxfordshire MDO Strategy Group, not only relating to Police performance but Social Services as well. Currently the Group is working on establishing better arrangements for the co-ordination of Court Psychiatric Reports. Delays and variable performance have been identified as a particular local problem. Fuller CPS representation on the Strategy Group would be welcomed, but the Group is clearly having a helpful impact.

Elmore's work with housing issues must also be seen in the context of reasonable levels of provision. The 1998 Annual Report indicates that the majority of clients are housed as the statutory responsibility of the local authority either in council or Housing Association tenancies. A key role of the Elmore Support Workers is in tenancy protection as might be expected.

As is also the case in the other 3 schemes in this study, the role of the Probation Service has substantially altered recently, but this is most marked in Oxford, where the Service was formerly a substantial service provider at the Probation Day Centre as well for some years playing a major role in the establishment and operation of the Oxford Network. The Day Centre continues and is operated by non-statutory providers. Moreover Probation is a significant funder of Elmore. It seems to me that although there is an acceptance of this changed status, and the implications of a national change of focus, there remains a real concern about Probation's current low profile.

Training and Information

A good deal of training work was undertaken under the auspices of the Court Diversion Scheme but Elmore's training work has been more limited recently, though the agency does provide mental health awareness training courses within the Oxford Co-operative Training Services (OCTS) framework and this is an important training provision for housing workers and others. The agency clearly has training expertise and could I think make a broader contribution if asked.

I attended a Magistrate's training event organised by the Probation Service and run by Elmore. This was well received, and is probably the kind of event that needs repeating from time to time. Similarly, though Police performance has improved there are bound to be continuing training needs and Elmore would be a suitable agency to take this forward.

Information about Elmore and other agencies is good but there is no Manual on Mentally Disordered Offender procedures or resources and this gap, similar to the issue raised by DIVERT staff, does need to be filled.

Dual Diagnosis Issues

The starting point for a consideration of this subject must be the Report 'Reflections on Dual Diagnosis in the City of Oxford' produced by Jeremy Spafford in April 1999 (8) This work was funded by the Department of Health and supervised by the Elmore Team on behalf of an inter-agency steering group. Though the research and findings relate to Oxford City, the issues identified have a much broader relevance and raise questions about service provision and co-ordination that apply to other areas.

Spafford indicates that the problem is a substantial one. At any one time between 5 and 20 people in Oxford lead very chaotic lifestyles and are involved with most if not all relevant agencies without getting an effective service from any of them. A further number, up to 315, have less chaotic lives but still receive an inadequate service due to their dual diagnosis. He estimates that they may become part of the smaller group if nothing is done. Given the connection with drug related crime this amounts to the main emerging challenge for those working with Mentally Disordered Offenders, particularly as the group causing most concern were young.

Spafford notes the sophisticated network providing support to vulnerable people in Oxford but points out that financial problems in the Mental Health NHS trust and growing concern about risk have caused many agencies to adopt access policies which frequently exclude those with a dual diagnosis label. He argues powerfully for more training, common assessment procedures, a range of improved substance misuse services, specific housing provision and the establishment of specialist resource provision either within a new

dedicated team or within existing services. He also argues for improved diversion from criminal justice and is one voice at least clearly in favour of a Court based initiative.

The main difficulty in all this is the current imbalance between an excellent pattern of community services for vulnerable people, and the paucity of services for substance misuse. They are relatively limited in Oxford despite recent improvements but have been virtually non-existent in the wider county. While there have been some encouraging developments in the non-statutory sector the decline in Trust services was described to me as catastrophic in several interviews. These sit oddly with identified community safety priorities that include drug misuse as a major issue. SMART, the arrest referral scheme is operating successfully and does refer appropriately to Elmore and other agencies, but the lack of referral options is a major deficiency for 'main stream' drug use let alone dual diagnosis cases. It seems to me that joint work between the Drug Reference Group and the MDO Steering Group is necessary to take these concerns forward. Oxford would be well placed to adopt the Spafford option of specialist provision within established agencies but substance misuse services will need rebuilding significantly. There are now some encouraging signs, including the establishment of a new service in North Oxfordshire. It does seem clear that the introduction of Drug Treatment and Testing Orders will have further impact on the pattern of local services.

The most recent contribution to the Oxford debate on dual diagnosis is contained in the Report of the Dual Diagnosis Demonstration Project conducted at the Luther Street Medical Centre for Homeless People (9). The Department of Health commissioned this study and Oxfordshire Social Services to examine prevalence among the Centre's patients, their impact on service development and the general accessibility of services to this population. The Report tracks treatment offered, the prevalence of different dual diagnosis symptoms, and the nature and outcomes of further referral. Its findings add considerably to the developing picture. The implications of this work are considered further in the later section on dual diagnosis, but several points are relevant here in that they add to an understanding of the context of Elmore's work. The Report concludes that the change in recent years has been away from alcohol as the drug of choice for the homeless towards Class A drugs obtained illegally, notably heroin, with a resulting impact on behaviour and the concerns of agencies working with them. The population is younger and struggles for access to services, even those specifically for homeless people. Among substance misusing street homeless people there were significant levels of clinical depression, psychotic illnesses and especially anxiety-related disorders. The Report notes that the Oxford Mental Health Trust is currently developing protocols and guidelines for managing dual diagnosis patients but concern is expressed that the focus at present seems to be on those with mental health problems already known to services who then develop concomitant substance misuse problems and this may not address the needs of patients needing access to secondary care with complex needs.

In the Report's conclusion there is reference to the teamwork approach at Luther Street and the model of primary care provider working seamlessly with local voluntary sector agencies

to provide an effective, professional service. Implicit is the notion that for progress to be made statutory services will need to be more flexible in their models of service delivery. This is the same message as Elmore's and the Revolving Doors Project described in the next section.

Management Structure

Elmore, as an independent Charity has a Management Committee that includes co-opted members from the funders, Police and Barnett House. The Support Team has a Steering Committee with psychiatric and medical input. The scheme is managed by a Co-ordinator and the project operates from offices within the Day Centre building near the centre of the city.

Summary

Elmore responds to the needs of Mentally Disordered Offenders who fall within its brief to work with 'hard to place people'. It operates within the range of Network Services and has extremely well developed skills at networking and advocacy. There is no formal diversion scheme, but Elmore visits the Police Station and Court as required. Police performance has improved considerably, and it seems that this and the availability of an effective network have had a significant diversionary effect that should be studied in more detail. The MDO Strategy Group is making a significant contribution. Though there is no widespread concern about the re-introduction of a Court based diversion scheme the Spafford research suggests that this issue should be re-examined and it is important to establish why the experiences between Reading and Oxford have been so different. Major research has recently been published on dual diagnosis that raises significant questions about the need for improved substance misuse services and specialist provision.

NOTES.

(4) Elmore Committee Annual Report 1998. The Elmore Committee 23, Park End Street, Oxford.

(5) Ditto.

*(6) Ann James. 'On the Edge' Mental Health Foundation *ibid*.*

(7) Matt Berkley. People with mental health problems arrested in Oxford -a review of needs for services. The Elmore Committee, July 1995

(8) Jeremy Spafford. Reflections on dual diagnosis in the City of Oxford-user and agency perspectives. The Elmore Committee. April 1999.

(9) Philip D. Evans. Dual Diagnosis Demonstration Project Report. The Oxford Homeless Medical Fund. August 2000.

3. Revolving Doors - High Wycombe

Background History and General Description

The Revolving Doors Agency was established in 1993 following the publication of the Reed Report. (10). The Agency was initially funded from a Telethon appeal and the objective was to research new ways of responding to the needs of people with mental health problems caught up in the Criminal Justice System. Three years of investigative work were then undertaken primarily in North London, including the tracking back of individual cases through the agencies who had been dealing with them. The findings confirmed the problems identified in Reed and echoed in 'On the Edge', the Berkley research on Oxford, and the Luther Street research quoted in the previous section. Service providers operated different assessment policies, tended to exclude those with multiple need and often operated inflexibly and in relative isolation. The model of the Link Worker began to be developed as a result of these investigations, based on identification at the Police Station, prompt follow up, and then sustained contact while links are negotiated with appropriate agencies in the community. This is a clear response to the call in 'On the Edge' for policy to move on from a preoccupation with the process of Diversion into a greater emphasis on finding ways of providing access to health care, social services and other support. While this has a good deal in common with the approach taken by the Elmore Team in Oxford, the Revolving Doors Agency has concentrated mainly so far on establishing relationships with mentally vulnerable individuals in contact with the Police. As work developed, however work in the local court developed as well as maintenance of contact with individuals in prison. Revolving Doors defines its client group as mentally vulnerable people with multiple needs

The High Wycombe Link Worker scheme resulted from work initiated in conjunction with the Thames Valley Police. A one-year research and development programme investigated local conditions and this work was published in 1997. (11). A 3 year project was then established on the basis of core funding from national charities, matched by Thames Valley Police and local statutory funders. A distinctive feature of the High Wycombe scheme has been the funding provided by Wycombe District Council from its Community Safety budget. The 3-year programme ended in June 2000, but funding has been secured to run for a further 3 years. This is practical evidence of the perceived impact of the Revolving Doors model but the issue of longer-term sustainability is discussed later. The scheme has been extended to cover the rest of South Bucks.

The High Wycombe scheme was paralleled by two similar initiatives in Bethnal Green and Islington, and the workers from all three schemes have a central manager as well as meeting together regularly. The overall project has been the subject of evaluation by the Home Office Research Development and Statistics Directorate as well as a 'best value' evaluation conducted by the London School of Economics. The findings from that evaluation are included in the Report 'Mental health, multiple needs and the police', published by Revolving Doors in July 2000. (12)

The Wycombe scheme began with 2 Link Workers and the Team has now extended to 3, with the appointment of a dual diagnosis post, though like the Elmore Team the Link Workers have a common job description and operate on a skill sharing model, rather than operating to specialisms. The Team includes CPN, social work, substance misuse and outreach work experience.

A more detailed description of operation and performance is given in the following sections but some general points about the approach should be borne in mind.

- Revolving Doors operates with a broadly defined group of clients, and the crucial target factors are mental vulnerability and multiple need.
- Though the primary focus is the Police station referrals can come from Prisons, Probation or the Court.
- Revolving Doors may contribute to diversion but does not see itself as a diversion scheme.
- Work with individuals may continue on a longer-term basis for up to two years.
- Since the overall aim of the scheme is to facilitate better performance by local agencies in meeting multiple need Revolving Doors does not envisage an indefinite future in local provision-it seeks instead to provide a model for work which is responded to by local services.
- The Link workers as a consequence have had development and action research responsibilities as well as working with cases.

Work at the Police Station

A Link Worker from the team visits the Police Station daily, and referral forms giving basic information about police concerns are collected then. The daily visits are seen as a means of sustaining regular contact with police staff and working relationships are positive. The service does not operate on a 24 hour basis, and Revolving Doors therefore is not engaged directly in Section 136 assessments, though some people who have been detained under Section 136 are later referred on to Revolving Doors. The Home Office research report which covered the period up to April 1999 (13) indicated that across the 3 Revolving Doors Projects in Bethnal Green, Islington and High Wycombe 88% of referrals followed arrest for an alleged offence or arrest on warrant. At High Wycombe only 6% of referrals followed an incident other than an arrest. The alleged offences covered a wide range and the Wycombe Team has had experience of some serious offenders, though the largest offence categories are for theft and drink associated charges. The research analysed the reasons given for police referral to Link Workers, though frequently more than one reason was given. Figures for the

3 schemes showed that drug or alcohol misuse was mentioned in 61% of all referrals, but depression (49%), aggressive behaviour (35%) and active distress (29%) were the next 3 highest referral reasons for police concern about mental state.

Link Worker assessment of people while still in custody happened in only 23% of the High Wycombe referrals, a lower proportion than in the other 2 schemes and this was felt to relate to the lower numbers of people being held in custody for court. Referrals are followed up with considerable determination by Link Workers and the making of contact may take a number of efforts, including home visits, in line with the Revolving Doors policy of assertive and persistent follow up. The Home Office study examined the presenting needs of people assessed by Link Workers. The results seem very similar to the profile of the Elmore Team's client group with a high level of multiple need. Cluster analysis showed a tendency for problems with mental state to be reported alongside lack of social support. Alcohol abuse and financial difficulties were assessed as being markedly more of a problem among referrals at High Wycombe than in the 2 London sites. Generally there seemed to be a good fit between initial police concern and identified need at assessment, though about a fifth of referrals were judged by the Link Workers across the 3 sites to be inappropriate - the issues included lack of a mental health problem, the person already having sufficient engagement with local services, being outside the catchment area or presenting too high a risk level to be worked with safely.

Of the 451 people referred across the 3 sites up to April 1999, nearly half were known to be charged by the police, 16% were cautioned, 10% released on police bail and 16% were given a caution or warning. Charges were most commonly brought at High Wycombe. It is interesting to speculate on the extent to which the availability of a known and visible referral option may encourage police diversionary action. My impression is that there is an impact, and the picture may be clearer when all outcomes are evaluated at the end of the research including a study of a control group of custody records at Holloway Police Station. It must be remembered however that the prime concern of Revolving Doors is with the support of people through the system and the creation of care patterns that meet their identified needs.

The picture provided in the Home Office interim research is borne out by the more recently published findings mentioned above. It may be useful, however to consider 'Mental health, multiple needs and the police further' since the report gives some final comparison with the Camden and Islington control group as well as well as the results of the work undertaken by the LSE on the cost and use of services.

The main operational conclusions from the overall data on 3 sites add up to an important statement about the nature of multiple needs and mental health. They are summarised as follows:

- Referral data from all 3 sites described a group of people with serious mental health problems and multiple needs, with similar demographic characteristics, mental health

needs, levels of drug and alcohol misuse and offending profiles. The implication is that although High Wycombe may have displayed some differences against the two Inner London sites the overall similarities are more important, giving the lie to some traditional assumptions.

- There is strong evidence for the existence of a ‘revolving doors’ group with mental health and multiple needs who are not being helped by health and social services as they are currently configured.
- Referrals to the Link Worker schemes were similar to the general population in terms of their reason for arrest, but very different in terms of mental health problems.
- People with multiple needs were less likely to gain access to appropriate health and social care services, and more likely to become victims of the ‘revolving door syndrome’ as a result.
- Referrals to the Link Worker schemes could be seen as part of a wider group with multiple needs.

The research on cost and use of services is a particularly important piece of work established to provide an independent picture of the cost benefit implications of the Revolving Doors Agency approach. The study compares the amount of service use and costs by clients of the Islington Link Worker scheme with a control group from Holloway Police Station. It also compares their experience one-year before and one-year after the point at which they came into contact with the police. The report provides detailed methodological information about costing techniques used and the basis for calculations. The main conclusions are summarised as follows:

- The police have more contact with this group of people than do social services. Cost estimations showed that the annual cost of this group’s arrests was greater than the annual costs to emergency services, community health services or social services.
- Evidence of a fall in use of emergency services and temporary housing, coupled with indications of more appropriate use of emergency services and better access to quality housing strongly suggests that the Link Worker scheme could have an impact on their clients’ use of certain community services.
- In the longer term the reduced costs to crisis services and of temporary housing offset the increase in costs in providing appropriate services to health, social services and local authority housing. This suggests that greater cost effectiveness for both clients and the community services concerned can be achieved.

The implications of this research are hard to overstate. Many of the Reports quoted earlier have spoken of the need to reconfigure services in order to provide access to services for those that have multiple needs and offend. The research appears to demonstrate that this can be achieved with considerable cost benefit gains. In piloting a model that can deliver change, Revolving Doors Agency has demonstrated something which has major implications for all agencies involved and for inter-agency working. There is no evidence to suggest that similar economic consequences would not apply within the Thames Valley. To shift budgets in due course across service providers is not an easy matter and a good deal of co-ordination at senior management level may be necessary. It is clear though that the funders of the High Wycombe scheme, led by the Thames Valley Police, have provided an important model whose advantages now seem very clear. This is an issue that will be returned to in Section 4 of this Report when elements of a comprehensive service are discussed.

Work at Court

As indicated earlier Revolving Doors does not aim to be a formal diversion agency, and attendance at Court has essentially been with the aim of supporting its clients through the court process, though clearly their involvement may well have an impact on court decisions including the cases where there is joint involvement with the Probation Service. As work progressed the Team did develop more involvement at Court but this did not alter its core approach and identified function.

There is no formal psychiatry/CPN based diversion scheme at Wycombe, despite a series of unsuccessful bids for funding in recent years. To some extent, for Police and other local agencies, Revolving Doors has emerged from the determination that if this option is not achievable, then something practical must be done to have an impact on early identification and referral. This is not to say that there is now no place for a specific court based scheme. The patchwork quilt development of services for Mentally Disordered Offenders meant that such a scheme was established in Aylesbury. The NACRO study on Buckinghamshire and Milton Keynes Needs Assessment published in 1998 (14) reported that during 1997 the sessional psychiatrist there saw 49 people or approximately 1 individual per week, of whom 57% were deemed to be in need of mental health services, yet Wycombe has never had such a scheme, and Oxford lost one supposedly on the basis of low figures. Other problems overtook the Aylesbury scheme and the position there is outlined later in this report. Within the Thames Valley we are a long way from the Government's vision of a national framework of court assessment. In Section 4 I return to this issue as clearly a consistent court assessment scheme is needed in all areas as part of a comprehensive service, but the experiences from Oxford and Reading suggest that a more flexible type of model is needed.

Referrals and Inter Agency Networking

If the overall Revolving Doors figures are examined the Home Office research shows that in High Wycombe over half of referred cases were taken onto the Link Workers' caseloads for short or long term work. A considerable amount of short term or one off work was undertaken but the Team carries an ongoing longer term caseload up to a maximum of 30 cases. Phone and face to face contacts are frequent by comparison with other agencies, and in line with its commitment to persistent follow up, Link Workers have to follow through on high levels of missed appointments. Work with cases also involves high levels of negotiation and liaison with other agencies. When the further demands of action research and development work with local services is borne in mind it is clear that the Link Worker role is a very demanding one. For these reasons the caseload is managed collectively and all cases are reviewed weekly so that work can be planned, and momentum maintained. Similarly the level of individual and group supervision is high, and this is contributed to by an experienced Social Services manager. Similar points about support and supervision were made in the information from Elmore and Luther Street quoted earlier.

The central objective with clients is to access them to local services, and develop networks of support. Inter-agency co-operation has worked well in Wycombe over a number of years and this has proved helpful, but there are some limiting factors, of which the most notable are the limited range of non statutory service providers, the serious lack of supported accommodation for single people, the limited specialist provision for ethnic minority people, and very limited services for substance misusers. The network in which Revolving Doors operates is therefore a very different one compared with Oxford and this can slow down the building of support packages for Revolving Doors clients.

The Revolving Doors mission includes the demonstration of working methods to mainstream agencies, and some shared cases with the CMHT have for example enabled mainstream workers to try new methods. There were also positive comments about work with local Probation Officers. The project has produced a working guide to the criminal justice and mental health services for people with multiple needs in South Bucks. (15). This is a comprehensive and well laid out handbook and meets a need identified that is not met in Reading and Oxford. The agency as a whole was responsible for the production of a guide for auditing local multi-agency arrangements. (16). This work was funded by the Home Office and has proved a valuable audit tool in a number of areas, including Milton Keynes.

As an agency Revolving Doors has from the outset given careful thought to the longer-term future of its operations. The intention is not to develop an increasing number of independent teams in different locations but rather work with local service providers and funders to adopt the work for themselves and sustain it on a permanent basis. There may be a number of models for this, including the pooling of resources to produce an identification and assessment unit that could carry on the work identified by the present team. The case for such a longer-term arrangement is compelling given the nature of work with multiple need

clients, but clearly there would have been gains in working arrangements with other services. This could be a successor independent agency, similar to the Elmore Team, but with a brief tied more specifically to criminal justice, or it could be established on a model like the YOT teams, and managed with secondments in a statutory framework, along the lines of the new team for multiple need clients being established in Milton Keynes, though this involves central government funding. Clearly, the extension of Revolving Doors for a further 3 years in Wycombe will provide a much better chance of this process being worked through effectively, but it will demand a considerable level of commitment, similar to the funding levels which support Elmore.

Of the four projects studied, Revolving Doors has the most developed model for service user involvement. Most studies of need have included elements of consultation with service users. This was certainly true in the work that Revolving Doors did prior to establishing its own services, and the current model of work certainly reflects that. For example, when asked, many people with multiple needs value reliability of contact much more highly than 24-hour availability. Similarly, professionals can underestimate the importance of friends and informal networks.

Maintaining such consultation once a service is running is not easy. Revolving Doors manages it by providing a regular informal social event at which discussion can take place. In the longer run this approach could be further built on, but it has already provided important local feedback.

Training and Information

The Revolving Doors documents mentioned above are themselves a significant training and information sharing initiative. Similarly the work of referral and working with staff from other agencies has training value in a locality which has previously had limited specific provision for those people involved with the criminal justice system who have multiple need.

A main focus for training activity has been the Police Service, particularly staff involved in custody work, and this is regarded as an ongoing task. Daily Police Station visits helpfully reinforce training. In the early stages, perhaps not surprisingly given local concern about street drinking, a number of inappropriate referrals were made, but training and regular contact have helped with this problem. Work has also been undertaken with some prison staff, and this is important given the commitment to providing continuity of care and contact.

The issue of dual diagnosis is discussed in the next section, but there may be a particular need in High Wycombe to promote agency, or inter-agency training on this subject, given the high incidence of substance misuse, especially alcohol, among referrals. The limited range of

alcohol and drug services reinforces the case for this. Revolving Doors is well placed to contribute with the recent appointment of a dual diagnosis worker.

Dual Diagnosis Issues

The early indications are that there is good collaboration with ACT's arrest referral work in the Wycombe area, including cross referrals and co-operation between workers. This is encouraging, though both agencies face the previously mentioned problem of limited referral options beyond detoxification provision. A similar issue is mentioned in Spafford's work on Oxford City, and this is a general problem throughout the Thames Valley, most notably in the more rural areas. It will be important to ensure that these issues are followed through with the Drugs Reference Group and the Drugs Action Team. Clearly when service is limited the existing agencies will tend to operate with strong appointment systems, waiting lists and an emphasis on the motivated client. These factors, as with other services work against access by dual diagnosis clients with multiple problems. Spafford raises these issues in relation to Oxford City and indicates two possible models for service development- provision of specialists within agencies, or a dedicated specialist team. It may be that a mixture of both models is needed for the situation in Wycombe, particularly if a 'first base' and assessment unit is to continue, whether run by Revolving Doors or a successor agency. It is encouraging that the Social Services Department has recently employed a dual diagnosis care manager who has regular contact with the Link Worker Team.

Given the major significance of dual diagnosis work in the Thames Valley, and the fact that there is now specialist experience within Revolving Doors it will be important for a full evaluation of work with dual diagnosis to be undertaken, with particular reference to onward referral and outcomes.

Management Structure

Revolving Doors has a local Advisory Committee for each of its projects. Though a central Management Committee is responsible for the agency as a whole the local Committees are seen as vital in building in local 'ownership' from the beginning. Given the emphasis placed on forward planning and longer term local responsibility the Committee is also designed to ensure good, open working relationships between the key 'players'.

This seems to have worked well in Wycombe, though the personal leadership of the Chair has been a particularly important factor. She is a Police Sergeant with extensive local partnership experience and her commitment has certainly contributed to the high level of District Council involvement through the Community Safety agenda-a connection seldom made explicit, but of great potential importance. Within the Thames Valley the Police have provided a good deal of practical local leadership from key individuals, not only in Wycombe but also at Oxford and Milton Keynes. It will be important for this contribution to

continue beyond the personal commitment of current individuals, and this is an issue discussed later.

The Wycombe Committee has good representation from the local agencies, and plays a supportive role with the project's staff. It was suggested to me that much of the present membership is at middle management level however, and more senior input may be necessary, as the issues of future structure and funding become crucial.

Summary

Though not a Diversion agency, Revolving Doors focuses on those involved with the criminal justice system primarily at the Police Station. It aims to work with those who have multiple needs and comparisons can be drawn with aspects of the Elmore team in Oxford. Referral figures indicated the importance of dual diagnosis issues and a worker was appointed in response to this. The scheme's working model emphasises the need for assertive and persistent contact and the main aim is gradually to access people to mainstream local services. To further this aim workers liaise closely with mainstream services and try to develop more productive and collaborative ways of working. A user consultation process is built in to the working model, and this also informs practice. The area has limited non-statutory services, and poorly developed substance misuse services and this limits referral options. There is no formal court diversion scheme, though Revolving Doors has become more involved in court attendance. There is local ownership through an advisory committee whose role may develop further when longer-term issues about funding and structure have to be tackled. The recently published findings covering the whole Revolving Doors initiative offer much important information about the economic and care benefits of this model.

NOTES:

(10) Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services. Chairman Dr. John Reed, Department of Health and Home Office 1992.

(11) Managing people with mental health problems. Thames Valley Police and Revolving Doors Agency, March 1997.

(12) Mental health, multiple needs and the police. Findings from the Revolving Doors Agency Link Worker Scheme. Revolving Doors Agency. July 2000.

(13) Evaluation of the Revolving Doors Agency's Link Worker Scheme: Second Interim Report. Home Office, October 1999.

(14) Buckinghamshire and Milton Keynes Mentally Disordered Offenders Needs Assessment. Buckinghamshire Health Authority. 1998

(15) Finding Support after Arrest, Revolving Doors Agency, 1999.

(16) Multi-Agency Review Framework, Revolving Doors Agency, 1999.

4. The Milton Keynes Mentally Disordered Offenders Panel and its place within the pattern of local services

Background History and General Description

The background to the Milton Keynes scheme is best understood in the context of the pattern of local services. This is covered in the NACRO Report of 1998 that provided an overview of the Milton Keynes situation (1).

Neighbourhood Services

The local government reorganisation of 1997 saw the establishment of a Milton Keynes unitary authority, and the establishment of a Neighbourhood Services Directorate which brought Housing and Social Services within an integrated structure. The Directorate includes a mental health service that consists of Social Services, Approved Social Workers, Rehabilitation Officers, Community Support Workers and Day Services. A member of the Mental Health Team works as a forensic social worker at Marlborough House, the Regional Medium Secure Unit.

Health Services

Four Community Mental Health Teams cover the city serving north, south, east and west on a quadrant basis. The Campbell Centre operated by the Milton Keynes Community NHS Trust provides a 38 bed Acute Admissions Ward, a Day Hospital and an Outpatients facility. Though Marlborough House is situated locally it is a Regional facility and cannot be regarded as having a specifically local brief. Nonetheless its presence and contact between workers does contribute to the development of local thinking and planning.

Probation

The Probation Service operates from a single main office in Central Milton Keynes, and operates on a functional division of work, so that Mentally Disordered Offenders may be dealt with by Community Supervision, through care or Young Offender Team workers. There is a Bail Scheme and regular contact with the other agencies but there is no specific mental health work. Probation provides partnership funding for drug and alcohol work, but not for specific mental health work.

Voluntary Sector

NACRO's Report commented on a range of provision which complements social services locally, but the main emphasis in Milton Keynes has been in the development of statutory services and there is no equivalent of the Elmore or Revolving Doors approaches. Indeed, work on multiple needs cases which is undertaken by those agencies in Oxford and High

Wycombe is likely, in Milton Keynes to be picked up by a new Joint Intensive Support Team run by Health and Social Services from central government funding. This Team was being established at the time I visited and although its brief covers the wider field it will be important to see what contribution it can make to Mentally Disordered Offenders. Certainly there is a case for comparative evaluation to be undertaken in due course, and a service based in the statutory sector is certainly one of the models which Revolving Doors will wish to examine in the longer term.

Overall therefore local services all relate to the specific area of Milton Keynes and reflect the changes in local government as well as the nature of the city. The emphasis has been on statutory services many of that have been designed relatively recently or re-organised.

Milton Keynes has a Mentally Disordered Offenders Steering Group. Several attempts were made to obtain funding for a Court diversion scheme prompted by developments elsewhere and the concerns of the local court. The failure to obtain funding certainly led to an exploration of other options, but several other factors also lay behind the adoption of an inter-agency panel. First, Milton Keynes Police had already developed with the NHS Trust two alternative Places of Safety at the Campbell Centre and the local Accident and Emergency Department for those who presented with mental health concerns, injury or serious intoxication. With assessments that resulted in admission to the Campbell Centre police investigation into offences tended to end unless the offence was very serious. This was seen as problematic in terms of follow up work and public protection. Secondly, there was felt to be considerable scope for improving inter-agency co-operation in both the decision making and management of Mentally Disordered Offenders.

Thames Valley Police took the lead in producing proposals, and as has been the case elsewhere, the particular contribution and commitment of the Inspector concerned has played a major part in the establishment and operation of the scheme. The scheme is described in more detail in the next section but the basic operation is as follows: Police Officers fill in the Force wide Mental Health Monitoring Form after reception into police custody. From this basic information about cases to be considered at the panel is distributed to the participating agencies, and information is then pooled at the next weekly panel meeting. The panel discusses each case, considers the issue of prosecution and agreed decisions are recorded in a standard format at the meeting. The aim is to have the commitment of regular representatives, and this is clearly an important issue in achieving consistency and trust. There are representatives from the Police, the Trust (Campbell Centre), Neighbourhood Services (Social Services) and Probation. The Campbell Centre representatives are the Unit Manager and Clinical Services Manager rather than clinical staff and there is an issue about how best Doctors could be directly represented. Similarly there is a question about possible regular involvement of the Regional Secure Unit and a representative already attends when the Unit is directly involved in individual cases. It is seen as important that there is a small core group that can meet regularly and act promptly.

The meetings are chaired by the Police representative, and discussions lead to decisions about further action, including discontinuance, caution or prosecution. The scheme has now been running for some 18 months and although there has been a variable workflow it has clearly increased the use of cautions, enhanced inter-agency functioning and incidentally provided a valuable weekly focus for other urgent discussion and negotiation. At the first panel meeting which I attended, for example, arrangements for custody cover during Cell refurbishment at the Police Station were dealt with. Between June and August this year I was able to attend a sequence of meetings as Probation representative during a period of relief cover and gained practical experience of contributing information about individuals. It was clear to me that the system offered considerable information sharing opportunities about local resources and concerns beyond the immediate brief of the panel.

A wider Steering Group whose role is discussed later oversees the Panel's work, but this has ensured wider ownership. Gains with wider implications have been the agreement on local section 136 policy and improved inter-agency information sharing. A particularly interesting development is the likelihood of the model evolving into consideration of 'community safety' cases that may be causing local concern to agencies. Several such cases were discussed during my sequence of visits, including a man with a substantial history of high-risk behaviour who was causing concern to Police. There is in any event some crossover of responsibility with the local inter-agency group monitoring Dangerous Offenders. While an extension of the panel's responsibility calls for careful planning and proper targeting, the extension of inter-agency work into crime prevention and community safety can be seen as a logical and cost effective step. If this does take place it will be an important model for the wider Thames Valley and will merit careful evaluation of its impact.

Police Station Work and Subsequent Operation

In this section and subsequently I do not follow exactly the format of the previous studies, since the function of the Panel Scheme is to facilitate decision making and inter-agency practice rather than provide a direct service. My comments are based on the views of professionals interviewed, examination of figures for the three months up to the end of 1999, and a reading of forms considered at panel meetings which I attended.

There seems little doubt that the completion of Mental Health Monitoring forms by Police Officers has improved considerably in terms of numbers completed and the quality of information. The range of concerns was wide in the forms I read, and I felt that if in doubt Officers were identifying concerns. There has been some local training to support this, and the need for further training is discussed later.

In the quarter reviewed 45 cases had been recorded. The offence groups can be categorised as follows:

- Theft 18
- Assault or Affray 6
- Specific drugs or drinks 7
- Bail or Warrant matters 3
- Damage 4
- Indecency 2
- Public Order 1
- Arson 1
- Attempted Murder 1
- Section 136 (No specific offence) 1
- Illegal Immigrant 1

Of the 45 cases all but 4 came from Milton Keynes addresses. The list includes a wide range of crime including a significant proportion of serious or very serious crime. The numbers involved make an average over the quarter of 3.75 cases per week, requiring police action workflow is variable and there were only 12 cases in October as against 17 and 16 in November and December respectively.

Not all cases come to the panel. Diversion can take place in the usual way when the Police Surgeon, Psychiatrist and Approved Social Worker see the offender. Where the offender is seen as 'vulnerable' but not 'sectionable' an Appropriate Adult will be involved and on completion of the investigation the position is discussed with the Custody Sergeant who determines whether to charge or bail for return to the Police Station in 3 weeks. In such circumstance referral will be made to the panel.

Of the 45 cases identified in the quarter concerned, 36 were actually referred to the panel, an average of 3 per week. This held as a working average for the sequence of meetings that I subsequently attended. Because of the variable workflow the panel meetings operate on a standing basis subject to cancellation if there is no business. Similarly if urgent action is needed phone consultation is used.

The panel decisions in the 36 cases were as follows:

- Prosecution 14 cases.
- Caution 2 cases.
- No Further Action 6 cases.
- Not Appropriate 11 cases. (This generally meant that after a pooling of information no mental health specific concerns were established. In most cases this led to prosecution.)
- Finally 3 cases were not discussed. This seems to have happened when subsequent events rendered this unnecessary.

It is possible to say therefore that at least 8 of the 36 cases led to a caution or no further action - just over 22% of cases reviewed.

A number of points can be made from these outcomes. Firstly, some use is being made of cautioning, and even when there are clear mental health issues this can be a constructive community safety outcome. Secondly there is further evidence of a secondary level of pre-court diversion in the number of cases meriting no further action. Thirdly a decision to prosecute is likely to have been taken on the basis of pooled information and may well serve as a signpost for action at the court stage if there is a need for fuller assessment. The operation of the panel can therefore be seen as having an impact beyond diversion into more consistent inter-agency performance in case management.

Court Issues

There is no specific diversion scheme at Milton Keynes Magistrates Court. It may well be that there remains a need for work at this level, though the focus might be more on prompt assessment and liaison than case identification or diversion from process. Clearly, as in Oxford the introduction of a court initiative would need to take account of the Panel's work and the pattern of statutory local mental health services. Assuming that Police and panel systems identify most cases at an early stage the planning of such a service would need to be based on a detailed examination of bail and sentencing outcomes for those who went forward for prosecution and eventual sentence.

Referrals and Inter-Agency Networks

Clearly the Panel system and the wider work of the Steering Group do facilitate inter-agency working. Some gaps were identified; however, notably the difficulty in obtaining suitable supported housing and residential placement, though the establishment of integrated local authority services ensures improved co-ordination.

As indicated earlier the establishment of a new Intensive Support Team may have substantial implications for inter-agency working. As is clear from the work of Elmore and Revolving Doors there is a 'hard to reach' group of people with multiple need who do not easily access local services and frequently fall through the net of conventional services. A substantial number of these are involved in the Criminal Justice System. These considerations will need to be borne in mind in planning the new service.

It was pointed out to me that there are still unresolved issues about direct admissions to the Campbell Centre that lead to an early discharge once prosecution has been discontinued. This may be an issue that the Steering Committee needs to pursue in thinking about the expanded role of the Panel in Community Safety cases.

It was suggested also that Chadwick Lodge, a local private hospital, known to take some offenders for treatment, should be more formally involved in local discussions and forward planning.

Training and Information

My understanding is that joint training around new procedures was provided for the police, social services, health and ambulance staff, and that the Mentally Disordered Offenders Panel featured as part of this training. There is still said to be considerable demand for training from Police Officers, though Mentally Disordered Offender issues are covered in the Induction Training of Custody Sergeants. In common with other parts of the Thames Valley the maintenance of consistent training for police staff is an important issue, and an inter-agency approach seems particularly desirable.

Dual Diagnosis Issues

The figures quoted earlier, and the anecdotal evidence indicates that dual diagnosis cases are becoming a major issue in Milton Keynes as elsewhere in the Thames Valley. There is Consultant level provision and a half time post has been sought for Social Services. In common with the rest of the Thames Valley statutory and voluntary services for substance misusers are relatively limited, and this is a limiting factor. It is unclear at present what impact Arrest/Referral will have in terms of diversion and the Panel may need to bear dual diagnosis issues in mind in planning the future development of its work. It may be that direct representation of drug and alcohol services is called for on the panel. Milton Keynes is in the process of forming its own DAT following the national realignment of DATs to be coterminous with Unitary Authority boundaries and the development of a specific Milton Keynes strategy on dual diagnosis will take place within that context.

Management Structure

The wider steering group supporting the Panel was set up before implementation of the scheme and was involved in consideration of the original proposals. Its purpose has been to monitor the scheme and introduce an inter-agency model of accountability. As well as the direct Panel agencies, the Steering Group has representatives from the Court, Crown Prosecution Service, local defence solicitors, and significantly a representative from the service user organisation for mental health services in Milton Keynes. The Steering Group receives regular reports and clearly plays an important part in both local ownership of the scheme and its credibility. It was suggested to me that attendance could be quite low and it will be important for the Steering Group to sustain momentum and consistent attendance as the scheme continues to develop.

Summary

In a large population area with well developed and recently reorganised local services the Milton Keynes Panel has had a significant impact on diversion and case management over the last 18 months, and its role may extend further into community safety concerns. Inter-agency working has been enhanced. The leadership of the Police has been crucial and good working relationships have been developed. The scheme has been monitored and supported by a more broadly based Steering Group. The rise of dual diagnosis work and the establishment of a joint Intensive Support Team may have a significant impact on local practice that will need to be taken into account. The Milton Keynes Panel as with the other three initiatives described has grown up to reflect local priority and local opportunity, but the training needs described for key staff are similar to elsewhere. Similarly the issues of limited treatment options for drugs and alcohol, and the lack of accommodation options for Mentally Disordered Offenders were also raised elsewhere. It does seem, though, that the emergence of the unitary authority, well developed planning machinery and less 'baggage' from the past give Milton Keynes distinct advantages in inter-agency working.

NOTE:

(17) Buckinghamshire and Milton Keynes Mentally Disordered Offenders Needs Assessment. Bucks Health Authority and NACRO. 1998.

5. Court Diversion/Assessment in Aylesbury

In the earlier section on Revolving Doors in High Wycombe I made reference to the NACRO Needs Analysis for Milton Keynes and Buckinghamshire, published in 1998. The Report described the Court scheme in Aylesbury and indicated that during 1997 49 cases were assessed by the sessional Psychiatrist covering the Court and 57% of those seen had been identified as having mental health problems- a steady average of approximately one case each week. Referrals had more than doubled over figures for the previous year. The Court followed the psychiatric recommendation in all but 3 cases. These figures suggested a reasonable level of demand for the scheme and local anecdotal evidence suggests that it was a well regarded resource.

Aylesbury was not covered in my first round of fieldwork but it was suggested that contact be established to include reference to Aylesbury in the final report. Accordingly I visited the Psychiatrist who now has formal responsibility for Court work and the Senior Probation Officer responsible for the Court. From those visits I am able in general to update the position and some important points emerged from the contact. This note cannot, however, claim to cover the overall position in Aylesbury and does not attempt to do so.

The Psychiatrist previously involved in the scheme worked on his own and without any direct nursing input to the scheme. 28 of the 49 people assessed were recommended for treatment within the Mental Health Act which may imply that the focus of the scheme was identification and response to formally defined mental illness rather than wider notions of mental disorder. There was some joint ownership of the project by way of an inter-agency group. Operationally, however, the sessional Psychiatrist conducted all the business. There seems to have been no standardised administrative structure for the work. Liaison with the Probation Service seems to have been conducted on a relatively informal basis. The work carried out clearly had a positive impact but when the Psychiatrist left no standby arrangements were in place. With a delay in replacement of the Psychiatrist the scheme effectively lapsed.

I met the current Psychiatrist responsible for the work relatively soon after her appointment. It did seem clear that the NHS Trust wished the work to continue. The difficulties facing the new Psychiatrist, who has forensic experience, included the lack of an inter-agency reference group or any written policies or procedures with guidance about her role. In any event her other responsibilities made the provision of the budgeted 3 sessions per week extremely difficult to deliver. Her own view was that a more effective model on the available figures would be to reduce the Psychiatrist input to one session per week and use the balance of the resources to provide CPN input- a model similar to that used currently in DIVERT at Reading and in the original Oxford scheme. As an initial step she intended to call an inter-agency meeting to examine these and other issues as well as re-establishing contact. In the longer run she felt that consideration should be given to a partnership between Trusts to deliver a more broadly based Buckinghamshire scheme covering Aylesbury and South

Bucks. There may indeed be merit in that approach providing it does not compromise the work of Revolving Doors and the service was organised to take account of existing work. Certainly the Government's wish, expressed in the 1998 strategy 'Modernising Mental Health Services' to implement a National Service Framework for the provision of mental health assessment schemes at Magistrates Courts and Police Stations will call for more joint planning and consistency than there has been up to now.

The view of the local Senior Probation Officer was that local working relationships with the CMHT were good but there were significant gaps in local provision so far as Court work and assessment were concerned. The lack of the Court service had removed the only dedicated provision locally.

It is to be hoped that provision in Aylesbury is re-established in the near future. The general lessons emerging from local experience are to do with the importance of an inter-agency framework, the difficulties of operating with a single practitioner and the absolute necessity of protocols and procedures which define responsibility, accountability and agreed methods of operation.

An Overview of the Main Comparative Issues from the Schemes Studied and Some Priorities for Further Investigation.

Chapter 10 of the Reed Report (18) is entitled 'The way forward' and suggests that the many subsequent recommendations are all pieces of a very large jigsaw 'whose essential purpose is to help ensure that mentally disordered offenders are cared for and treated by the health and social services and not drawn unnecessarily into the criminal justice system'. Work on the local jigsaw has gone a long way in each of the 4 areas studied in this report, though the individual patterns vary because of differing histories, variation in the services available, and funding opportunities. These variations also owe a good deal to the leadership of key individuals and agencies, with the result that different models inform each local approach. I have tried to describe and compare these approaches, as well as identifying the remaining gaps, since in none of the areas was there a belief that a comprehensive pattern of services had been achieved.

Reed goes on to summarise the guiding principles for work with mentally disordered offenders which informed his review. These were that there should be regard to the quality of care and proper attention to the needs of individuals; that care should so far as possible take place in the community rather than in institutional settings; that care should take place under conditions of no greater security than is justified by the degree of danger they present to themselves or to others; that care should maximise rehabilitation and the chance of sustaining an independent life, and that care should take place as near as possible to their homes and families if they have them.

Reed identifies a number of 'fundamental issues' across the board from diversion to prison health care. Although I have been primarily concerned so far with diversion and community approaches this list of issues, plus several new ones, forms a useful agenda against which to compare and comment on the Thames Valley projects.

A Positive Approach to Individual Needs

This is plainly easier to achieve when the need presented involves mainstream mental health problems without the complications of behaviour problems, dual diagnosis issues and social exclusion. If we keep to the broad definition of disorder suggested in 'On the Edge' however many offenders in the Thames Valley projects presented exactly those problems. Assessment of need and then negotiated referral to mainstream provision is a central objective of the Elmore Team and Revolving Doors. Although they make contact in different ways both emphasise the need to work persistently over time with individuals, and hold contact while making an assertive approach to other service providers. Neither agency sees itself as primarily focused on diversion, though a diversionary impact is achieved. In Reading, Divert undertakes similar work but shorter time limits and more limited networking opportunity make the process more difficult. It is interesting that both Elmore and Revolving Doors both have a range of skills but pool them within a supportive team structure designed to ensure

safe continuity of care. It is notable that both agencies are responding more easily to the challenges of dual diagnosis and developments in other agencies.

This model appears to have the flexibility to respond to different patterns of local provision—certainly there are marked differences between Wycombe and Oxford. An outstanding issue is whether it can operate effectively across a wider area outside a main population centre, and it will be important to see how Revolving Doors copes over time with its expansion to the whole of South Bucks. There would be equivalent issues in Oxfordshire. It may be though that any formula for a comprehensive service needs to include this model, and the new Intensive Support Team in Milton Keynes will certainly need to take account of it.

The numbers worked with through this approach seem at a superficial level to be small until it is remembered that this is an exceptionally demanding group which will usually need extensive help if it is to make use of mainstream services. In the end it may be a more cost-effective approach than it seems, given the wider importance of community safety issues. The Revolving Doors/ LSE work on cost and benefit sheds very important new light on this question. There does seem to be clear evidence justifying the model of intervention and its potential ability to achieve better results by spending existing resources differently.

A Flexible Multi-agency and Multi-professional Approach

The four projects studied have all in their way contributed significantly to a more flexible inter-agency approach. This has steadily built over time in Reading and will now need to be applied in East Berkshire. A brief for working on the wider network of agencies is central to the objectives of Revolving Doors. With that project and with Elmore there is a feeling that mainstream agencies can be helped to operate more flexibly and effectively in a model of shared working.

Flexibility between disciplines and agencies is most likely to flow from connected policy work and an acceptance of shared responsibility. In each of the areas studied there is either an inter-agency strategy group or a steering group for specific initiatives. It seems to me that the complexity and range of the Mentally Disordered Offender agenda calls for a strategy based group with reliable representation at a sufficiently senior level that discussion can be connected with action. It is easy for such groups to concentrate on a small number of presenting concerns or plans, and lose the overview. The regular auditing of progress seems essential and the framework provided by Revolving Doors is a helpful one for this work.

A particular priority needs to be the dual diagnosis agenda, and there is now an awareness of this in each area. The connection of strategy work in mental health with that in substance misuse needs more attention and there is evidence that this is now beginning to happen as outlined in Section 3 of this Report. Cross-representation with Drugs Reference Groups is an important part of the process, but more needs to be done. The work undertaken by Spafford in Oxford helpfully identifies the main policy issues, and the recent work from the Luther

Street Centre in Oxford adds powerfully to an understanding of the issues affecting a particularly disadvantaged group whose tendency to use illegal drugs now ensures that they are regularly pulled in to the Criminal Justice System.

There are similar issues across the area about connecting to the Community Safety agenda that has its own recently established infrastructure. As well as inter-agency policy groups there are now also specific structures in place for the management of dangerous offenders. Again the developing experience from these structures needs to be linked to strategy work on Mentally Disordered Offenders.

The Milton Keynes Panel model is a helpful one in many of these respects. It not only provides an important diversion function, but also aids consistency and ensures that information and working approaches are shared between agencies. It will be important to monitor how this work progresses into an extended community safety function.

Training issues were mentioned as a concern in each of the areas, and it is hard to see how joint working between professionals can be further developed without the continuation of good training schemes. This is a difficult issue at present. Training budgets in all agencies have been stretched by the demands of new legislation or other competing priorities. Within Thames Valley Police mental health training is not a standard requirement and decisions about its availability are devolved to local management. Among Police Officers I gather there is a wish to have more training and this is mirrored in other services. This is frustrating, since good training material does exist, and it would be a relatively straightforward task to produce standard inter-agency training modules for the Thames Valley as a whole. The Thames Valley dimension will become even more relevant when the amalgamated Probation Service comes into being in April 2001. The Thames Valley Mentally Disordered Offenders Forum might usefully pursue these training issues.

The Complementary Role of General Mental Health and Specialised Services

Clearly a strength of the Reading model is the availability of a CPN and Psychiatrist who can make prompt assessments and refer effectively to general mental health provision, whether on an inpatient or community basis. In many parts of the Thames Valley there is concern about the availability of short term in-patient provision, though the capacity of the Campbell Centre suggests that the position is better in Milton Keynes than elsewhere variable responses were reported in response from CMHT's dependent on local resources and priorities. With difficult or multiple need cases referral (or re-referral) was often difficult and required considerable persistence. Much more work seems to be necessary on common assessment processes and criteria.

The Probation Service has traditionally undertaken much work in this area either by way of bail or post conviction intervention. This is bound to remain the case, though the change of emphasis in recent years to work with more serious offenders has tended to reduce the

Service's overall input to work with the full range of mentally disordered offenders. A number of those interviewed from other settings acknowledged the reasons for these changes, but were concerned about a trend towards less involvement with and knowledge of other agencies. This is both a training issue and a policy challenge, since the Probation Service not only provides work on offending behaviour which is relevant to many mentally disordered offenders but also provides a crucial link with the courts. Probation also provides an important scarce specialist resource in Approved Bail and Probation Hostels. The Hostels already provide care for significant numbers of mentally disordered offenders, and have built connections with mental health services to support this work. There remains an argument in the overall Thames Valley context for some specialising of function with the Hostels. A first step might be an audit of the current range of work undertaken.

Various models were in place for linking people to other specialist services, notably housing and employment. This is more easily achieved when these services are part of an established local network. Patterns of service varied considerably in the different areas, including the different balances between statutory and voluntary sectors. Since housing and employment are the two factors most closely associated with crime reduction, access to the relevant provision is of great importance. Persistence and patience are often necessary with this client group, and I wonder whether there is a place for volunteer mentors, in this and some other areas of work with mentally disordered offenders

The main dual diagnosis issue in access to specialist services is the relatively limited drug and alcohol service provision. The position is even more limited in outlying areas. In a situation of scarce resources those with dual or multiple need are likely to be disadvantaged, not only in respect of local provision but access to residential rehabilitation that is itself hard to find. There are no easy short-term solutions to these problems, but at the least dual diagnosis should be the focus of joint work between the Drug Action Teams and the Thames Valley Mentally Disordered Offenders Forum. Similarly work needs to take place locally between Drug Reference groups and Mentally Disordered Offender Strategy Groups.

Closer working between the police, health and social services to avoid unnecessary prosecution of mentally disordered suspects

It is clear that the Thames Valley Police have taken seriously the need for improved performance within the service itself, and efforts have been made to do this alongside key local agencies. In all the projects studied working relationships were good, though the pattern of response depended on local opportunity as well as local police leadership. In Reading and Wycombe police initial identification was followed up by assessment from partner agencies. In Oxford agencies were brought in as the need arose and in Milton Keynes for the past year the panel system has ensured an inter-agency approach to decision making. In each of these areas there has been a diversionary impact, but there have been other gains as well in terms of inter-agency functioning.

A particular and intractable issue is the tension between the Force's commitment to devolved management and the ability to standardise good practice. As the Force Liaison Officer pointed out there is a model section 136 Policy and ideally each Police Area should have an agreed policy, an inter-agency group and a panel for consideration of cases. Local management priorities are not the only problem. Resource pressures in other agencies, particularly the Health Service are a limiting factor, and in some areas the number of cases is low enough to cast doubt on the significance of the problem. It may be that in such areas there is an undercounting because of lack of training. The fact remains, however, that mentally disordered offenders in those areas have less chance of diversion or prompt onward referral. As indicated earlier the Revolving Doors extension throughout South Bucks may offer valuable evidence for the future. A fuller test however would be for the Force to pilot an inter-agency initiative in a low incidence area. This might be more feasible if several areas joined together to adopt a panel scheme, co-ordinated by the police and supported by a wider range of outside professionals. In one way or another it will be important for the panel system to be adopted more widely as a standard response to decision making about mentally disordered offenders. Maintenance of the other schemes will depend on funding provided by other agencies, but there too the introduction of panels would help to maximise diversion and enhance inter-agency functioning. Extension of work to include 'community safety' cases may offer an important new model and assuming that this continues to develop in Milton Keynes the development should be carefully monitored.

Thames Valley Police have also made important commitments to the extension of Arrest Referral in drug cases. The issues connect up clearly in the dual diagnosis agenda. Where initiatives exist alongside schemes for mentally disordered offenders an effort should be made to ensure good cross referral and collaboration, and progress should be carefully monitored.

The study of the four schemes showed up interesting differences over the arrangements for Places of Safety other than the Police Station. Local arrangements reflect different levels of bed shortage and considerable negotiation was necessary before a single bed option was made available in Oxford. This contrasts strongly with the long established co-operation in Milton Keynes. It is important that the need for an available alternative is not lost as an issue and this should remain a concern of local strategy groups.

The other major issue is the importance of sustained Police training. While the priority group is clearly custody staff there is a case for much wider awareness training. Inter-agency training initiatives do have proven value and in Oxford a training programme was piloted. Ideally a Thames Valley wide model of training should be adopted, capable of adaptation to local circumstances. Police awareness and concern is an important element in mobilising local concern. Such work is not however regarded as core training and Area Training Officers have so far been reluctant to take matters forward. Again the Community Safety agenda may help to change priorities.

Co-operation between criminal justice agencies, health and social services on diversion from prosecution and diversion from custodial disposals

The DIVERT scheme was the most developed initiative of those studied though an evaluation of its overall impact is urgently needed. It is clear that since the publication of Reed the value of such schemes has broadened into risk assessment with a public protection dimension. There remains a strong argument for skilled psychiatric assessment at court in terms of speeding up process and avoiding the delays in assessment that can damage defendants further. Moreover nurse involvement in court based teams enables a much wider impact to be achieved, not least in helping to co-ordinate agency responses.

The expansion of DIVERT to the rest of Berkshire is a major development, but will produce a strange pattern of provision in the Thames Valley, since the only other specific scheme would be the smaller scale model due to resume operations in Aylesbury. In the short term the position seems unlikely to change and the development of other options has partly stemmed from a determination to tackle the problem from a less intractable angle. Certainly the work of Elmore and Revolving Doors suggests that any future court schemes in Oxford and Wycombe would need to be planned differently. It is perhaps time that a new model was tried, possibly on the basis of rota availability from CMHT's. The evidence from DIVERT does seem to be that regular intervention is required and that 70% of the work relates to general psychiatric rather than forensic needs. The Government's apparent commitment to a network of schemes at Police Stations and Courts presumably implies that initiatives in the two settings would be connected. The commitment should help with the argument for more resources and a consistent pattern of coverage should be a high priority.

The issue of Court based work for the smaller court remains a difficult question, in relation to numbers and geography. The best prospect remains the grouping of courts referring to a larger centre, despite the undoubted complexities of funding and organisation, but the planning of any new schemes would need to take account of this issue.

There are other issues relating to the avoidance of delay and custody. The maintenance of Bail Schemes and the role of Approved Hostels have already been mentioned in the context of Probation Service amalgamation. Another issue is the co-ordination of Psychiatric Report provision. The Oxford Steering Group is presently tackling this, but similar issues are present elsewhere. A commonly reported and enduring difficulty is misunderstanding by some Psychiatrists about Probation Service provision and this undoubtedly contributes to the low level of Probation Orders with psychiatric conditions. Similarly, Probation staff often need help in understanding the range of local mental health provision, including its limitations. Local Strategy Groups could well promote better practice in this area, and Probation Officers seem generally to wish for more training on mental health issues. It should be mentioned that there is no shortage of training material for Social Services and Probation staff. The NACRO Training Manual for example has been available since 1994. (19) It seems rather that competing priorities have reduced the level of training provided.

Reed saw the Probation Service as an important facilitating agency at local level and this is clearly the case in some parts of the Thames Valley. The Service is however undergoing a major transition with the national modernisation agenda, tighter priorities, and the introduction of new and more centralised management structures. In the Thames Valley the pace of change has been very fast, and will culminate in the establishment of a new amalgamated Service. Traditionally the Probation Service played a major role in continuity of contact with minor repeat offenders who had multiple needs including mental disorder. To a considerable extent this was welcomed and expected by other agencies. Much less of this work is now undertaken and there has been a variable impact on other local services. In Oxford where Probation had been a major service provider in its own right, as well as a leading Network member the impact has been very considerable. In Wycombe, Revolving Doors undoubtedly picks up much of this work though only on the basis of new arrests and not on direct referral from Probation staff. In Reading the Berkshire Service remains a major stakeholder in DIVERT, but staff there described a growing sense of isolation from mainstream practice.

In effect the Probation Service is in the process of redefining its role with Mentally Disordered Offenders. This has a number of implications.

- Firstly, there is a need for clarity about contribution to inter-agency structures. It seems important that Probation retains a regular presence at an appropriate level of authority, whether on Strategy Groups or Panels. The Service remains well placed to link court issues with the wider field, including the prisons.
- Secondly, the Service will have a continuing function as a provider of funding, and the two existing Services have very different models. In Berkshire the main and enduring commitment has been to the DIVERT scheme within a clear-cut criminal justice context. In Oxfordshire and Buckinghamshire funding has continued to reflect differences which pre-date amalgamation of the two Services. As a result Elmore receives a significant level of funding for its work with offenders within a wider client group, but very limited funding is provided elsewhere. Over time ways will need to be found of ensuring a more consistent distribution of resources, and this seems likely to shift to a model of purchasing services as is the case with other areas of partnership work. This will have considerable implications for independent service providers, but will at least have clarity.
- Thirdly, as indicated above there is a general feeling that Probation Officers, working with serious offenders in a more overtly public protection context, now need more training and support on mental health issues.

An improved range of community care services, including accommodation and day services.

The position over accommodation varied considerably in the four areas studied. In Oxford, with a range of available projects and good local authority provision the problem seemed less pressing than elsewhere, though a good deal of ongoing work was invested in maintaining tenancies where these existed. The issue of retention of accommodation is in many ways as important a question as accommodation finding and needs to be taken into account in creating individual care packages. In the other three areas, although Housing Departments have improved links with the other agencies there are real difficulties in placement. The lack of suitable and supported 'dry' accommodation for people attempting to change their drinking or drug taking was mentioned everywhere as a particular problem.

Day provision reflects a similar pattern, and again dual diagnosis cases present the most significant challenge. The models of persistent follow through of cases offered by Elmore and Revolving Doors seemed more likely to achieve access in a planned way to day care and other provision, but the limited overall availability of services must be the main concern. As indicated in this report the biggest deficiency lies with drug and alcohol services and there is a need for much more 'joined up thinking' between the inter-agency structures for mentally disordered offenders, substance misuse and community safety. The recently established Primary Care Groups are now finding their place in terms of the establishment of local primary care responsibilities and it will be important to ensure that they are fully involved in consultation. They may well prove to be very helpful in building a case for more responsive and targeted community services.

In all the schemes discussed there was reference to the work of Community Mental Health Teams, responsible throughout the Thames Valley for delivery of mental health care within the community. The Community Psychiatric Nurse (CPN) is the main front line provider of care and they frequently have very high levels of experience in dealing with difficult and demanding patients as well as co-ordinating the delivery of treatment. The schemes studied in this Review all spoke of the importance of good liaison and working arrangements with the CMHT's, but the main problems lay in accessing people to them. The priority for most CMHT's is to deal with severe and enduring mental illness. There does seem to be a well identified problem about the inflexibility of these boundaries in many parts of the Thames Valley. This difficulty has much to do with resourcing and concern about a potential 'opening of flood gates'. If there is to be a development of services for mentally disordered offenders the CMHT's will require more resources and more systematic links with the Criminal Justice system. This is likely to grow as an issue given the growing evidence about dual diagnosis. As is indicated earlier one possible model would be for them to be directly involved in the provision of Court services.

The limited nature of an overview study precludes any close examination of specific provision for women, or the issues facing women in general provision. In all areas, services

were coping with far higher numbers of men than women, in line with most data about the offending population. Local Strategy Groups could usefully investigate the situation and a more detailed assessment of the overall Thames Valley position might suggest the need for some pooling of effort between the geographical areas.

In Wycombe, Revolving Doors staff spoke specifically of the limited referral options for black people and the report, 'Mental health, multiple needs and the police', quoted earlier notes that while 22% of referrals to the Link Worker schemes were from black and other ethnic minority groups, broadly reflecting the local populations, the proportion of black people from African and Caribbean backgrounds referred to the schemes was smaller than the population arrested. The Report concludes that tackling this problem will be an important priority in the further development of projects and the recruitment of black and ethnic minority workers operating within a team approach is suggested as an important part of the way forward. The Thames Valley has a number of centres with substantial black and ethnic minority populations and with a younger age profile than the white population. Similarly there is growing concern about the range of problems affecting asylum seekers. In parts of the Thames Valley there needs to be a focus not only on levels of service provision but how the criminal justice system as a whole is coping with black and ethnic minority offenders who have mental health problems. In 1990 Deryck Browne's study on these issues, *Black People, Mental Health and the Courts*, (20) issues were raised about a disproportionate use of remands, psychiatric assessment and medical disposals with black defendants. A more detailed evaluation of Thames Valley services would need to look not only at statistical data but a range of case studies to establish the current position.

The expansion of medium secure and associated 'outreach' services

Given my focus on diversion and community based networks I have not been able to examine this area of concern, though Reed identified it as one of the fundamental issues to be faced. Reed particularly mentions provision for learning disability cases, and longer-term medium security needs. Clearly any fuller investigation will have to examine these matters in the context of overall provision.

A stronger research base to underpin service improvements and training.

The case for further comparative research, fuller project evaluation and more systematic inter-agency training programmes is indicated throughout this report. I hope that this overview will assist in the drawing of priorities for that work. Similar issues are raised in the next section on prisons. None of the local arrangements offers a comprehensive range of provision. A fully developed response would need to incorporate early identification, good quality assessment, inter-agency decision making and the ability to hold on to people long enough to access them to packages of care provided by responsive mainstream services. The main elements of a model of comprehensive provision are outlined in Section 4 of this report. Some very good work is undertaken in the different areas, but there is a long way to go,

particularly in dual diagnosis work. There is a good sense of this, particularly where strategic inter-agency work has been done on identifying gaps, but there is an urgent need to think about services outside main population centres.

Much of this report has inevitably been about structures and models, but the real issues are to do with the reduction of harm. Mentally Disordered Offenders can certainly inflict harm and the community as a whole gains if they can be helped away from offending. But the harm these individuals can suffer from an unresponsive criminal justice system, or care services they cannot use remain a major indictment of our social system. Mortality figures for this group indicate that it can go beyond harm to a question of life and death. Those are the realities behind the statistics, and they are well known to many of those who contributed to this work.

NOTES:

(18) Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services. Department of Health and Home Office 1992

(19) Working with Mentally Disordered Offenders- A Training pack for Social Services staff and others dealing with Mentally Disordered Offenders. NACRO 1994

(20) Black People, Mental Health and the Courts, Deryck Browne, NACRO 1990

Section 2

Mental Health Issues In Prison

Introduction

The purpose of this section is to provide an overview of the main issues concerning mental health provision in four prisons within the Thames Valley. The four prisons, Bullingdon, Woodhill, Aylesbury and Reading were each visited in a planned day so that a range of prison staff was consulted. It was also possible to examine local procedures and visit the key sections of each prison including Health Centres, Reception facilities and Segregation Units. Wherever possible an effort was made to meet with CARAT staff so that links between health provision and substance misuse work could be assessed. The prisons were selected to provide a reasonable range of function. Given the overall purpose of this review it was clearly important to see the two Thames Valley 'local' prisons, Bullingdon and Woodhill. The Woodhill visit also provided an opportunity to see a national resource, the Close Supervision Centre. Although this has no specific local or regional function its experience in dealing with the most intractable management problems in the prison system and its impact on the 'host' prison raise a number of interesting questions. Aylesbury, too, has a catchment much wider than the Thames Valley but its work with young offenders and the history of its health care provision also raise important policy issues. Reading was chosen for similar reasons and because of its status as a Remand Centre for young offenders. Part of the Reading visit included an open meeting with prison staff and this proved to be a valuable consultation exercise. The scope of the review, and the time available, meant that other Thames Valley prisons could not be visited. This is clearly a limitation, but nonetheless it is hoped that the main issues emerge clearly enough.

I was considerably helped by the involvement of Barbara Treen, currently seconded from the Prison Service to the Thames Valley Partnership. As well as providing a clear picture of current policy issues in the Prison Service she arranged the visits and participated in them. Her extensive knowledge of each establishment and many of the staff involved contributed greatly to an understanding of the main concerns.

In order to provide a clearer analysis this section begins with a summary of current Prison Service policy questions and then addresses thematically the main areas of prison operation where mental health issues arise. Thanks are due to all staff and inmates who contributed to our understanding. My overall impression was that there has been a considerable sensitisation of prison staff to mental health issues in recent years, though competing priorities, staffing constraints and a continuing lack of suitable training provide major and difficult constraints. Nonetheless we found a number of examples of good practice as well as constructive ideas for change, and these have been included wherever possible in the analysis.

The Policy Context of Mental Health Work in Prisons

World Health Organisation (Europe) Health in Prisons Project - Consensus Statement on Mental Health Promotion in Prisons

This statement published in 1999 acknowledges that as a group, prisoners suffer disproportionately from, and are especially vulnerable to mental disorder. While much of this is the result of their difficult backgrounds some must also be the result of the stresses imposed by imprisonment. The central notion is that as well as prisons providing treatment for those suffering from mental disorder there is a wider duty to provide regimes which reduce stress and promote better mental health. The Prison Service Director of Health Care, Dr. Longfield promoted the statement to the Service in July 1999. He commented that in a number of areas such as anti-bullying and suicide/self harm strategies there were a number of examples of good practice to follow. The Consensus Statement provides a valuable focus for identification of wider mental health needs and raises also the substantial issue of mental health promotion for prison staff.

HM Chief Inspector of Prisons Reports

The work of the Inspectorate in recent years has had considerable and often well-publicised impact on the Prison Service. The Inspector's Annual Report in 1997/8 referred to the need for a fundamental change in attitude among prison staff in favour of 'human engagement' and away from the 'old culture'. The Thematic report on suicide subsequently called for 'healthy prisons' - a useful concept in considering how prisons respond to mental health needs and mental health promotion. Within the Thames Valley, the Inspection of Reading Prison raised a number of concerns about suicide prevention and it was clear from our visit that this has had a significant impact on priorities within the prison. The Thematic Inspection of Close Supervision Centres published recently has considerable implications for the Woodhill Unit promoting as it does an integrated model of care with increased psychiatric and psychological input.

Training Needs of Prison Officers in Relation to Mental and Personality Disorders

In May 1999 the Prison Service Health Care Directorate and the Prison Service Training Department agreed that the World Health Organisation Collaborating Centre at the Institute of Psychiatry would carry out a piece of work identifying the training and other support needs of Prison Officers in working with mentally ill or personality disordered prisoners. The Final Report was completed earlier this year. (21) The study and its findings are of great importance given the number of times the lack of training was mentioned at each of our four visits. Accordingly it will be helpful to summarise here the main findings, not least because the study also brings together a digest of the main research about incidence of mental disorder and the policy context of prisons.

Studies of psychiatric morbidity among prisoners show extremely high levels of all kinds of mental and personality disorder. In the male population anti-social and paranoid personality disorders top the incidence list followed by mixed anxiety and depression, then borderline personality disorder. In common with the general population outside prison, sleep problems, anxiety, depressive symptoms and fatigue are very common in all types of prison. Though psychotic disorders are less common they are up to 20 times as common as in the general population and those with psychosis occupy three quarters of the beds in prison health centres - an issue considered later when the problems of NHS transfer are considered in relation to the Thames Valley prisons. Rates of self-harming behaviour without suicidal attempt also come lower in the list of prevalence, though at 7% of male prisoners the rate is still high. The researchers found that non-suicidal self harm was more common in sentenced inmates than those held on remand. Again the impact of self-harm on prison regimes and policies has a disproportionate impact on prison operation. It also raises some interesting issues about communication and health roles between health care and 'wing' staff that are discussed later in our analysis.

The report seeks to place Prison Service care in a wider policy context. Staff need to have the skills to carry out their roles and work with mentally disordered inmates must fit within the wider context of changes in prison health care policy, including closer working between prison and NHS health care staff and the move to a community care model of working within the NHS. Transferring this model of care to a prison setting would mean that mentally disordered inmates spent most of their time on ordinary location while still under the care of health care staff. As the Report indicates, whatever model is taken the levels of disorder are so great in prison that even if the most severely disordered are held in health care centres or transferred to the NHS very many inmates with less severe disorders will still be supervised on ordinary location. We found several good examples of health care outreach work in our visits, though such schemes were often bedevilled by staff shortage. A critical gain from such schemes is the improvement in health/wing communication and trust that can result. Lack of such trust is rightly identified in the Training Project Report as a major problem in moving towards a 'community care' approach.

The Report identifies the main problems facing Prison Officers. Unpredictable impulsive potentially violent or self-mutilating prisoners caused most problems and such prisoners were often those with personality disorders. There were though many inmates who a health professional might consider to have a mental disorder of which officers were not aware. There was real confusion for many staff (including non-mental health trained health staff) about adjustment reactions and depression. An adjustment reaction is a normal reaction to unpleasant experiences that becomes depression when the severity and duration of symptoms reaches a certain point. The Report says that almost universally officers and other staff regarded depression as not being a mental condition if it was related to understandable issues. Similarly there was a tendency for officers to focus mainly or exclusively on risk of suicide or self harm and consider these behaviours as separate from and unlinked to mental disorder. As the Report says a more complex model of understanding depression and suicide

in prison is needed, one that acknowledges both psychiatric and situational factors and does not see them as alternatives.

The Report's key recommendations are summarised as follows:

- Awareness training should be mandatory for all officers.
- A mental health Resource Officer should be appointed to each Wing or Unit to function as a focus, resource and liaison point with health care. Such staff should have more training.
- A written practical guide should be available to each Wing or Unit.
- The Prison service should commission a University or University/ Voluntary Organisation partnership to develop training for trainers courses for NHS and Prison Service staff who could then jointly deliver training to Prison Officers.
- Training should focus on skills and attitudes as well as knowledge and should be appropriate for the wide range of disorders encountered in prisons.
- Core competencies should be developed which would overlap with but not be identical to prison health care competencies.

The Report is comprehensive and challenging. The Prison Service has so far concentrated primarily on procedures to combat self-harm, suicide and bullying. It also has some committed staff who wish to do more. A more comprehensive approach to training would be difficult to introduce for all the obvious staffing and operational reasons. However the lack of such training contributes to low job satisfaction, high stress levels and poor communication between health care and Wing staff. Fundamentally, though it limits in a major way the quality of care that can be provided and the prospects of moving to a more thoroughgoing prison community care model. The Report will be referred to again in the analysis of issues facing the Thames Valley prisons.

Casework Information Needs Within the Criminal Justice System

This Report results from a study undertaken jointly during 1999 by the different Inspectorates involved in the Criminal Justice System. (22) It examines all the processes used for the exchange between services of information about those going through the system. Its objectives included the identification of key areas where there were obstacles to communication and the making of recommendations that might achieve improved information exchange.

Two areas of information exchange covered are particularly relevant in considering the position faced by Thames Valley prisons- those issues around information which travels with the prisoner and the provision of information to prisons by other agencies.

The review found that the nationally agreed PER form which accompanies the prisoner were not always filled in accurately and this can create considerable difficulties for escort contractors, prisons and the courts. This was mentioned as an issue in several of our visits and the form is to be reviewed nationally. The Thames Valley Partnership's work in the development of a key agency contact directory and a form to go with juvenile offenders to custody is specifically mentioned as an example of good local practice. Problems remain about the timely availability of Pre-Sentence Reports to prisons following sentence, however and Inspectors found no consistency in whether prisons received PSRs with the warrant or not. They noted that PSRs and any attached medical information were not sent as a matter of course. Again this was raised during visits, and discussions are currently taking place between the Lord Chancellor's Department and the Home Office about a standardised agreement on this responsibility. The issue is clearly an important one given the need for prompt and accurate information about mentally disordered offenders, many of whom receive relatively short sentences.

The Inspectors made a number of points about the information needs of prisons. Risk Assessment, sentence planning, resettlement planning and substance misuse treatment all require information from other agencies to be effective. The Report notes that the planned joint Probation/ Prison assessment document has the potential to close many of these gaps but other gaps will remain, notably the provision of medical information which bears strongly on the issues of psychiatric need and substance misuse. Because of the review of arrangements for health care provision in prisons which was underway at the time of the Report no proposals are made for improving the exchange of medical information, but the Inspectors drew these issues to the attention of the Task Force responsible for the Prison Healthcare Review. It was clear that these problems impacted seriously on the prisons we visited. The 'local' prisons particularly received inmates from a wide catchment area and reported a very wide range of responses. The problem seemed most acute in relation to medical information. CARAT workers also reported variable responses from outside treatment agencies and there were examples of good and very poor practice. Where agencies were committed to good through-care practice the position was brighter and the performance of Revolving Doors seems to offer an example of good practice.

Examples of good prison based practice are given in the Inspector's Report and we found echoes of these examples in the Thames Valley, notably at Reading where the Probation Department was able to make good use of information from the Berkshire Probation Service database. Unfortunately this option was not available for offenders coming from other Probation Areas. In the same prison the Senior Probation Officer had devised a form which followed up information needs with outside Probation staff.

Though detailed arrangements for the exchange of medical information may need to be taken forward at a national level it would be appropriate for the Thames Valley Mentally Disordered Offenders Forum to consider a strategy for the promotion of good practice, including enhancement of protocols with partner organisations and better use of the Probation service database following the establishment of the Thames Valley Probation Service.

Prison Healthcare Reorganisation

The Reed Report, cited earlier in this report felt that mental health services should be contracted in from the NHS. Since that time there have been many twists and turns in the argument over how prison health care should be provided and organised. The Chief Inspector of Prisons, in a discussion paper, 'Patient or Prisoner' suggested that responsibility should move from the Prison Service to the NHS. The Government's current policy, however, is to aim for a partnership between the Prison Service and NHS. The policy is summed up in 'The Future Organisation of Prison Health Care'; a Report produced by the Prison Service and NHS Working Group in 1999 (23). This document notes the wide variation of organisation, quality, funding, effectiveness and links with the NHS. It acknowledges that a substantial programme of change is needed and that this should be taken forward over the next 3 to 5 years by a formal partnership between the Prison Service and NHS, though funding and departmental accountability would remain broadly as they are at present. Within the Government's overall NHS Priority Framework mental health problems in prison are seen as a significant problem area. The following points are highlighted.

- Care of mentally disordered prisoners should develop in line with NHS Mental Health policy.
- Special attention should be paid to better identification of mental health needs at Reception Screening.
- The Care Programme Approach should function satisfactorily in prisons and mental health outreach work should take place on prison wings.
- Prisoners should receive the same level of community care within prisons as they would receive in the wider community.
- There should be effective communication and joint working between NHS mental health services and prisons.

In this model the Prison Service can be seen as a provider of primary care and a purchaser of secondary care. In the thematic analysis that follows, examples are quoted of some good practice and emerging fresh ideas. However the most striking concern from our visits was

the continuing isolation of Prison Service Healthcare from outside NHS provision. The problem is a complex one involving a number of factors. These include a mutual ignorance of management structures and the 'means' to do business; resource limitations, staff attitudes inside and out and poor take-up or maintenance of promising initiatives. What seems clear is that no real change can be achieved whether in training or service delivery unless commitment is made to a more planned and managed partnership. It may well be that the Thames Valley Mentally Disordered Offenders Forum could facilitate a programme of work. As a first step key managers might be helped to develop a clearer working understanding of structures and lines of accountability. It would be important to include in future work representation from those involved in the planning and co-ordination of substance misuse work. The Thames Valley prisons are part of the Prison Service South Central Region. They constitute the bulk of it however and it should be possible to provide proper liaison with those prisons and other agency outside the Thames Valley itself.

At a national level the first step in implementation of change has been the establishment of a Joint Prison Health Task Force. If work were to be taken forward in the Thames Valley then the Task Force is an important reference point over the next 3 years since its roles include the dissemination of good practice and the identification of organisational models of local delivery which meet needs, are cost effective and improve health outcomes. It will be particularly important to ensure that mental health needs remain as a priority for the Task Force and that some of the additional resources earmarked by Government for the modernisation of mental health services impact on the offending population and prisoners.

Consultation Proposals for Reform of the Mental Health Act

Report of the Expert Committee

In rounding off this review of the context of prisons and mental health issues it is important to bear in mind the planned Reform of the 1983 Mental Health Act. The view of the Expert Committee, published in November 1999, is that it would be quite inappropriate to permit compulsory treatment for mental disorder in prison. 'The priority', they say, 'must be to ensure that all those with mental disorder of a severity which would attract compulsion outside prison are transferred to a suitable hospital facility.'

As will be seen later transfer still remains a time consuming and overcomplicated "bedchase" for the Doctors serving in Thames Valley prisons. The Expert Committee's proposal therefore is of particular interest. They recommend 'the introduction of a right of prisoners to an assessment of their mental health needs ' They go on to further recommend ' A power in the Secretary of State to direct the transfer of a prisoner to hospital for compulsory assessment. If long term compulsory care and treatment was required it would then be provided in hospital, under restrictions if necessary, on the authority of the tribunal.'

Such proposals do have major implications for a system which still struggles to transfer from prison to hospital in a timely and cost effective manner. It is to be hoped that the Task Force will consider some of the resource implications in its forward planning work.

Thematic Review of Mental Health Issues in the Four Thames Valley Prisons

Reception Arrangements and Screening for Mental Health Problems

In the three prisons (Bullington, Woodhill and Reading) where prisoners typically arrived from court there was some reference to the variability of PER information, as mentioned earlier, but a generally positive picture was given of the performance of Escort Contractors, who were seen as reliable in the passing on of concerns about observed behaviour. Some similar comments were made about the receipt of information from Probation and Social Services (often by fax) about new inmates who were seen as being at risk within suicide prevention procedures. Such information is viewed very positively by Reception staff. There remain many cases where such information would have been useful but is not sent, including wider mental health concerns and any knowledge about medication and substance misuse. Clear views from our meetings with reception staff was that the information is important and outside agencies do need to take this message on board more systematically. This has considerable implications for the Probation Service with its recently changed approach to court cover and for those schemes that provide mental health intervention at court.

Inevitably Reception staff tend to prioritise self-harm and suicide prevention issues. They are expected to do so and we found considerable clarity about identification and referral. There was, however a recognition that more training would be helpful, particularly around the need for a better understanding of adjustment reaction and depression. As is noted earlier this was also seen as a key training issue in the project report on Prison Officer training.

Typically the arrangement for medical screening is for there to be an initial contact with a Nurse followed by contact with a Medical Officer within 24 hours. Working arrangements between screening staff seemed generally positive. When concerns about a prisoner's mental state were identified admission to Health Care provision for observation was arranged. Lack of suitable provision at Reading is a major issue at present though there are plans to improve provision.

Several of the Medical Officers we spoke to claimed high detection rates of mental illness through the reception screening process. Other prison staff were less confident that this was the case, and Wing staff who received prisoners generally spoke of their concern about lack of information about prisoners whom they were concerned about. This has been noted earlier as a national concern, and we certainly found evidence of it in our visits. It may be necessary to await a national agreement on exchange of medical information before real progress can

be made. There is no doubt however that training of Prison Officers is a very high priority as well.

At Aylesbury very few prisoners were received on first reception into custody, having either been on remand or at another prison following sentence. Nonetheless many of the issues identified above applied. The point was also made that establishments transferring prisoners often provided a poor quality of information.

Health Care Provision and its Relation to the Wider Prison

Medical staffing establishment in the Prison Service is generally calculated on a formulaic basis, often complicated by changes in prison function, specific local negotiation and accidents of history. There seems to be a strong case for clearer needs planning process that could take into account the specific staffing requirements for dealing with mentally disordered offenders. If the Prison Service/NHS partnership being worked on by the Joint Task Force is to mean anything there will need to be greater clarity about such planning and the distinction between prisons as providers of primary care and purchasers of secondary care. At present too much is left to the varying aptitude and experience of local health managers.

We were struck by a number of anomalies in the prisons visited. Access to a Psychiatrist is very limited in both Aylesbury and Reading, both dealing with populations of high-risk young men. In Reading the position is compounded by psychiatrist time being concentrated on court assessment and limited availability of GP time-only 18.5 hours per week.

The main concern we found however related to the shortage of nurses against establishment. For example at the time of our visit Bullingdon had five nursing vacancies with a heavy reliance on agency provision and overtime working, but the situation was similar in other establishments. The problem is a complex one reflecting the position in the wider community and the South East of England generally. A number of Managers spoke with real concern about the difficulty in attracting and retaining staff citing the lack of financial incentive and the particular demands of prison working as major reasons. Limited contact with the wider NHS world contributes to the problem and we were impressed by the Aylesbury Health Centre Manager's scheme to offer training placements to Luton University School of Nursing. There does seem to be a strong case for building on this initiative elsewhere as well as exchange placements between the prison and Community Mental Health Teams.

The range of contribution being made by a relatively small number of RMNs was impressive and ranged from counselling individuals through to health promotion work. Of particular interest was the presence or planned introduction of an outreach approach in each prison. Outreach initiatives using dedicated nursing staff are the most obvious evidence that a community care approach can be adopted in prison. Where schemes were in operation they were typically used to support inmates returning to normal location after a period in the

Health Care Unit, but they were also involved with self harming inmates where 'hospital care' was seen as unhelpfully colluding with manipulative behaviour- an issue further discussed in the later section on self harm. There was clear evidence both from outreach nurses and wing staff that the contact was helpful in supporting Prison Officers and breaking down the tensions between medical and wing staff. Clearly the approach could be taken further and would be a necessary accompaniment to improved prison officer training. The approach is so important to mental health work in prisons that it should be further studied in the Thames Valley context perhaps by way of research and a networking conference. A particular danger for the outreach approach is its vulnerability to being cut back at times of staff shortage.

Prison Health Centres ranged considerably in terms of bed availability and physical conditions. The main deficiency remains at Reading. At Bullingdon and Woodhill there is specific and recently built provision. At Aylesbury the Health Care Centre occupies a large purpose built and relatively unused small hospital, devised some years ago as a national mental health unit for the young offenders estate. Lost in a change of policy and philosophy the building awaits a new function.

Linkages with the National Health Service

Our general impression was that there remained little systematic dialogue between Prison and NHS managers, beyond contact over individual cases, though there were some exceptions including contact initiated from Aylesbury with its local Tindal Centre. As is indicated earlier responses from health providers outside are not always constructive either. If the 3-year programme of the Task Force is to mean anything this problem will need to be addressed more systematically. It may well be that within the Thames Valley an initiative could be made at Regional level where the Mentally Disordered Offenders Forum is already established with prison representation- collaborative work on training, staff exchange and shared policy work all seem suitable areas of potential. In seeking to develop key policies such as outreach work the prisons do need outside support and reference points. It can be done and the Prison Service has changed radically in recent years in its approach to structured programmes and drugs work.

The Transfer of Mentally Ill Prisoners to Hospital

This issue was specifically discussed with Senior Medical Officers at Bullingdon and Woodhill. In both establishments considerable efforts were made to identify suitable cases for transfer within the terms of the Mental Health Act. It was indicated at Woodhill that the numbers from the main prison were in the region of 20 to 30 cases per year. A number of concerns were expressed about the difficulties which could arise in securing an available bed once the two clinicians involved had agreed on the medical necessity of transfer. At Bullingdon effective use of regular Forensic Service visiting sessions meant that assessment could be undertaken without delay. The difficulties in securing placement were time

consuming for the Doctors involved and sometimes meant serious delays in transfer, close to the 28-day limit of the Section. This could be distressing both for inmates and the staff involved in their care. One suggestion was for a 'Bed Manager' role to be established at Area level in the Prison Service with the co-operation of the Health Authorities. This idea merits further investigation. In the longer run Reform of Mental Health legislation, as mentioned earlier may give the Home Secretary powers of direction in this matter. Even then it is hard to see how this could operate efficiently without co-ordination.

Wider Mental Health Initiatives in the Four Prisons, Including Suicide Prevention, Responses to Self-Harm, Bullying and Vulnerability

On the broadest level it would be fair to say that every Prison Department has a part to play in the creation of regimes which promote healthy activity and recreation. Education programmes, the wider availability of television and specific local initiatives such as the Woodhill Volunteer Counselling Service all play an important part in developing the possibility of a 'healthy' prison. There were certainly good ideas in operation but also frustration about the impact of scarce resources in limiting Physical Education and other activities. On the other hand the growth of approved programmes is highly relevant to mental health promotion and treatment. There are issues about careful targeting but Thinking Skills courses, for example, may be highly relevant. One of the outreach nurses at Bullingdon indicated that she suggests referrals to such courses as appropriate and this is an example of well-integrated work.

The central issue in terms of mental health is the need to monitor the progress of inmates after they have moved onto the Wing. We were told of several Personal Officer schemes but there remain continuing problems about the continuity and maintenance of this type of work. Several managers felt that the strong levels of mental health identification at Reception were not sustained on the Wing. The two main factors seemed to be operational constraint and lack of training. The Prison Officers and their immediate managers remain the key staff group if further progress is to be made. They are expected not only to identify and protect the vulnerable, but manage the large numbers of personality disordered prisoners whose behaviour can present grinding and frightening problems on a day to day basis. The Project Report on Training of Prison Officers in Mental Health issues previously quoted makes an eloquent case for a required training programme. One of the suggestions in the Project Report is for each Wing to have a Mental Health Resource Officer with extra training capable of acting as a reference point, and source of expertise. There are some dangers in that notion that has been used before in the Prison Service without conspicuous success on race issues and other areas of concern. Certainly to have a Wing Resource Officer without a training programme in place for other staff would be a fundamental mistake. Our impression during visits was that Prison Officers would welcome further training. It is certainly important that the Project Report is discussed widely within the Thames Valley and there may be scope for local initiative in piloting training, given the importance of the issue.

Suicide prevention initiatives have been regarded as a priority concern within the Prison Service during recent years and we were made aware of the action taken in all the 4 prisons visited. The problem is an awful and intractable one that has been well-documented in Inspection reports and the Press. The problem is at its most acute in Young Offender establishments and Reading had received adverse criticism in an earlier Inspection Report. Responses at Reading had included a redesigned record of watches for those identified formally as being at risk. This has been accompanied by the development of a small number of specially designed care suites which limit the physical opportunity for harm and allow another inmate, one of the Prison's 'buddies' to be present if necessary. A specially constituted Panel reviews those on watch every 72 hours. In this way regular review is ensured and necessary referrals can be made.

The 'buddy' scheme in Reading deserves particular mention. Listener schemes were in place in the other prisons and these were constituted on the normal lines with Samaritan involvement in the training. A committed Senior Officer who selects and trains a small number of 'buddies' personally runs the Reading scheme. The 'buddies' are closely supervised but undertake support work with vulnerable inmates and are available on a duty basis, including regular duty on Reception. The scheme is a practical attempt to cope with the problem in a Remand Prison of limited time availability for training and high turnover. This scheme and the operation of listener schemes in the other prisons would benefit from a fuller evaluation. As with many other prison initiatives the 'buddy' scheme owes a good deal to individual staff commitment and there is a need to ensure that such initiatives are better shared as good practice than is often the case.

There is perhaps in all prisons a tendency to rely overmuch on administrative procedure. While this certainly ensures safe accountability and consistency there is always a danger that the procedure blinds staff to the wider picture. The risks of an overemphasis on suicide prevention procedures are twofold-first there is a danger of missing the less obviously vulnerable, and secondly the suicide prevention risk may be seen as having a detached life from the individuals overall mental health problem. As has been suggested by the Training Project Report prisons actually need a more complex model of depression and suicide than they have at present.

Self-harm was a major issue in each of the prisons but again seemed to present most frequently in the Young Offender establishments. Self-harm presents one of the interesting tensions between health care staff and Wing staff. Health Care staff are often well aware that all self-harm requires careful assessment but can be dysfunctional manipulative behaviour from individuals seeking protected hospital care away from the Wing. Admission in those circumstances can be to reward the dysfunctional behaviour which then becomes harder to manage. In prisons with medical outreach nursing staff are well placed to support the Wing staff in coping with the individual on normal location. At Aylesbury a particularly interesting initiative by the Health Care Manager is the planned involvement of staff from the Maudsley Hospital in training prison staff on these issues.

We were made aware of anti-bullying Units at both Aylesbury, and Reading. The Aylesbury programme has been recommended for accreditation and provides a modular residential course over a 14-day period. It may be that the work of these Units should be more widely shared and they may have particular interest for YOTs in the Thames Valley.

Dual Diagnosis Issues and the Work of CARAT Teams

Whenever possible during visits we did make contact with members of CARAT Teams and Prison staff with a specific brief around drug and alcohol misuse. As might be expected dual diagnosis cases constitute a significant minority within the large group of identified substance misusers in prison populations. The standardised CARAT Casework Record which covers assessment and treatment issues has a specific section on Psychological Health and attempts to identify problems from a wide range of symptoms. The Detoxification Co-ordinator at Bullingdon estimated that within an estimated 90 to 100 drug referrals per month, an average of 15 cases had dual diagnosis problems and she felt that these numbers were increasing. At Woodhill a similar proportion was estimated and it is clear that experience from the prisons needs to be taken into account carefully in wider needs assessment and service development planning. At present that does not always seem to be happening. We were told at Bullingdon that until recently CARAT workers had been inputting to the Drug Misuse database, but that this had been ended pending Home Office decisions about data collection on CARATS.

The need for prison and community contact is not only to do with mapping the problem and improving planning but avoidance of isolation and the better through care linking of services inside and out. This seems to be most easily achieved when a Prison Service specialist is involved and a number of efforts were made to achieve this in all the prisons, particularly the 'locals', Bullingdon and Woodhill. The further development of good working links needs to be regarded as an important priority. This needs to apply to apply to community based agencies as well as prison services. For those offenders in multiple need the approach pioneered by the Revolving Doors Agency, described earlier in this Review, seems the most likely to succeed.

Within prisons the identification and treatment of dual diagnosis cases is more easily tackled when CARAT and Health Care staff operate in a well integrated way which is understood by Wing staff. Specialist Health Care responsibility and outreach work on the Wings do make this more likely, and at Bullingdon particularly considerable progress had been made. This included referral to the NACRO Resettlement Unit who were able to concentrate on the accommodation issues which are often crucial in resettlement packages.

Any detailed examination of CARAT working is beyond the brief and resources of this Review. It does seem clear that CARAT experience, properly analysed and shared, will provide a major source of new information for Drug Action Teams, since many of those identifying problems in prison have not actually had prior contact with outside agencies. It

is also a fact of life at present that for many parts of the Thames Valley access to services is much more available in prison than the community. In referring cases on for post release work CARAT workers described real difficulties, and this is an experience they share with Arrest Referral workers. The involvement of the Ley Community in Bullingdon is in this respect a very important initiative and this work may have a good deal to say about new forms of service linkage.

Alcohol service provision continues to be at a much lower level and this has important implications for dual diagnosis work. While access to detoxification has certainly improved in prisons ongoing work is quite limited, though in Woodhill the Prison's own non-CARAT Substance Misuse Worker does take on alcohol cases and this extends overall provision considerably. Given the prevalence of alcohol problems in the offending population and the established connection with dual diagnosis it must be hoped that the CARAT initiative can be extended into alcohol work as soon as possible.

The Close Supervision Centre at Woodhill

We were able to visit the Woodhill Centre and spoke to the Centre Governor and some staff members. Though this Unit is part of a national system and this Review does not address NHS or Special Hospital provision, it would be wrong to ignore the Woodhill Centre in a consideration of mental health issues in prison, not least because of the impact it has on the wider prison population. There are now two national Centres, at Durham and Woodhill and the national system has recently been the subject of a thematic inspection. (24) The CSC system replaced the previous Continuous Assessment System (CAS) which was known colloquially as the 'Merry-go-round' and resulted in the long term segregation of prisoners who could not cope with special unit regimes. The aim of CSCs was to provide a new form of regime in which such prisoners were challenged to behave satisfactorily with the aim of returning them eventually to normal conditions. Woodhill provides the small staged units that enable inmates to be assessed then moved on to an intervention or restricted regime depending on their progress. There is also a segregation unit. The national system has been in place for some two years and the implication is that the Woodhill Unit is dealing with a highly dangerous population of 24 prisoners at any one time. 60% of them according to the Thematic Inspection Report have had history of referral to Special Hospital and all could be regarded as suffering from severe personality disorder.

Even a short visit to the Centre made it clear that this is an extremely isolated and stressful setting for staff, who are in fact dealing with the most dangerous and intractable offenders in the prison system. The Thematic Inspection Report suggested that the Centre threw a disproportionate burden on the prison's health care staff and this included a number of mental health and related problems. The Report acknowledged that the necessity of tight behaviour control limited the possibilities for use of conventional mental health methods of intervention. Nonetheless there was a need for a health care needs analysis of the CSC population, relief for health care staff and fuller assessment work on mental health needs

including Forensic Psychiatric input and an expanded role for Psychologists. It is clear that in reviewing the whole system the Chief Inspector would like to see a new model developed for mental health treatment in CSCs, within which there is more specialist involvement and better training for staff. Responses to these proposals may well need to be planned at a national level, but there may be a case for the building of local links with the nearby Secure Unit at Marlborough House.

NOTES:

(21) Training Needs of Prison Officers in relation to Mental and Personality Disorders. WHO Collaborating Centre, Institute of Psychiatry. 2000

(22) Casework Information Needs within the Criminal Justice System. MCSI. 2000

(23) The Future Organisation of Prison Health Care. Prison Service/NHS 1999.

(24) Inspection of Close Supervision Centres, August-September 1999, A Thematic Inspection. Home Office 2000.

Section 3

A Further Consideration of Dual Diagnosis Issues and the Perspectives of the Thames Valley Area Drug Action Team Co-ordinators

Introduction

Issues surrounding the identification of dual diagnosis cases and the ways in which services respond to them have been mentioned throughout this report. The purpose of this section is to comment further on some of the key questions of identification, assessment and treatment before moving on to a consideration of policy development in the Thames Valley.

Definitions

As in Section 1 my starting point is Jeremy Spafford's helpfully practical working definition. 'Dual diagnosis describes a condition whereby a person has a mental health problem and a substance misuse problem and, if one were resolved, the other would still cause concern. The term becomes useful when the duality of the diagnosis prevents agencies from being able to offer an adequate service'

Phillip Evans in his previously quoted report on the Dual Diagnosis Demonstration Project at Luther Street in Oxford used a somewhat more specific definition for the purposes of the project:

'Any patient with a mental health disorder which has been diagnosed by a psychiatrist or has consistently been identified by a General Practitioner who also has a clearly identified history of problematic substance misuse (including alcohol).'

He goes on to comment that the definition would include patients with personality disorders and those who have a history of problematic substance misuse even where there is no evidence of addiction or psychological dependence. It excludes those on anti-depressants with no specific diagnosis or history of depression, and those with a history of self-injurious behaviour without a history of depression or other mental illness.

There is a range of other definitions arrived at for a range of other purposes from research through to gate keeping of service delivery. Once the basic co-existence of two conditions is stated an overall definition then has to find its way round the everlasting distinction between broadly defined mental health problems and a more restricted definition of the mental health component involving only 'severe and enduring mental illness'. Dual diagnosis definition like everything else in the field of mental health provision, runs quickly into this central 'rock in the road' based in current legislation and much mainstream practice.

There is certainly a need to be careful about easy catch all definitions which may be so general as to offer no clinical clarity, and in the present state of treatment provision, lack of skill or knowledge may limit the treatment of one of the two conditions. Similarly some treatment environments are not suitable for both conditions. A recognition of these issues is necessary in considering policy options, but many have argued that the medical emphasis implied in the term is unhelpful, and that the whole notion of 'dual diagnosis' can too easily become, as Evans puts it ' a dustbin or exclusion label, used to identify the difficult or dangerous client'.

It may be that 'dual diagnosis' should be regarded as a term with limited shelf life and that the priority of research should be to produce a better typology of complex needs capable of being responded to by more standardised assessment techniques and with different agencies learning less isolated and more collaborative ways of working.

For now, it may be safest to use the broader definitions quoted above and to remember three main points. Firstly these problems are not new. Secondly they may provide the most important of incentives to build services more responsible to the wider range of complex needs, and thirdly there is an intimate connection with 'offending behaviour' heightened by Community Safety concerns and the evidence from Oxford and elsewhere about dual diagnosis cases showing a younger age profile with extensive use of illegal drugs.

Prevalence

The problems identified above all tend to make prevalence studies difficult and the range of different information systems in agencies adds to these problems. I am grateful to Lesley Johnston, Buckinghamshire DAT Co-ordinator for her written summary of a range of studies. Generally it would seem that prevalence rates are lower than in the United States where much of the earlier epidemiological work was carried out. Nonetheless the figures are high. Gournay and Sandford's 1996 study (25) surveyed 185 nurses working in psychiatric units and community teams and 68% of respondents reported illicit drug use in their work area. Cantwell and others (1998) studied 168 subjects presenting with first episode psychosis and co-morbidity was identified in 37% of the sample. Other local surveys suggest that between 8% and 15% of those seen by CPN's and CMHT's have dual diagnosis.

Previously quoted local research also suggests that there is a substantial problem. Spafford shows that 22% or 247 people from Luther Street's active patient list had dual diagnosis. 105 or 30% of the long-term patients of one CMHT had drug and alcohol problems of which 52 were regarded as serious enough to require referral to Addiction Services. 589 individuals with either a serious mental illness or severe personality disorder presented to the John Radcliffe Hospital in 1997 having deliberately self harmed. Over half such patients were misusing alcohol and more than a quarter of them, drugs. Spafford's overall estimation is that within Oxford 5 to 20 people at any one time lead a very chaotic lifestyle and may be involved with most if not all relevant agencies without getting an effective service from any

of them. Larger groups who are less chaotic receive a less than adequate service due to their dual diagnosis and they may add up to 315 people at any one time.

Evans' Luther Street research initially suggested 13% of the presenting population at the Centre through a 12 month period but a wider scale search of all current patients revealed a much larger proportion of 52%. Evans suggests a delay in detection of underlying problems and a low initial return of information from previous clinical contacts as contributing to the low initial figure - further evidence of the complexity involved in mapping dual diagnosis.

Both studies now suggest the existence of a sizeable problem characterised by confused and often ineffective service responses. In common with other local surveys there is clearly an over representation among the homeless population but there are large numbers beyond that group. However, these studies prompt a number of further questions. It does seem logical that there should be heavy over representation in larger urban centres since people gravitate to the resources within them, but there seems little evidence of the position in smaller centres. Similarly, if the availability of illegal drugs is adding to the figures and the age profile of dual diagnosis cases may be younger than previously anticipated, then the overall numbers may not take account of those not yet in touch with agencies. Similarly those who present to drug or alcohol agencies may not 'stick' because the mental health component or the complexity of their need can not be met by the existing methods of the agency. Limited facilities in substance misuse as well as mental health services suggest that this may be a very significant group in the Thames Valley. Future investigation should certainly take into account the experience of the Youth Services, YOTs and the Probation Service as well as GPs.

I am aware that in recent months there has been evidence of further needs assessment work, notably the initiative in Slough which has fed into the development of a wider Berkshire strategy described later. Similarly the Oxfordshire and Buckinghamshire DATs are using available information to inform strategy. This is the right approach. It is obviously sensible, given the urgency of the needs identified to use the available information to begin shifting policy. It is possible to worry too much about information gaps before taking action in most areas of social concern. The likelihood is that as the fuller picture emerges policy needs will become more sophisticated. The problem with this issue is that the initial shifts in policy are considerable, and once made need to be monitored on a continuing basis. Shared ownership of a clear strategy across the mental health and substance misuse fields is vital and there needs to be an appropriate, effective infrastructure to support this.

Treatment Issues

Dual diagnosis patients/clients are a heterogeneous group. Gafoor and Rassool (27) suggested in 1998 that they are, though, most likely to come from the following categories:

- A primary psychiatric disorder with a secondary substance misuse disorder.

- A primary substance misuse disorder with psychiatric complications.
- Concurrent psychiatric and substance misuse disorders, for example alcohol dependency and depression.
- An underlying traumatic experience, for example post traumatic stress disorder resulting in both substance misuse and need disorders- many suggest that this is a significantly under diagnosed group.

Add in the multiple needs factors of difficult behaviour, homelessness and other aspects of multiple need and diagnosis can be seen as a complex exercise involving the assessment of a number of areas. Lack of commonly agreed assessment criteria and methods are a significant barrier to the meeting of need. It does seem clear that conventional treatment settings are inappropriate and unsuccessful in treating dual diagnosis cases, particularly poly- drug users. Lesley Johnston identified a number of factors in this failure and these are as follows:

- Failure to address the specific needs of the substance misusing population.
- Treatment of the psychiatric disorder alone does not alter the outcome of the dual diagnosis patient.
- The alcohol or drug addiction appears to determine the clinical course and need to be addressed equal to the psychiatric disorder.
- The lack of combined services and integrated treatment.

Lesley Johnston goes on to point out that there are in effect 3 basic models for treatment.

- The Serial Model in which mental health and substance misuse disorders are treated consecutively, usually without much communication between mental health and substance misuse services.
- The Parallel Model, mental health and substance misuse staff providing two concurrent services that are an improvement on the serial model but has a number of potential weaknesses around the difficulty of integrating treatment, a tendency for clients to leave because of complications related to their co-morbidity and a tendency for the separate services not to adapt to each others operations.
- The Integrated Model where mental health and substance misuse services are provided concurrently in the same setting by one team. Given the level of prevalence now being identified this approach may be unrealistic without a major overhaul of services

In reality it is unrealistic to expect one model to be capable of meeting all the needs of those classified as having a dual diagnosis. Nonetheless the basic typology may be helpful in identifying options and planning policy. At present limited resources, lack of workers with crossover skills and lack of commonly owned assessment processes and protocols all provide obstacles to more detailed work beyond inter-agency liaison.

In making sense of this for the Thames Valley, it may be helpful to think in terms of a mix of models based on differential levels of need. Spafford, Luther Street and Revolving Doors all speak of the existence of a core of people in multiple need who cannot access existing services and among them are significant numbers of dual diagnosis people. The Luther Street, Elmore and Revolving Doors approaches involve in their different ways persistent follow up, close team working with pooling of skills and an intensive support system for workers. It is argued in the final section of this report that a community based team of this kind is needed as an essential component of a comprehensive service for Mentally Disordered Offenders in each main Thames Valley population centre. Logically such a team should be resourced to cope with the special needs of multiple need dual diagnosis cases, supporting their access to main stream services and following them through for sustained periods of time.

So far as the wider majority of dual diagnosis cases are concerned the integrated model of treatment described above seems unrealistic and developing strategies are facing the policy choices outlined by Spafford. Do you establish a specific team to provide distinctive services to the dually diagnosed or seek to adapt existing services by introducing specialist workers into teams, who may work to facilitate improved staff performance, liaise more effectively with other providers, and work directly with individuals or a mixture of these tasks? This approach is being established in a number of Thames Valley settings. Implementation depends on the establishment of good protocols and guidelines and over the next 12 to 18 months it will be important for information and progress to be shared across areas with a view to developing a clearer sense of what good practice is and how it can best be achieved. I stress this because the sharing of good practice has in the past been limited on other issues, causing isolation and a tendency for the wheel to be reinvented with depressing regularity. Into this information loop should be brought Criminal Justice staff, Primary Care providers and service users.

In the previous section of this report on prison issues, reference was made to dual diagnosis issues, including the need for good levels of co-operation between health care staff and CARATs teams. For those already identified as dual diagnosis cases the quality of information coming into the prison is crucial if efforts are to be made to take treatment forward and a good approach to through-care is vital. Some cases are actually identified in prison a collaborative working between CARAT, health care and wing staff then becomes vital. My impression is that it remains difficult for prison staff to stay in touch with some of the developing issues and they too need to be taken into the information loop about practice and policy. It was suggested to me that CARAT levels particularly in Young Offender

establishments may not be high enough to cope with the demand potentially involved and this needs to be borne in mind in resource planning. Within the Prison Service Area as a whole (which includes the Thames Valley) thought should be given to a specific development post which could interact with community services on dual diagnosis, within the spirit of the Prison Service/NHS partnership.

The Perspectives of DAT Co-ordinators

I met with the three DAT Co-ordinators in the Thames Valley. Early next year the structure will change to provide a separate DAT for Milton Keynes. In Berkshire the position will change more radically with the introduction of a DAT for each of the 5 Unitary Authorities which make up the former County area. In Oxfordshire the position will be unchanged.

Much of the information provided above was gleaned from the 3 Co-ordinators who were all committed to the need to services developed which responded more effectively to dual diagnosis needs. They raised a number of other points that should be recorded in this overview of issues.

Oxfordshire

- The Oxford Mental Health Trust is currently developing protocols and guidelines for managing dual diagnosis patients, and the re-organisation of the Trust has achieved a good deal by way of a stronger structure and greater stability.
- There was a concentration of substance misuse services in Oxford City and DPAS has indicated a need for services to be developed elsewhere in the County.
- Models for responding to dual diagnosis would need to take account of smaller towns and rural areas.
- GPs were treating more drug users and it was important that Primary Care Groups were involved in discussion about dual diagnosis practice and development.
- The DAT Action Plan for 1999/2000 included the objective of ensuring that people with dual diagnosis were provided with appropriate treatment services with the DAT to co-ordinate strategy following the outcome of the Luther Street pilot.

Buckinghamshire

- Joint Financing had achieved a dual diagnosis post in Milton Keynes based at the Campbell Centre, and the role was to work with staff rather than clients.
- There was a significant shortage of experienced main stream drug workers that could leave agencies over-dependent on volunteer input. This had been seen clearly in connection with CARAT recruitment and did not apply only to Buckinghamshire.
- A Dual diagnosis post had been established in South Bucks within Social Services and there were good working links with Revolving Doors.
- A protocol had been agreed operationally between Revolving Doors and the Arrest Referral provider ACT on the advice of the DAT Co-ordinator.

Berkshire

- A major piece of Needs Analysis Research had been undertaken in Slough by Mental Health Strategies. This reported recently and adds significantly to knowledge about dual diagnosis.
- A Commissioning Standards Guidance Framework had been introduced across the Berkshire Health Authority Area that took account of dual diagnosis issues.
- A Joint Commissioning Group had been established which would enable continuity to be sustained across the new 5 DAT structure to be introduced next year.
- A Development Strategy had been developed for Substance Misuse Services which addressed dual diagnosis issues and an Implementation Plan was currently going through a full consultation process with a view to endorsement in November 2000. This process, including an audit of provision, will have been accomplished within a year. The overall strategy is an important one and its main points are summarised below, as the contents have wider implication for other parts of the Thames Valley.

The main elements of the Berkshire strategy are as follows:

- That a more detailed inter-agency strategy should be developed.
- A key lead agency should be identified.
- There should be closer liaison between CMHT's, Assessment and Outreach Teams and Drugs Agencies.

- There should be joint training.
- There should be Cross Agency secondments.
- A clear pattern of Community Support and Rehabilitation should be established.
- There should be a pattern of User participation in the operation of services.
- Services to black users should be developed.

The implementation plan includes the following proposals:

- Rapid access to assessment and treatment.
- Investigation of a mental health help-line.
- 2 Liaison Outreach posts to be established across CMHT and Drugs Services in Reading and Slough respectively with the 2 workers responsible as key workers on dual diagnosis cases.
- Dual diagnosis cases will be the responsibility of a lead consultant.
- More appropriate detoxification options for dual diagnosis cases will be explored.
- Establishment of 3 structured Day Care programmes that will include dual diagnosis need in the specifications.

The DAT Co-ordinator indicated that the role of the Health Authority Mental Health Commissioner had been crucial in achieving this level of planning. As well as his established interest in DIVERT he supervises the DAT Co-ordinator and Chairs the Joint Commissioning Group.

Other Issues

The implementation of Drug Treatment and Testing Orders (DTTOs) raises particular issues in respect of dual diagnosis. There is some evidence from the pilots that dual diagnosis cases were excluded particularly on the ground of assessed lack of responsivity and likelihood of a constructive response is indeed a requirement within the new Orders. Though it is not possible to develop the issue fully here it would be regrettable if this became either a blanket ban regardless of individual circumstances or the Probation Service did not have in place an alternative agreed option for supervision which did not disadvantage the dual diagnosis offender. This needs to be borne in mind in the development work for DTTOs in the Thames

Valley and policy decisions will need to be clear before contracting of service providers begins.

Several of those consulted raised issues about the work of Youth Offending Teams (YOTs) in respect of dual diagnosis. The general picture seems to be that they may lack either the substance misuse or mental health input, to respond to the needs of the youngest dual diagnosis cases. I am not clear what the situation may be on the ground but this issue certainly merits further consideration.

NOTES.

(25) K. Gournay and T Sandford. 'Double Bind.' Nursing Times 1996.

(26) Cantwell et al 'Prevalence of Substance Misuse in First Episode Psychosis', British Journal of Psychiatry. 1999.

(27) M. Gafoor and Rassool G Hussein. 'The Co-existence of Psychiatric Disorders and Substance Misuse. Working with Dual Diagnosis Patients. Journal of Advanced Nursing. 1998.

Section 4

Some Conclusions and the Necessary Components of a Comprehensive Service for Mentally Disordered Offenders

A Summary of the Main Overall Conclusions

An overview study of this kind cannot describe in detail every feature of work with mentally disordered offenders in the whole of the Thames Valley. Nonetheless, I have attempted to give a picture of the main community based initiatives and their interaction with main stream mental health provision. I have gone on to describe some of the main issues relating to prisons on the basis of a series of visits to four establishments. Finally I have returned to dual diagnosis, an increasingly significant issue in work with offenders, and one which presents a range of complex problems. A theme throughout the Report is the necessity of coherent response to multiple needs, and for mentally disordered offenders dual diagnosis is very often a central issue.

The main conclusions can be summarised as follows:

- In no part of the Thames Valley does a comprehensive service exist. There are a number of important initiatives that demonstrate good practice, but they have often been introduced in relative isolation rather than as part of an overall plan.
- In areas where an inter-agency forum or steering group exists there is more sense of a pattern of services and the gaps in provision. This facilitates the identification of priorities and makes it possible to audit services.
- Outside the main population centres, services are very limited and over dependent on good working relationships between small groups of workers from the different agencies.
- Where good practice or significant initiatives exist there is little evidence of wider information sharing or standardised implementation. This applies both to projects and procedures, and includes such issues as common practice by police on Section 136 cases.
- Government's wish to have a national framework for Police Station and Court assessment is a long way from implementation across the Thames Valley. If progress is to be made from the present patchwork then lessons will need to be learnt from past problems and the effective practice that does exist. More imaginative use of partnerships across boundaries may be needed.
- Many agencies, both statutory and non-statutory, continue to provide services that either exclude or work unsuccessfully with many clients/ patients. The mentally disordered

offender population includes many people with multiple needs and any comprehensive pattern of service needs to take account of this reality. Within the Thames Valley successful models do exist and need to be learned from.

- In many parts of the Thames Valley there is reasonable liaison between agencies working in the Criminal Justice System and key mental health units, such as CMHT's. There is, though, limited evidence of systematic inter-agency working. Pressure on CMHT resources tends to mean strong gate of access to those services.
- More systematic evaluative work is needed on mentally disordered offender initiatives in order to assess effectiveness. It follows that schemes should have clear objectives and performance targets.
- The lack of Resource Manuals about local systems and provision was raised on a number of occasions. Good models do exist for this within the area and should be adopted in similar format. They should include information about prison matters, and manuals need to be available in prisons.
- Accommodation issues were frequently mentioned. Where multiple needs were being worked with systematically those involved had long term commitment to tenancy maintenance. A wider range of accommodation provision is needed with appropriate support and the special contribution of Approved Hostels could be further developed on a Thames Valley basis.
- The changing role of the Probation Service is not yet well understood by other agencies. Within the new Thames Valley Probation Service there will need to be development of an overall policy which addresses partnership issues and the role of Probation staff.
- Significant concerns were raised about the problems of young offenders with mental disorder and it seems clear that many of them have dual diagnosis problems, involving use of illegal drugs, notably heroin. YOTs need to consider their provision to cope with these problems and there is need for wider service development both in the community and prison.
- There needs to be much more contact between the Prison Service staff involved in mental disorder and outside agencies, along the lines envisaged by the Prison Service /NHS Task Force, and there were several existing examples of imaginative work.
- Prison Officers had crucial training needs that the recent Training Project Report had well identified. While a national strategy may well be needed to take this forward in more standardised format there may well be room for work in the Thames Valley on an inter-agency basis. This had happened in some places in the past. The potential for exchange placements for key staff might also be considered.

- Training generally was regarded as an important priority, particularly for Police and Probation staff.
- Dual diagnosis work involved a range of difficult challenges to services. The existence of appropriate protocols between the substance misuse and other agencies was seen as a necessity.
- Deficiencies in the availability of services for substance misuse were noted in many parts of the Thames Valley. Those services that did exist were often not well placed to respond to dual diagnosis problems.
- In planning responses to dual diagnosis an overall strategy needed to be agreed, such as the current work in Berkshire. Leadership at a senior level was necessary and there were real dangers in piecemeal development.
- There were some serious concerns about the identification, assessment and treatment options open to black people with mental disorder. Strategies were needed to respond to under-identification and unresponsive services.
- A strong argument was made for systems of user consultation in mental health services, including agencies dealing with Mentally Disordered Offenders. Several good models existed for this in the Thames Valley, at Revolving Doors and on the Steering Group of the Milton Keynes Panel.

National Context

While some of the conclusions summarised above call for a more imaginative approach to use of existing resources, and others for better ways of undertaking current responsibilities there is a clear necessity for an increase in the resources to deal with Mentally Disordered Offenders if more comprehensive services are to be achieved. The purpose of this section is to summarise the main national policies and research that would support the case for development.

Government Policy

- The Government's 'Modernising Mental Health Services' strategy first outlined in 1998 involves a £700 million investment between 1999 and 2002. This includes the need for a national framework of mental health assessment schemes at Magistrates Courts and Police Stations as well as specialist 'inreach' mental health services in prisons.
- The final Report of the Government's Crime Reduction Cross Cutting Review (28) was published in June 2000 and analyses levels of expenditure across different areas of

Government relating to the whole field of crime and disorder. The Report notes that in addition to the Modernising Mental Health funding further improvements are envisaged through bids for adult community mental health services as well as £140 million for child and adolescent mental health services. It suggests that both these areas will need to be complemented by related improvements in Personal Social Services. Children's and Adolescent services will require further support from the Educational Psychology service.

- The Review 'considers that it is a legitimate and appropriate aim for mental health services to reduce crime and criminality. Priority treatment should be given to those whose condition is linked to criminality. Therefore in prioritising access to and continuation of care. Mental health services should take account of the wider social costs including crime of different types of condition including severe personality disorders.'
- The Review goes on to suggest a development of more suitable performance measures and concludes in a key recommendation as follows: 'New investments in adult mental health services and in child and adolescent mental health services which are aimed at improving interventions for groups such as the personality disordered, who are likely to be involved in offending, should be accompanied by targets to reduce that involvement'.

Community Safety

- Another key strand of Government policy is the structure on Community Safety introduced by the Crime and Disorder Act. Local authorities and the Police have joint responsibility for annually reviewed plans produced after a consultation process to reflect local priorities. The infrastructure to implement plans includes managers from many of those agencies who have responsibility for Mentally Disordered Offenders. This Report has noted a number of crossover concerns and at a local level there is often crossover representation. On regular occasions Government has pointed up the connection between the two agendas, not least in the consultation process around the proposed new Mental Health legislation. There is clearly potential within the Thames Valley for more of this work to be linked. The Community Safety structures should be able to add support to the case for comprehensive services to deal with Mentally Disordered Offenders.

Revolving Doors Research on Costs

The research work conducted on costs and reported in 'Mental health, multiple needs and the police' has major implications for the funding and delivery of services to those Mentally Disordered Offenders with multiple needs. As the Report indicates:

'... a practical, preventive initiative working with broad referral criteria and delivering a flexible range of supports, can engage people successfully and stop them 'falling through the net' of services. And it can be done with little or no impact on the overall cost to services. The before and after comparisons of our cost study show that preventive Link Worker

interventions shifted the cost of services used by this group away from expensive crisis services - the police, accident and emergency and temporary housing. They moved instead towards primary care and community mental health services- a more appropriate way of supporting this group and likely to improve their quality of life. Linking people back into services produces a better balance of costs and outcomes.'

The implications for planning of services for this group need to be taken fully into account.

Components of a Comprehensive Service for Mentally Disordered Offenders.

The purpose of this final section is to suggest the main components of a comprehensive pattern of services to deal with Mentally Disordered Offenders including those who may have multiple needs and are at risk of falling through the net of existing services.

Components relating to service delivery are dealt with first, followed by components relating to co-ordination, liaison and training. The service delivery components are dealt with in the normal sequence of Criminal Justice processes. They are not intended to suggest a standardised 'blueprint'. Some interventions could and should be standardised across the Thames Valley. Others may need to vary in structure and detailed method, given the wide range of current provision and starting point. Indeed the range of locality may mean that it would be unhelpful to aim at exactly standardised provision, even if there was a realistic prospect of implementing such a model.

Following Arrest

- A Thames Valley Police generic policy on Section 136 should be introduced across the whole Area to ensure consistency and fairness in local arrangements
- Training of custody and other Police staff should be on the basis of a rolling programme.
- Alternative places of Safety should be available to Police throughout the Thames Valley.
- In addition to established medical assessment procedures there should be a system of referral to other appropriate agencies. This should operate in a co-operative way with Arrest Referral provision and a standard protocol should regulate liaison and information sharing.

Pre-Prosecution and Court

- There should be a Panel system along the lines of the Milton Keynes scheme in each Police area, capable of meeting regularly as required and using existing agreements on information sharing and recording.
- The work should be supported either by a Steering Committee or the proposed local MDO Forum and aggregated data should enable local and Thames Valley wide monitoring of numbers and performance to take place.
- Further work should be done on the extension of Panel work into the implications of panel work for the management of Community Safety cases.

- Each Court or group of Courts should have a Court assessment scheme after consultation with the Magistrates Courts Service to consider likely demand in each area.
- Information from Police Station screening and Panel considerations should be shared with the scheme as necessary.
- The scheme should have a sufficient level of CPN cover to allow liaison and referral work.
- Sessional Psychiatrist input should be targeted on formal assessment and available at an agreed time each week.
- Court staff, Magistrates and Probation Service staff should have sufficient training in the options available and the local scheme that they can be involved appropriately.
- When custody follows Court appearance there should be a clear Thames Valley wide agreement on the nature of information to be sent to the prison, together with a statement about timing.

Treatment

- There should be an extension of the Link Worker model, piloted by Revolving Doors throughout the Thames Valley for those identified as having multiple needs. The priority would be to introduce schemes initially in the main areas of population. The schemes would vary in size and composition reflecting local circumstances. They would work particularly on long term support and the accessing of individuals to mainstream care.
- Health Authorities and Trusts should undertake an audit of CMHTs to establish where there are gaps in the service and examine whether they might contribute further on their own or in partnership to work with Mentally Disordered Offenders.
- A coherent strategy needs to be in place in each area for the development of dual diagnosis services with clear arrangements as to lead agency and service specification.
- Managing Dual Diagnosis issues needs to be part of the role of DATS and joint commissioning authorities should be set up in each area to commission relevant services.
- Substance misuse services, as a whole should be further developed in the Thames Valley.
- Particular priorities are the needs of young people, faster response to crisis and the lack of provision outside main centres of population.

- More suitable supported housing options need to be developed.
- The Probation service needs to develop a Thames Valley wide policy on the role of its staff that is clearly communicated to the other agencies.

Prisons

- Priority should be given to the development of the Health Care outreach approach in prisons.
- Consideration should be given to the introduction of a Bed Manager to expedite prison/hospital transfers.
- Priority should be given to the training needs of Prison Officers on mental disorder.
- Every effort should be made to involve prison in local mental health groupings.
- Prisons should seek opportunities to extend further their partnership work on mental health.

Local Structures

Every area or group of areas should have a standing MDO Forum on the lines of successful existing models. The Thames Valley MDO Forum offers an established structure for the local groups to link with and this should be used to compare strategy, development and evidence of good practice.

At a local level there should be clear links with Community Safety Partnerships including local authorities, housing departments and DATS.

NOTE

- *(28) Crime Reduction- Final Report of the Cross Cutting Review. HM Treasury June 2000.*

Appendix

(List of those consulted in the preparation of this Report)

Thames Valley Partnership

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Thames Valley Police HQ

Simon Pont and Mike Vince.

Oxfordshire and Buckinghamshire Probation Service HQ

Linda King.

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Aylesbury

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Prison Service

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