The Bradley Report April 2009

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The objectives of today's workshop

- To review what the Report covers and recommends
- Summary of the Government's response
- What can we do in our areas - group discussion
- What are the blockers
- How can we remove the blockers

Aims of Bradley's report

- Examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to **other services and the barriers to such diversion**
- Make recommendations to government, in particular on the organisation of effective court liaison and diversion arrangements and the services needed to support them
- 82 recommendations – no extra funding for diversion services (Bradley at OHRN conference 24.09.09)

Background

- Need to improve Prison mental health services
- Victims want more relevant community treatment disposals for non violent crimes
- HOC 66/90 recommended MDO's receiving care and treatment from health and SSD’s rather than via CJS
- YOS’s to have qualified MH worker responsible for referrals to services

The Policy context

- Reduce social Exclusion – wider social factors influencing re-offending
- Gov 5 year strategy for protecting the public and reducing re-offending – strong emphasis on community sentencing
- NHS mental health contract includes improved continuity of care, improved access to beds and CJ liaison teams*

Government response

- A National Programme Board has been established, includes health, social care, criminal justice for adults and children – Chair is David Behan, DH director general of social care, local Government and care partnerships.
- National Advisory Group for NPB and Government being set up
- Supports PCT's and CJ partners in jointly planning and commissioning delivery of services
- CQC and CJS inspectorates to examine impact of joint commissioning on improving access to appropriate agencies
- CJMHTs to be responsible for ensuring continuity of MH care of persons in the CJS*
- Review mental health care provision in custody

Continued:

- Review of NHS prison inreach services
- MOJ, DH, social care and CJS organisations are now working together to look at how to make services more responsive
- mental health needs often not addressed in prison because the person doesn’t meet the ‘threshold’
- Joint information sharing protocols are needed across all agencies

Early Intervention – neighbourhood Teams

- Mental health services need to be more flexible and willing to join in a multi-agency approach – not only where the client is known to them
- Neighbourhood teams should establish local partnerships and referral pathways for person's with MH or LD and involved in ASB or low level offending

Continued

- Neighbourhood police opportunities:
  - Community support officers are eyes and ears of police
  - Identifying persons with mental health problems
  - Those at risk of offending or re-offending
- Need to improve engagement with health and social services to ensure interventions occur earlier in offender pathway
- Need to develop joint actions and sustainable solutions

Continued

- With minor offences police should consider recording the crime (NFA) and then signpost to local relevant health and social care services*
- Vulnerable person persons given ASBO's or PND's may be accelerated into CJS rather than appropriate services*
- Information on MH or LD should be obtained before use of ASBO or PND or pre-sentence reports following breach –
  - How would the increase requests for information be met?
  - 'Diversion' doesn't equate to admission or acceptance of MH input
- "It is widely accepted that drugs and alcohol can mask MH issues and make identification problematic" – *ditto for MH services?*
- Reliance on self-reporting unreliable due to fear of discrimination – or used to avoid arrest/prosecution

Arrest and prosecution

Healthcare in Police Custody Currently a mix of:

- FME
- Privately provided services
- Police employed custody nurses
- Liaison schemes
- It is the only place where NHS commissioned care is not available

Arrest and custody stage is the least developed in the offender pathway, their MH problems are more likely to be noted at court or sentence stage, whereas this should be the point where valuable information is gathered for other agencies at a later stage.

Recommendation

- transfer commissioning of health care services to NHS
- Improve Appropriate Adult services

Custody

- FME request MHA assessment where relevant – FME's need more formal psychiatric training (not currently a requirement)
- Establish if on CPA then obtain assessment by CMHT staff member enabling access to treatment/follow up
- Duty solicitors variable in knowledge of mental health – never contact MH services for information
- Timely access to Appropriate Adult (need is often missed, and availability not consistent)
- Avoid persons being on remand until court establishes their mental health problems (too late)
- Custody is only stage in CJS where primary NHS care is not available, nor is care in custody subject to NHS governance and performance measures

CPS

- CPS code advises diversion from CJS where offender has MH *issues* and prosecution is not in the public interest –
  - Unless offence is serious or there is a high risk of re-offending
- No clear definition on mental disorders that would not be appropriate for cautions -
  - recommendation for review of use of conditional cautions + guidance to relevant agencies
- Access to information not consistent, CPS left to 'infer' from evidence – often only heard from solicitor or family when case in court

The Court Process

- Courts, health service, probation and CPS should work together to agree a local Service Level agreement for the provision of psychiatric reports and advice to the courts
- CPN's or SW's to provide court reports – psychiatrist only if hospital order is likely*
- DoH and HM courts service to issue guidance for sentencers and probation re MHTRs
  - A core SLA will be agreed and implemented by April 2011

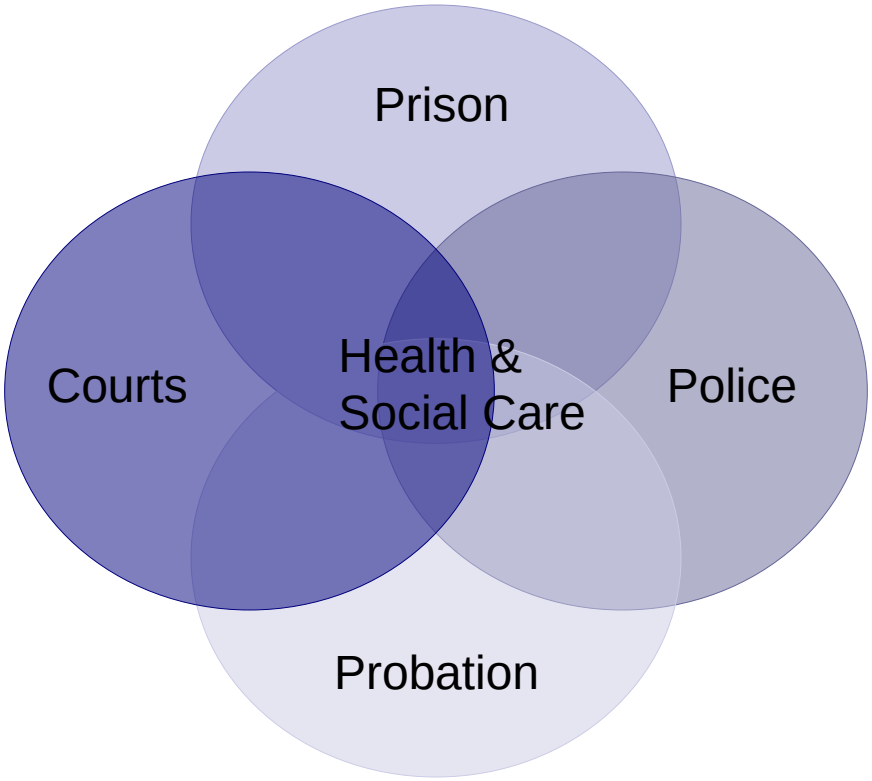
Court Process

- Alternatives to remand in prison (approved premises) is limited, only 3 of the 101 deal with mentally disordered offenders and provide mental health services
- PCT's should identify and meet the health needs of residents in approved premises
- Magistrates can request pre-sentence report from probation, but these do not always identify/raise mental health issues
- Magistrates need to know what services available locally to inform their court decisions
- Psychiatric reports may be delayed – recommend a service level agreement for commissioning reports and advice to courts
- Need more holistic court approach – currently separate courts
- Mental Health Treatment Requirement (MHTR) is one of 12 community sentences available – in ‘06 only725 of the 203,323 community orders were MHTRs.

Prison, community sentences and resettlement

- Prison reception should be a continuation of addressing MH needs, not 1st point at which they are identified. Liaison and diversion services should facilitate this
- Increased primary care into prisons – enabling prison inreach teams to focus on persons with severe mental illnesses
- Joint care planning between mental health services and substance misuse services in prisons (dual diagnosis (+PD) not to be used as reason for exclusion
- CPA to be used in prisons prior to release
  - Difficulty in assessing number of persons with MH problems as only have probation for persons with 12 month or longer sentences

National Programme Board vision of more responsive services



Criminal Justice Mental Health Teams

- Aim – to avoid uncoordinated approach to implementation of liaison and diversion services
- Accountable to Programme Board (including health, social care and criminal justice)
- A national Advisory Group to support Ministers and Programme Board

Liaison and Diversion

- Where these start at custody, rather than courts, they can improve identification and assessment of mental health (+LD) problems – perhaps we should be looking at even earlier diversion, i.e. where neighbourhood policing services identify problems?
- Schemes have developed differently and inconsistently, with diverse aims and objectives, should have:
  - Core minimum standards
  - National network
  - Reporting structure
  - National minimum dataset
  - Performance monitoring
  - Local development plans
  - Key personnel

- Recommendation that CJMHTs are made mandatory in the NHS contract for mental health and learning disability to ensure:
  - Focussed liaison and diversion services at police stations
  - Continuity of care across offender pathway
  - Information sharing
  - Data collection
  - Links to MAPPA
- Must have nationally compatible IT infrastructure for information sharing

The questions to discuss and feed-back on are

- What have we got now?
- What are the challenges to make it work better?
- Are there any quick fixes that don’t depend on extra resources?

- Lord Bradley's review of people with mental health problems or learning disabilities in the Criminal Justice System' is at http://www.dh.gov.uk
- The Written Ministerial Statement and Government's response is at http://www.justice.gov.uk