Mentally Disordered Offenders

Inter-Agency Working

Produced by the Home Office and the Department of Health – 1995
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Introduction

It is the Government’s policy that those suffering from mental disorder who require specialist medical treatment or social support should receive it from the health and social services. Those who are suspected of committing criminal offences should be prosecuted where this is necessary in the public interest. In deciding whether a person should be charged, it is essential that account is taken of the circumstances and gravity of the offence and what is known of the person’s previous contacts with the criminal justice system and the psychiatric and social services.

Where proceedings are instituted, access to treatment or care should not be delayed or prevented and the needs of mentally disordered people should be properly met, for example, by the use of bail with a condition of residence at a hostel or a hospital, by remanding to hospital, by transfer from prison to hospital or by the making of a hospital or guardianship order. However, mentally disordered people should not be drawn into the criminal justice system unnecessarily, for example in the hope of securing treatment in prison. Detention in prison is likely to be damaging to the mental health of a mentally disordered person, and the Prison Service is not equipped to provide treatment equivalent to that available in hospital.

These principles were set out in Home Office Circular 66/90 about the provision within the criminal justice system and the health and social services for mentally disordered offenders. It described the existing powers available and it also encouraged the development of inter-agency co-operation as the means of making the most effective use of resources and of developing arrangements so that the treatment and care needs of mentally disordered people are met whether or not criminal proceedings are taken.

Since the issue of the Circular in September 1990, a wide range of initiatives has been undertaken, both centrally and locally. This booklet, which has been produced jointly by the Home Office and Department of Health, gives some information about these developments and reinforces specific points about the role of those involved in cases at a local level. We hope this may be helpful in assisting those working in the criminal justice system and in the health and social services in reviewing current local arrangements and in considering what more might be done to promote effective inter-agency working.
1. **Centrally Funded Projects**

**Pilot Projects**

The Home Office joined with the Mental Health Foundation to fund three pilot projects on mentally disordered offenders to run for three years from July 1990. These were undertaken by the National Association for the Care and Resettlement of Offenders (NACRO) and took place in Birmingham, Kirklees and Liverpool. Their purpose was to encourage effective co-operation between those working in the criminal justice system and the health and social services to ensure that the health and care needs of mentally disordered offenders are met. The aims included identifying the changes needed at a strategic level to make more effective use of available resources, and improving the structures, networks and working practices at service level. It was hoped that this approach would produce examples of good practice for wider application.

A policy development officer was appointed for each area and steering committees set up in all three under the chairmanship of a Senior Recorder for each locality. The other members were senior officials from each of the key agencies in the criminal justice system and the health and social services. The initial meeting of each steering committee was held in March 1991 and interim reports on progress were submitted to a national steering committee comprising officials from the Home Office, the Crown Prosecution Service, the Department of Health and representatives from the Mental Health Foundation.

**Programme of work**

Each local steering committee agreed a programme of work in three phases. The first was to establish a common understanding and approach to the problem which included a comprehensive review of current arrangements for dealing with mentally disordered offenders in the project area. Three types of information were sought; the perceptions of relevant professionals working in this field; factual information about the range and scope of services and resources available and statistical data about the numbers of offenders being dealt with. This produced a core of findings on which recommendations for change could be based.

The second phase involved agreement on, and implementation of, recommendations for change, many of which have already been put in place. Many of these recommendations concerned either new or improved agreements on policies and procedures while others tackled specific problems. They included:

- the development of a rota of trained volunteers to act as ‘appropriate adults’ (who are required to attend during questioning by the police of mentally disordered person);
- improved training for the police, clerks to the justices and magistrates;
- the production of laminated cards setting out procedures and options for the police and courts;
- improved arrangements for passing information to the Crown Prosecution Service; and
- consideration of the development of cautioning panels and a system for ‘fast track’ processing by courts of cases involving defendants suffering from mental disorder.

This booklet describes several of these proposals in more detail.

All three projects have had a considerable impact on local arrangements and acted as a catalyst for other initiatives. There is a clear commitment to continuing inter-agency arrangements beyond the period of NACRO’s direct involvement. In addition to responding to the local recommendations, NACRO produced distance learning materials for the police, magistrates and justices’ clerks.
and good practice guidelines. Policy development officers have arranged seminars for middle managers and front line staff in each of the areas to try to ensure effective dissemination.

**Evaluation**

The final phase involved the evaluation and assessment of the three projects in order to provide information about the resource implications of such schemes and ways in which they might be developed in future. A key finding from the three projects is the need for development to be overseen and driven by inter-agency groupings which bring together senior representatives from all of the relevant agencies. The evidence from the NACRO projects suggests that where such a body is established, together with a clear work programme, it is possible to achieve a good deal within the context of existing staffing and resources, for example, by making effective and appropriate use of key staff time. Such improvements also helped clarify important gaps in existing provision and led to new initiatives such as the attachment of a community psychiatric nurse to a police station in Birmingham (see section 3).

The Home Office Research and Planning Unit has undertaken an evaluation of the pilot projects. It concluded that participants in local steering committees thought the projects had been useful and that, without NACRO’s involvement, change would have been slower and more difficult to achieve. The value of an independent facilitator in helping to obtain inter-agency agreement was also recognised.

An account and evaluation of the NACRO initiative for mentally disordered offenders was published in April 1994 (as a 1994 London Home Office – NACRO – Mental Health Foundation Occasional Paper). This can be obtained from the Home Office Library, Queen Anne’s Gate, London, SW1H 9AT.

**Current work**

The Home Office also funded NACRO to undertake an additional project to assess the extent to which the lessons from the pilot projects have general application. NACRO has identified existing inter-agency initiatives in several new targeted areas and helped to build on these by using a refined version of the comprehensive review undertaken in the three original project areas and by developing improved information recording and monitoring arrangements. NACRO is being funded to continue this project work in 1994/95 and developed a computerised information system to provide quick information about good practice and practical advice on developing inter-agency schemes. Details of the services NACRO offers are set out in the Home Office letter of 26 August 1994 which was issued to health and social services under cover of a Department of Health letter of 26 September 1994.

**Psychiatric Assessment Panels**

Annex C of Home Office Circular 66/90 described a multi-agency assessment scheme in operation in Hertfordshire which had been established to co-ordinate the contributions of various agencies involved in preparing various reports on an accused person’s mental state and the availability of hospital accommodation or community care. The improved service to the court, which receives a more detailed assessment of the accused and information about the available options other than a custodial sentence, enables mentally disordered offenders to obtain access to the health and social services and offers the opportunity of preventing further offending and mental relapse.

In view of the proven value of the Hertfordshire Scheme, the Home Office decided to fund the Hertfordshire Care Trust for two years from Autumn 1990 to employ a probation officer and a community psychiatric nurse to promote the panel assessment scheme and the concept of inter-agency working. The aims of these panels are to encourage closer inter-agency work; to provide courts with more constructive and coherent reports in terms of the assessment of the
individual and to propose a co-ordinated package for the management of the individual’s case which may, where appropriate, include a probation order with or without the condition of psychiatric treatment and may also involve links with the education and housing services.

Although the constitution of a panel may vary according to local requirements, a typical panel may include a consultant psychiatrist, a clinical psychologist, a community psychiatric nurse, a probation officer and a social worker. It may also include a general practitioner, a housing officer, an employer and members of the individual’s family. The initial pattern was for panels to consider cases during the period of adjournment for medical and social reports but during the course of the project a variety of schemes emerged to meet local circumstances.

The high level of commitment of the organisers meant that the development project met its aims very effectively. Requests were received from around the country for the organisers to give advice about multi-agency working and to participate in local steering groups which had set up and managed assessment schemes. At the conclusion of the project, some 40 schemes were in existence and half that number more in planning. The demand created by the organisers’ efforts seems likely to continue for some considerable time.

Evaluation

The Home Office has also undertaken research into the effectiveness of panel assessment schemes and has looked, in particular, at the operation of three specific schemes and the impact at national level of promoting the idea. The study concluded that where panel assessment schemes have been operating they have made a significant contribution to ensuring that properly informed decisions are made about mentally disordered offenders. While there is no single ideal model, because each scheme is adapted to meet local needs, a number of common features were identified as key elements:

♦ all agencies involved must make an initial commitment including a willingness to allocate resources needed to make the scheme work;
♦ a steering group is needed from the outset to give a sense of joint ownership of the project, common purpose and a vested interest in seeing the arrangements succeed;
♦ membership of the group must be at senior level to be able to implement agreed policies;
♦ arrangements must be set up to monitor and evaluate the scheme.

More information is contained in Research and Planning Unit Paper 76 available from the Information Section of the Home Office Research and Planning Unit, Queen Anne’s Gate, London SW1H 9AT.

Contact point

The organisers developed considerable expertise in the practical aspects of multi-agency working and clarifying the roles of the various agencies. Although the project has concluded, one of the organisers – Mrs Dorothy Tonak MBE – has kindly agreed to continue to respond to enquiries about the knowledge and experience she has gained. She has acted as an adviser to the University of Hertfordshire which offers programmes designed to meet the training needs of the various disciplines involved in multi-agency working. She also assists a multi-disciplinary team established by the Centre for Mental Health Services Development at King’s College London, which provides assistance for local agencies in developing joint strategies for improved local services for mentally disordered offenders.

Mrs Tonak can be contacted at: Little Adstock, Adstock, Bucks, MK18 2HT (0296 713439) or The Centre for Mental Health Services Development, King’s College London (0171 333 4194).
Enquiries about the University of Hertfordshire programmes should be made to:

Lisa Maclean, Division of Mental Health, School of Health and Human Sciences, University of Hertfordshire (01727 823333 ext 2763). After June 1995, enquiries should be directed to the Hatfield Campus (01707 284000).

REGIONAL CONFERENCES

A major joint central initiative in 1992/93 to promote inter-agency co-operation and the development of effective local inter-agency arrangements has been the series of conferences in the (then) 14 health regions in England and in Wales. The Home Office, with the support of the Department of Health, commissioned and funded the Mental Health Foundation to organise the conferences, which were aimed at senior managers and practitioners in the health and social services as well as senior members of the judiciary, magistrates, the legal profession, the police and the prison, court and probation services.

The purposes of the conferences were defined as follows:

(i) to stimulate joint working between health and social services in both the statutory and non-statutory sectors, criminal justice agencies, magistrates and the judiciary;

(ii) to emphasise the importance of effective arrangements for the assessment and, where necessary, access to health and social services of mentally disordered offenders (whether detainable or not under the Mental Health Act 1983);

(iii) to consider the full range of services that needs to be in place to complement (ii) as well as their planning, purchasing and provision; and

(iv) to encourage the joint development of local action plans.

The consensus of those involved in the organisation of the conferences and participants who responded to the delegates' questionnaire is that the events have been successful and, in general, met most of the aims of the project. In particular, the conferences have raised awareness of mental health issues and of the nature and concerns of the different services and professions in relation to them and generated considerable interest in carrying forward issues at the local operational level as well as at management level. A significant degree of agreement, enthusiasm and commitment among all practitioners was evident although a wide range of issues and questions were identified about the difficulties in taking forward inter-agency working.

Evaluation

The Mental Health Foundation published a report on the conferences in November 1994. It includes the findings of a survey of over 200 delegates, undertaken by the Home Office Research and Planning Unit, which indicates that these events are regarded as having made a useful contribution to the development of local arrangements. The report has been circulated widely to those working in the criminal justice system and in the health and social services. Further copies are available (price £9.50) from the Foundation at 37 Mortimer Street, London, W1N 7RJ. The two Departments, together with the Foundation, are considering how best to build on the achievements of the conferences.
2. Health and Social Services

Health care policy

The Government supports the policy that mentally disordered people who require treatment and support because of their health care needs should be cared for or treated:

♦ with regard to the quality of care and proper attention to the needs of individuals;

♦ as far as possible, in the community rather than in institutional settings;

♦ under conditions of no greater security than is justified by the degree of danger they present to themselves or others;

♦ in such a way as to maximise rehabilitation and their chances of sustaining an independent life;

♦ as near as possible to their own homes or families, if they have them.

Review of services for mentally disordered offenders

A joint Department of Health/Home Office review of services for mentally disordered offenders (The “Reed” Committee) completed its work in 1992. It circulated for consultation eleven advisory reports – which have now been published in 7 volumes between 1992 and 1994: the Final Summary Report (Cm 2088); service needs (report of the community, hospital and prison advisory groups and a Steering Committee Overview); finance, staffing and training; the academic and research base; special issues and differing needs; race, gender and equal opportunities; and people with learning disabilities.

Copies of all these documents can be obtained from HMSO.

A copy of the chapter in the review’s final report discussing the way forward is given in the annex to this booklet.

The Government considers that the findings of the review will set the agenda for the development of services for mentally disordered offenders for many years to come.

Advisory committee on mentally disordered offenders

The Secretary of State for Health and the Home Secretary have accepted a recommendation arising from the review of services to appoint an advisory committee on mentally disordered offenders. Its terms of reference are to advise the Government on issues referred to it arising from the implementation of the recommendations of the Reed Committee and on other issues relating to provision for mentally disordered offenders referred to it by the two Departments. Its members are drawn from relevant services in health and social services, the criminal justice system, and the voluntary sector, together with representatives of government departments. Its secretarial is provided jointly by C3 Division of the Home Office and the Health Care Division of the Department of Health.

Review of Legal Powers and Community Care

An official review team was formed in January 1993 to consider urgently whether new legal powers are needed to ensure that mentally ill people in the community get the care they need and whether the present legal powers in the Mental Health Act 1983 are being used as effectively as they can be. It was carried out in the light of the fact that the principle of a locally-based service for mentally ill people has proved to be successful: the great majority of discharged patients are leading peaceful and safe lives in the community.

As a result of the review, the Secretary of State for Health announced on 12 August 1993 a Ten Point Plan to reinforce community care for mentally ill people. The Ten Point Plan is designed to strengthen the working of the Care Programme Approach, in particular for the most vulnerable
patients. It includes a new power of supervised discharge to improve the care of patients who have been detained under the Mental Health Act 1983 who need special support after they leave hospital. Legislation will be introduced at the earliest opportunity.

Guidance on the discharge of mentally disordered people and their continuing care in the community was issued to health authorities and local authorities in May 1994 (HSG(94)27/LASSL(94)4). This will be supplemented by the publication of a new Guide to Arrangements for Inter-Agency Working for the Care and Protection of Severely Mentally Ill people, which was issued for consultation on 10 October 1994.

**Mental Health Task Force**

A special Mental Health Task Force started work in January 1993 to promote and assist the more concerted, comprehensive and speedy implementation of Department of Health policies for mental health services, with particular regard to the creation of more locally based and accessible services.

**Social Services Training Package**

In mid 1993, NACRO (National Association for the Care and Resettlement of Offenders) was commissioned, through the Social Services Training Support Programme, to prepare a social services training package about working with mentally disordered offenders. The training pack was launched in March 1994. It has been circulated to all social services departments, probation services and police forces. It is also available to health authorities on request from the Department of Health. NACRO and the Social Services Inspectorate have been running a series of seminars (1994/95) to promote the training package.

The Department of Health has also commissioned the preparation of guidelines on training forensic social workers, which will be available in 1995.

**Key requirements for health and social services**

The Department of Health has helped raise the awareness of mental illness and push forward action by the relevant services by including it as one of the five key areas in the Government's strategy for health. ‘The Health of the Nation’ White Paper (CM 1986, 1992).

The NHS planning and priorities guidance for 1994/95 (NHS Management Executive Letter (93)54 and EL(94)55) has:

- identified services for mentally disordered offenders as a “first order” Ministerial priority; and
- made clear that future service development should follow the direction set by the DH/HO review.

The guidance requires NHS authorities to work with personal social services and criminal justice agencies to develop strategic and purchasing plans for services for mentally disordered offenders and similar people, based on the joint Department of Health/Home Office review of services. These should include:

- an effective range of non-secure and secure services (including those for patients with special or differing needs, such as people with learning disabilities or psychopathic disorder, ethnic minorities, young people and women);
- arrangements for the multi-agency assessment of offenders and, as necessary, access to health and social care services;
- meeting the mental health care needs of transferred or discharged prisoners;
- the placement, within six months, of special hospital patients who no longer require high security.

For the time being services for mentally disordered offenders must be protected at least at 1993/94 levels until 31 March 1995. (Executive Letter (92)6,
as modified by the NHSME Communications Summary, April 1994).

Regional Directors of Public Health have co-ordinated a comprehensive needs assessment for mentally disordered offender services, in which the Special Hospitals Service Authority and the Prison Service were involved (NHS Management Executive Letter (93)68).

**Care Programme Approach**

From 1 April 1991 all district health authorities were required to initiate the Care Programme Approach in collaboration with local social services departments (Health Circular (90)23 and Local Authority Social Services Letter (90)11). This involves drawing up explicit individually tailored care programmes for all in-patients about to be discharged from mental illness hospitals and all new patients accepted by the specialist psychiatric services. The needs of each patient, both for continuing health and social care and for accommodation, should be systematically assessed and the appropriate arrangements made. A key worker is identified to keep in close touch with the patient and to monitor that the care package is, in fact, delivered. If an adequate package of care cannot be agreed and provided in the community, the patient should be offered alternative in-patient care.

The Government has taken several further steps to reinforce community care for mentally ill people, including the introduction of the Mental Illness Specific Grant to encourage local authorities to increase the level of social care available to people with a severe mental illness, the issuing of guidance on the discharge of mentally disordered people and their continuing care in the community (Health Service Guidelines (94)27/Local Authority Social Services Letter (94)4) and the introduction of supervision registers. The latter are aimed at those patients who are judged to be at significant risk of suicide, severe self-neglect or of committing serious harm to others.

**Key Factors**

The Department of Health has identified certain mechanisms as essential in providing an effective service for the health and care needs of mentally disordered offenders. These are:

♦ a multi-agency focus to ensure that all those with a responsibility for mentally disordered offenders, whether in the statutory, voluntary or independent sectors, are working to a common agenda;

♦ arrangements at the court and pre-court stages for assessing mentally disordered offenders and ensuring they obtain access to the appropriate health and care services;

♦ links between the NHS and prisons for the effective transfer of mentally disordered prisoners who require in-patient mental health treatment and to plan continuing care on release;

♦ application of the Care Programme Approach to ensure that the care of patients with mental health care needs who are discharged from hospital or prison is properly co-ordinated (involving criminal justice agencies where necessary).

The main elements of this service are:

♦ a range of community services, including supported and non-supported accommodation, day care and primary or out-patient health care. Other services such as employment and education, may also be needed;

♦ secure and non-secure hospital services, including;

♦ in-patient psychiatric care, either on a general ward or with a low degree of security (eg an intensive care or locked ward);

♦ medium secure or similar services (for both short or long-term in-patient treatment) and associated “outreach” services;
♦ high security provision (currently in the special hospitals, which are a centrally-financed service). There need to be effective links between special hospitals and the wider NHS. Two Regions (South Western and Mersey) have recently signed service agreements with the Special Hospitals Service Authority.

For offenders with learning disabilities, there must be special attention to:

♦ people with mild to moderate disabilities who are liable to fall through the net of care;

♦ people who need some form of secure provision.

Central capital funds of over £45 million have been allocated in the period between 1991-1995 to increase the number of NHS places nationally from about 700 at present to more than 1150 in 1996. Development beyond the current target will be based on local comprehensive assessments of need. Further capital funds to develop medium secure places will be made available through the main NHS capital programme if commissioning authorities and trusts agree that there is a viable case for doing so. This procedure allows authorities to establish their own priorities and seek funding to develop services accordingly.

£4.4 million additional revenue funding (in 1994/95) has been allocated nationally for the purpose of helping to fund medium secure places. This includes support for places that are being made available on a short term basis to relieve current pressure either within the NHS or in the private sector. The additional revenue can also be used to assist with start-up costs, including staff training as new places come on stream.

Needs assessments for a range of secure and some non-secure services were undertaken by Regional Directors of Public Health in 1992 and 1993 (NHS Management Executive Letter (93)68). The Special Hospitals Service Authority and the Prison Service also took part. Consideration is being given to future arrangements for these services. The Department of Health wishes to see the medium secure programme diversify to include longer-term provision and services for specific groups.

Local authority community care plans

A scrutiny of local authority community care plans for 1993/94 indicated that about half had included services for mentally disordered offenders. Health and social services agencies should involve criminal justice agencies in identifying service planning requirements in community care plans. It is important that health authorities provide local authorities with information about mentally disordered offenders. A training package for social services staff working with mentally disordered offenders, produced by NACRO, was launched in March 1994 and is being supplemented by a series of seminars.

Wales

Policy in Wales in relation to health and social care derives from three strategic documents: Mental Illness – strategy for Wales; the protocol for Investment in Health Gain – Mental Health, and the report of the All Wales Advisory Group on Forensic Psychiatry. The latter in particular addresses the needs of mentally disordered offenders and appropriate service responses. It also informed the police decision in Wales for the strategic development of forensic services.

The mental illness strategy confirms the need to give highest priority to the most seriously ill and the most vulnerable. It has established an annual review process with comprehensive plans for each country compiled on an inter-agency basis.

Reference should be made to the Welsh Office for clarification of policy as it affects the principality.
3. **Police**

The police service will be the first contact that mentally disordered people have with the criminal justice system. This may be because intervention is called for under the terms of sections 135 and 136 of the Mental Health Act 1983 in the interests of a mentally disordered person who may be thought to be in need of care or control. It may also be because the person is suspected of committing an offence. Circular 66/90 provided guidance on the police response in such circumstances. The following points are intended to supplement that Circular.

**Definition of mental disorder**

It is important to recognise that the term mental disorder (which is used in legislation) includes mental illness, psychopathic disorder and mental impairment. The term mental impairment refers to people with mental handicap and is also known as learning disability. Mental handicap/learning disability can be a mild, moderate or severe disability which may affect the ability of individuals to communicate and/or to understand. This is of particular relevance in deciding whether to call an appropriate adult, and also in developing training.

**Co-ordination**

It may be helpful for a senior police officer of Assistant Chief Constable rank to take on responsibility for the development of force policy in relation to mentally disordered people and to ensure that effective co-operation is developed with other services and agencies both in the criminal justice system and health and social services. This would include responsibility for the force’s policy on deciding when to charge, to caution, or to take no further action, in relation to mentally disordered people; for the establishment of procedures in agreement with local health authorities to ensure that people with mental health needs who are detained are seen at an early stage by a mental health professional such as a psychiatrist or a community psychiatrist nurse and, where appropriate, an approved social worker; and, taking into account advice from the health and social services representatives, for ensuring that suitable arrangements are in place for the detention and examination of mentally disordered people.

**Local Schemes**

The following are three examples of locally developed schemes which may be of particular assistance to the police in responding to cases where mental disorder is suspected.

**Barnet Crisis Intervention Service**

This is a 24-hour, seven days a week, on-call service in which a multi-disciplinary team (doctor/social worker/community psychiatric nurse) provides support to those experiencing mental health or emotional crises. It has been in operation since 1970.

The rationale behind the scheme is that early intervention, preferably in the home where individuals are likely to be less confused, will in many cases enable problems to be dealt with without recourse to hospital admission or heavy medication. It is, therefore, concerned with prevention and treatment not simply assessment. It has resulted in a dramatic reduction in the need for psychiatric beds in the area (to about one-third of the national average) and a reduction in the use of medication and in the number of suicides and attempted suicides in the district.

Some individuals may have, or might have in the future, come to the attention of the police and so the service has acted to prevent individuals from becoming involved in the criminal justice system as well as from in-patient care. Referrals will usually be from GPs but they could also come from the police when the team will not only assess but provide follow-up treatment as well.

The service is part of the psychiatric service for the Barnet area and receives no special funding, although the savings it generates more than compensate for the costs. Further information about the service can be obtained from Dr Ratna, Consultant Psychiatrist at the Barnet Psychiatric Unit, Barnet General Hospital, Welhouse Lane, Barnet, Hertfordshire EN5 3DJ. (0181 449 5707).
Canterbury and Thanet Community Healthcare Trust

A multi-agency working party was set up in April 1991 with representatives from the police, probation service, courts and health and social services, chaired by the Director of Mental Health Services for the Trust, in response to concerns about the numbers of people with mental health care problems who were being remanded to prison.

The police station was identified as the place of initial intervention. The police surgeon, having been called out by the duty officer, calls on the duty psychiatrist and approved social worker to assess individuals at the police station who might then be directed into health or social care as appropriate. The scheme has resulted in a considerable reduction in the number of mentally disordered offenders having to be referred to the court. Further information can be obtained from Ian Wright, Director of Mental Health Services, Canterbury and Thanet Community Healthcare Trust, Littlebourne Road, Canterbury, Kent CT1 1AZ (01227 459371).

Bourneville Lane Police Station

A community psychiatric nurse (CPN) is based at this police station to offer advice and guidance to the police on how to respond to the needs of mentally disordered offenders and to obtain access to the psychiatric and social services. This pilot scheme has been running since October 1992 and includes two other police stations within B Division of the West Midlands Police.

The main benefits of the scheme include better and more comprehensive assessments at the police station because the CPN works with the custody sergeant on a daily basis; improved access to psychiatric services and the opportunity for the CPN to liaise with other agencies where hospital admission is not appropriate and to offer follow-up care.

Further information about the service can be obtained from Stuart Wix, Community Psychiatric Nurse at the Reaside Clinic, Bristol Road South, Rubery, Rednal, Birmingham B45 9BE (0121 453 6161).

Place of Safety

Circular 66/90 drew attention to the desirability of ensuring that, wherever possible, police stations are not used as places of safety for the detention of mentally disordered people. Police stations will not have the facilities necessary for the welfare of such people and detention in them is likely to be damaging to their health.

The police service is asked to agree with local health authorities and social services departments suitable arrangements for the detention and assessment of mentally disordered people. This may involve the use of social services accommodation or hospitals, depending on availability and on whether the person is likely to require hospital treatment.

In cases where the use of police stations cannot be avoided – for example, in relation to the investigation of serious offences – it may also be advantageous for each police force to consider developing a policy on the use of specific, identified police stations for the detention of mentally disordered people where arrangements can be established for their speedy assessment by a mental health professional. These could be designated stations established under the Police and Criminal Evidence Act. With this approach, it may be possible to arrange at all times, at specified stations, for there to be on duty a police officer who has specialist training in dealing with mentally disordered people. Alternatively, forces may prefer using a ‘call out’ system of trained officers.

When to consider charging

The police have a crucial role to play in determining whether a mentally disordered person enters the criminal justice process. The existence of mental disorder should never be the only factor considered in reaching a decision about charging. The need to protect the safety of the public may indicate that formal action is needed. It is important to recognise that prosecution does not prevent the individual having access to the health and social care services. A range of options is available to courts to ensure that a person
receives treatment and care (see Section 5). A mentally disordered person can also be transferred from prison to hospital by the Home Office (see Section 6).

Determining when prosecution is the proper course can be a finely balanced judgement. To help reach a decision, the police will need to find out whether the person has any history of mental disorder or has had any previous contact with the criminal justice system. Good links with the local psychiatric and social services are essential to provide a ready source of advice about the person’s current mental state and any previous psychiatric history.

This information should help the police to determine whether an incident can be assessed as an isolated event, and to decide an appropriate way forward, taking account of the gravity of the offending and the potential risk to others if the behaviour recurs. Although an incident may be a minor matter in itself, it is important to establish whether it represents the latest in a developing pattern of dangerous behaviour which requires intervention by the criminal justice system for the protection of the public.

The police will want to consider any options offered by health and social services staff which may include compulsory admission to hospital using the powers available to doctors and social workers under the Mental Health Act. However, if the person’s current or previous behaviour appears to put others at risk, it will be preferable to charge so that the court can consider whether a disposal, such as a hospital or guardianship order, is required for the longer term protection of the public as well as enabling the person’s health and care needs to be met.

**No further action and cautioning**

In cases where prosecution is not necessary in the public interest, Chief Officers of Police will wish to ensure that adequate alternative forms of response are available. This may involve no further action by the police, or the cautioning of suspects if they are able to understand the implications of their actions and this is not a case of repeated offending. In such circumstances, it will be desirable to coordinate the response of the police with the local probation and social services to ensure an appropriate response to the person’s mental health needs.

**Information and training for police officers**

The use of specified stations for the detention of mentally disordered people will help in ensuring the involvement of police officers with the necessary knowledge of procedures for responding and for liaising with other services. It will be helpful also to make widely available to all officers who come into regular contact with members of the public brief guidance on relevant information and action to take. This might be done, for example, by means of a plastic laminated card or, alternatively, where there is a central command and control computerised system this may produce a guidance checklist.

Chief Officers will also wish to consider whether current arrangements adequately meet police training needs, particularly for officers whose duties mean they may be called on to assist mentally disordered people. The following two initiatives may be of interest:

Merseyside Police has produced a training package which provides officers of all ranks (but particularly beat officers) information that will be of use in their dealings with mentally disordered people in public and private places. The package consists of a booklet (The Mentally Ill in the Community) and an accompanying video. The booklet gives details of medical terminology, summarises and defines the most common mental disorders (signs and symptoms), provides a range of do’s and don’ts in terms of police approaches, considers the management of violence and provides flow charts of the ways in which a mentally disordered offender might be dealt with depending on particular circumstances. The video covers similar aspects and is intended to accompany the manual. Further information is available from Inspector Barry Delaney, Merseyside Police, 0151 777 6061.

The Metropolitan Police, in partnership with the British Transport Police and the National Schizophrenia Fellowship,
launched a new training video in October 1994. The video (A Meeting of Minds) forms part of a package, available from the end of 1994, intended to address training for officers from constable to inspector. Officers will first receive a distance learning module on legislation, local practice and procedures, and recognising and responding to mentally disordered people. They will then take part in a seminar or workshop based discussion. This will include the video which aims to dispel some of the myths surrounding mental illness and to show officers how to make informed judgements about the best course of action in situations involving mentally disordered people. Further information is available from Inspector Chris Auger, Central Planning Unit, Yew Tree Lane, Pannal Ash, Harrogate, North Yorkshire HG2 9JZ (01423 871201).

Information for the Crown Prosecution Service

In deciding whether to prosecute, the Crown Prosecution Service is guided by the Code for Crown Prosecutors. If there is enough evidence to prosecute, Crown Prosecutors will also need to consider the public interest factors in reaching a decision about prosecution. They must balance the factors for and against carefully and fairly. While the existence of mental disorder is a factor against prosecution, it must be weighed against the seriousness of the offence and the possibility that it might be repeated.

It is consequently important for the police and the Crown Prosecution Service to be aware, from an early stage, of any relevant information concerning an accused person’s mental disorder so that this can be taken fully into account. For example, where prosecution is necessary, a remand to hospital can be made by the court rather than to prison custody.

There are a number of stages at which information about the defendant’s mental state may be sought. For example, the police may identify a potential problem and seek medical advice pre-charge. After the police have charged or bailed the defendant, it will fall to either the court or the defence to seek a medical report if a mental health problem is suspected. It is customary for the prosecution to be shown a report ordered by the court, but there is no requirement or equivalent customary practice for the defence to disclose the contents of any report which it has sought.

There may well be some rare circumstances when the Crown Prosecution Service wishes to have its own report on the defendant’s mental condition. In such circumstances it is open to the Crown Prosecution Service to approach the defence to obtain agreement to the defendant being seen by another doctor so that a further medical report may be prepared.

It should be noted that in the case of a defendant charged with murder, a medical report should be obtained before bail is granted. In the case of a defendant who is in custody, the Crown Prosecution Service will assist the court in obtaining a medical report by submitting the committal papers.
to the Prison Health Care Service or to a nominated doctor once committal has taken place.

Any information the police have about an accused person’s psychiatric condition should be recorded in the police file which is passed to the prosecutor. Where the police have arranged for a detained person to be examined by a medical practitioner in accordance with the requirements of the Code of Practice for the Detention, Treatment, and Questioning of Persons by Police Officers issued under section 66 of the Police and Criminal Evidence Act 1984, or by a community psychiatric nurse where arrangements for this have been set up in conjunction with a local health authority, a note of the medical practitioner’s or nurse’s assessment and advice should be included in the file that is sent to the Crown Prosecution Service.

Appropriate adults

The presence of an “appropriate adult” during the questioning of mentally disordered persons suspected of committing an offence is required in circumstances set out in the PACE Code of Practice Code C (in particular Annex E of Code C). To ensure that the police have ready access to people who are suitable to act as appropriate adults, Chief Officers are asked to discuss with Directors of Social Services, Chief Probation Officers and representatives of voluntary organisations arrangements for access to such people who may, for example, include people from voluntary bodies specialising in providing care and support for mentally disordered people. It is important that anyone acting in this capacity has received training in order to carry out the role effectively.

There is a potential conflict which may arise where an approved social worker is called in by the police to make an assessment for the purposes of the Mental Health Act and is subsequently requested to perform the role of “appropriate adult” during an investigative interview. One person should not be asked to fulfil both functions. Similarly, it would be undesirable for the person’s own probation officer to be asked to undertake the role.

In September 1994, the Home Office began a review of the role and functions of the appropriate adult and related matters, such as their availability and the need for training and improved guidance.

Mental health assessment schemes at magistrates’ courts

The Government welcomes the development of arrangements at magistrates’ courts which facilitate the assessment of accused persons and a response to their mental health needs. This ensures that courts have expert advice which may assist them in the exercise of their powers, and it helps facilitate access to the health and care agencies and to avoid unnecessary remands to prison custody. Further details are given in section 5.

The co-operation of the police will play an important role in ensuring the success of such schemes at courts, in particular in establishing arrangements for access by mental health professionals to people detained in cells at courts, and in assisting in the transporting of mentally disordered people to hospital where a police presence is desirable for the protection of the public. Chief Officers are asked to co-operate with courts, probation, and health and social services in ensuring the success of such arrangements.
4. **Probation Service**

The probation service has an important role to play in relation to mentally disordered offenders in fostering the development of close co-operation at a local level between the criminal justice system and health and social services. Where prosecution is necessary in the public interest, the probation service will wish to ensure that the Crown Prosecution Service and the courts have relevant information available to them to enable the court to decide whether the defendant can be safely bailed or remanded to hospital instead of prison before conviction and sentence, and to decide on the suitability of non-custodial disposals after conviction. The probation service will also wish to ensure that arrangements exist locally so that, where a prosecution is not necessary in the public interest, mentally disordered people are not drawn unnecessarily into the criminal justice system (for example, in the belief that only this course will ensure access to treatment).

**Co-ordination with health and social services**

Chief Probation Officers may find it helpful to allocate to a senior member of their service responsibility for developing service policy in relation to mentally disordered offenders, for liaising at a senior level with members of related services, and in particular for developing co-operation with directors of social services. This will include regular reviews jointly with local social services management of the arrangements for responding to the needs of mentally disordered offenders and the development jointly of plans to improve that response where necessary.

A guide for probation service managers on working with the health and social services in the management of mentally disordered offenders has been prepared by the Association of Chief Officers of Probation. Copies are available from the Association of Chief Officers of Probation; 20/30 Wakefield Lane, Wakefield, West Yorkshire WF2 85P (01924 361156).

**Information for the courts**

At courts where arrangements have been established for access to mental health professionals to assess defendants and advise on appropriate intervention, the probation service should be satisfied that effective arrangements are in place to identify defendants who might benefit from such an assessment and to ensure they are able to receive it. In other cases, the probation service will wish to consider in consultation with justices clerks and local health and social services whether further steps are desirable to ensure that courts receive appropriate information about the mental health of defendants, for example through the commissioning of psychiatric reports for courts.

**Bail**

Bail Information Officers need to use specialist resources to help assess and meet the needs of mentally disordered offenders, so that they can safely put forward information to help the court decide whether a non-custodial remand is appropriate. The probation service will wish to consider how access to these resources can best be obtained.

The probation service has an important role to play in ensuring the availability of accommodation. Responsibility for providing accommodation may rest with other services. For example, in the case of people released on police bail, it may be appropriate to look to local housing authorities, social services or voluntary organisations for assistance in providing accommodation. If a court grants bail with a residence requirement, an approved bail hostel might be appropriate. The probation service will wish to consider whether the range of accommodation and its accessibility is sufficient to ensure that mentally disordered people are not remanded to prison solely because of their homelessness or for lack of suitable facilities in the community. Consequently adequate support must be available in bail hostels both for the bailee and for the staff of the hostel to enable them to respond effectively to the needs of bailees who are mentally disordered.
Psychiatric assessment panels

These were described in Section 1. The Probation Service will wish to be involved in monitoring the progress of these schemes to ensure their effectiveness.

Non-custodial disposals

Chief Probation Officers are asked to review, in conjunction with local health and social services, the effectiveness of non-custodial disposals with which they are involved. It is important that mentally disordered offenders who require medical supervision or treatment are able to receive it in the community where it is in their mental health interests and this does not put members of the public at risk. The probation order with a condition of psychiatric treatment offers a useful means of enabling the court to achieve this.

The number of probation orders with conditions of treatment has been steadily decreasing over the last 10 years. HM Inspectorate of Probation has undertaken an examination of the use of such orders in five probation areas to try to identify how their effectiveness can be assessed and improved. Just under 140 individual cases were examined, many of which were extremely complex, but the Inspectorate concluded that some 60% of these had been effective disposals. The report identified a range of factors which can influence the effectiveness of such orders and made a number of recommendations, in particular, concerning the need to increase inter-agency contact and to improve the policy and procedures for making orders and their subsequent supervision.

The Home Office is considering jointly with the Association of Chief Officers of Probation, the best way forward in responding to these recommendations. The report was published in November 1993 and copies were circulated to the Probation Service. Additional copies are available from HM Inspectorate of Probation, Room 355, Home Office, Queen Anne’s Gate, London SW1H 9AT.

There may be other circumstances in which medical treatment is not appropriate for mentally disordered people, who will nonetheless be eligible for other non-custodial disposals, such as probation orders, or community service orders. The suitability of such disposals should be assessed in each case in the light of the needs of the individual concerned, and defendants should not be excluded from consideration solely on account of their mental disorder.
5. Courts

**Magistrates’ Courts**

Justices’ Clerks will wish to review the arrangements at their courts for obtaining professional advice to ensure the identification of defendants suffering from mental disorder and to avoid remanding them to prison. Circular 66/90 drew attention to the options available to the courts both before and after conviction.

Guidance has also been issued by the Lord Chancellor’s Department in the booklet entitled “Best Practice Guide on Mentally Disordered Offenders” available from the Courts Business Branch, Magistrates’ Courts Division, Lord Chancellor’s Department, 30 Great Peter Street, London SW1P 2BY.

The Government attaches importance to ensuring that those suffering from mental disorder are not imprisoned unnecessarily. If medical reports are required before sentence, arrangements can be made for this either on bail, from an assessment scheme or through a remand to hospital. If treatment is thought desirable after conviction this can be provided in the community, for example by means of a guardianship order or, if the offence is serious enough and there is a medical recommendation, a probation order with a condition of psychiatric treatment. Treatment in hospital as an in-patient is available both as part of a probation order with a condition of psychiatric treatment and under the provisions of hospital orders. In the case of defendants whose mental disorder is not amenable to, or does not require, medical treatment, the courts will wish to consider their suitability for other non-custodial disposals.

**Mental health assessment schemes at magistrates’ courts**

Arrangements for providing the magistrates’ court with advice and assistance from mental health professionals have now been established at many courts. The Home Office has made funding available to assist about 50 such schemes by meeting the costs of psychiatrists or community psychiatric nurses who attend court. Rural courts which only occasionally have to deal with mentally disordered offenders may, where jurisdiction allows, wish to consider making arrangements for such cases to be heard at a convenient larger court where an assessment scheme operates.

There is no one preferred model for an assessment scheme which should be designed to reflect the local needs of magistrates courts and the availability of local health and social services. It is important, however, that in developing a scheme, a range of practical factors are considered and that any areas of potential uncertainty about the operation of the scheme and the respective roles of participating services and agencies are resolved. The issues which need to be addressed include:

- assessment of the likely local need;
- local agreement between those working in the criminal justice system and the health and social services about the nature of the scheme with a clear understanding from the outset of the contribution from each and where the lead responsibility lies;
- whether there are other interested parties such as defence solicitors, housing officers or voluntary agencies which could usefully be involved;
- depending on the type of scheme, access to a psychiatrist or a community psychiatric nurse and an approved social worker on a regular basis or on call;
- clarification and resolution as far as practicable of difficulties arising from the lack of common boundaries and catchment areas;
- clearly defined arrangements for activating the scheme; access to interviewing facilities and office support and access to court records subject to suitable safeguards;
- clear responsibility for the provision of suitable transport for those admitted to health or social services provision and for their return to court if need be;
- clear relationship with Bail Information schemes and local arrangements for providing information for the Crown Prosecution Service.
**Training**

An example of a local training initiative is the multi-agency programme devised in Tynedale at the instigation of the Court Users Group and in conjunction with the local psychiatric services. A series of seminars, under the heading “Dealing with Mentally Disordered Offenders”, was developed to cover a range of mental health clinical and legal aspects and further training sessions are in preparation. Further details are available from Miss P Axon, Clerk to the Justices, Tanner House, 20 Gilesgate, Hexham NE46 3QD.

**Crown Courts**

Guidance was provided in paragraphs 10-16 of Circular 66/90 on the powers available to Crown Courts in relation to mentally disordered people. The law in relation to people found unfit to plead or not guilty by reason of insanity, which was described in paragraphs 13 and 16 of that Circular, was amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991. Guidance on its provisions was given in Home Office Circular 93/91.
6. **Prison Service**

**Health Care Service for Prisoners**

It is the responsibility of the National Health Service to provide treatment for mentally disordered offenders who require treatment in hospital for their mental disorder. The Prison Service is responsible for the provision of primary health care compatible in range and quality to that provided in the community by general practitioners and out-patient services. It is its policy to provide such care through a combination of directly provided services and through contracting-in from outside health service providers such as the National Health Service. However, mentally disordered offenders needing psychiatric in-patient treatment should be transferred to hospital for that treatment. They cannot receive equivalent treatment in prison, as the Prison Service is not equipped to provide it, and detention in prison is likely to be damaging to the mental health of a mentally disordered person.

For prisoners who are regarded as requiring treatment in hospital for mental disorder, arrangements will be made to transfer them to hospital under the provisions of sections 47 and 48 of the Mental Health Act 1983. Close cooperation with the National Health Service has resulted in a substantial increase in the numbers of such patients in recent years. However, it remains a cause of concern that seriously mentally disordered people are inappropriately committed to prison and the Prison Service will lend full support to arrangements designed to reduce the likelihood of this happening, such as the development of arrangements for psychiatrists to assess people detained in police stations, and the establishment of inter-agency panels and assessment schemes at courts.

Prison medical officers were asked in Circular 66/90 to ensure they had in place effective arrangements for examining all new arrivals in their prison to ensure the speedy identification of mental disorder. In all cases where a prisoner is identified as requiring treatment in hospital a request should be made to his/her local hospital psychiatrist, or to his regional forensic psychiatrist, or to a special hospital, according to the patient’s treatment and security needs, for an assessment to be made with a view to making a hospital place available. In any case of difficulty, C3 Division of the Home Office should be informed at an early stage so that they may assist in resolving problems which may arise. Guidance on these arrangements have been provided to all prison medical officers by the Director of Health Care and by C3 Division.

**Remand prisoners**

Remand prisoners have the same right to hospital treatment as all other citizens. Medical officers should bear in mind the possibility of arranging their transfer to hospital when examining them and forming a view on their treatment needs. In any case where a medical officer reaches the view that a remand prisoner would, if still in the community and seen on an out-patient basis, be assessed as requiring in-patient treatment for mental disorder, the medical officer should seek to arrange transfer to hospital in the normal way. In case of difficulty, C3 Division should be informed.

Where a remand prisoner is transferred to hospital under the provisions of section 48 of the Mental Health Act 1983 for treatment, the receiving hospital will wish to consider whether it would be appropriate to recommend to the court detention in hospital after conviction through the making of a hospital order under the provisions of section 37 of the 1983 Act, or the suitability of some other form of treatment oriented disposal such as a probation order with a condition of psychiatric treatment or a guardianship order. Consideration of these courses of action will help to remove the need for the patient to return to prison.

Close links with the health services and C3 Division are essential for transfers to be arranged effectively.

**The Bracton Clinic/ HM Prison Belmarsh Scheme**

A good example of links with the National Health Service working effectively may be found in the scheme run by the Bracton Clinic at Bexley Hospital and HM Prison Belmarsh. The Bracton Clinic provides a court liaison service at four magistrates’ courts in its catchment area. In addition,
since June 1991, two psychiatrists in higher training have been seconded to the prison. They are responsible for preparing psychiatric reports, providing psychiatric care within the prison health care centre, assessing references from prison medical officers, arranging assessments by catchment area services and expediting transfers to hospital. The scheme is supervised by the Consultant Forensic Psychiatrist at the Bracton Clinic. Further details are available from Dr J Parrott at the Bracton Clinic (telephone 0322 526 282).

Durham cluster/Newcastle Mental Health NHS Trust

A contract has been made with Newcastle Mental Health NHS Trust for the supply of a complete psychiatric service to HM Prisons Durham, Frankland and HM Remand Centre Low Newton. Teams of experienced psychiatrists, nurses and psychologists visit the prisons regularly to assess both remand and sentenced prisoners and to provide appropriate treatment. High priority is given to providing in-patient NHS beds at the earliest opportunity for prisoners whose condition requires treatment in hospital. Further details are available from Dr R G Mitchell, Head of Health Care at HMP Durham (0191 3862621 x2340).

A similar but more limited scheme is in operation at HM Prisons Bristol, Gloucester, Leyhill and HM Remand Centre Pucklechurch. Details of this scheme are available from Dr M Rowlands, Head of Health Care at HMP Bristol (01272 426661).
7. **Legal Representatives**

As a Home Office Circular, 66/90 could not offer guidance on the role of legal representatives, but it is recognised that solicitors, particularly those acting in the defence of mentally disordered suspects, have an important role to play in the implementation of effective inter-agency working and in helping ensure that mentally disordered people gain access to treatment and care services. In preparing this booklet, the opportunity has been taken to include advice relating to the role of the legal representative. This section has been written in conjunction with the Law Society’s Mental Health and Disability Sub-Committee.

It should be noted that solicitors acting for mentally disordered clients retain the duty to listen carefully to the client and where possible to take the client’s instructions and to act on them.

It is recommended that all criminal law solicitors, particularly duty solicitors, should find out about local facilities and services for mentally disordered people. The arrangements of services will vary from area to area, but local information can be obtained from the local social services department, probation service and district health authority and the regional health authority can provide details of any local reception centres and regional facilities (including medium secure facilities) as well as access to national facilities, such as the Special hospitals.

In particular, it is essential for defence solicitors to be aware of, and if possible to be involved in the operation of any local inter-agency assessment schemes for mentally disordered offenders. Again, arrangements for such schemes will vary according to local needs and resources. The local justices’ clerk is likely to be aware of any schemes in the area, and to have details of the contact person.

For out-of-hours emergencies, the regional and/or district health authorities will have identified named psychiatrists who can be contacted for urgent assessment or admissions to hospital, and the local social services department will have an emergency duty team which will include an approved social worker (ASW).

Solicitors acting for mentally disordered defendants will need to have a working knowledge of the following:

- Parts I, II and III of the Mental Health Act 1983 and the accompanying Code of Practice concerning the definitions of mental disorder, and provisions for both informal and compulsory admission to hospital.

- the provision of the Codes of Practice under the Police and Criminal Evidence Act 1984 (PACE), relating to mentally disordered suspects, in particular PACE Code C, Annex E.


- Home Office Circulars 59/90, 66/90, 93/91 and 12/95.


- Local policies made under the Mental Health Act 1983 Code of Practice, particularly for the use of section 136 (police powers to remove a mentally disordered person to a place of safety).

**At the Police Station**

The responsibility for the identification of mentally vulnerable suspects lies with the custody officer, where necessary advised by the police surgeon (forensic medical examiner). However, solicitors will need to be diligent to make sure that “borderline” mentally vulnerable people, who are included within the wide definition of mental disorder under section 1 of the Mental Health Act, are identified so that proper safeguards under PACE Code C can be implemented. The courts are increasingly excluding evidence not taken in accordance with Code C and are criticising solicitors for not giving active advice.

Where an appropriate adult is called in, the solicitor should see the client alone at first, in order to explain, in simple terms, the role of the appropriate adult, and how
that differs from the role of the legal representative. In particular, the solicitor should explain that while he/she is bound by legal privilege the appropriate adult has no such duty of confidentiality and, in certain circumstances, may be asked to pass information to the police in the interest of public safety (see guidance from the Law Society’s Criminal Law Committee, [1993] Gazette 19 May, 41).

Before a mentally vulnerable client is interviewed by the police, the solicitor should spend time with him/her to make an assessment of the client’s ability to understand the caution and the questions put to him/her. It may also be helpful to discuss this with the appropriate adult. It should be noted that verbal performance is often better than intellectual ability, and that mentally vulnerable people, particularly those with learning disabilities, are often easily suggestible and eager to say what is expected of them.

During the interview, the solicitor should ensure that the questions are put in simple language, using terms which are understandable to the client (eg even words like “caution” may mean little to a learning disabled client). The solicitor should be alert to the use of words or phrases which can be misunderstood, and should intervene to ask for questions to be explained, or to remind the client that he/she is not obliged to answer questions if that is the solicitor’s advice.

The solicitor should watch for signs that the client may be getting distressed or anxious, and ask for regular breaks to relieve the stress or to be able to consult privately in order to check the client’s understanding. If the solicitor is not satisfied with the client’s understanding, he/she should ensure that these concerns are fully recorded on the custody record and/or on the tape.

The solicitor should be aware of all possible alternatives to charges being made (as set out in Circular 66/90) in order to assess whether access to the health or care services at this stage might be the appropriate option, or whether the matter can be dealt with through a police caution or other quick disposal. If charges are made, the solicitor should try to avoid the client being kept in police cells, as confinement of mentally vulnerable people can lead to swift deterioration, and should press for the client to be cared for in the least stressful environment. It may be helpful to involve an approved social worker. The solicitor should also press for an early court date, to avoid long delays after charging before appearance in court.

**Appearance in Court**

Before an appearance in court, the solicitor should try to determine whether a psychiatric or other medical report will be required. This should be identified at the first hearing, and the solicitor should also consider making an application to the court to order a pre-conviction report (eg in cases of unfitness to plead, or recommending particular forms of disposal) in order to avoid delay at a later stage. Unless the client gives instructions to the contrary, the court should also be alerted to any previous involvement of the client with the psychiatric services, so that the request for a report can be directed to a psychiatrist known to the client.

Where a medical report is requested by the court, the cost of that report will be met by the court. If the solicitor decides to obtain a medical report, he/she should ensure in legally aided cases that prior authority is obtained from the Legal Aid Board for the funding of that report.

It is essential to try to avoid remands into prison while waiting for the report. All other options should be considered, including:

- bail home with or without conditions
- bail to hospital with conditions of residence/attendance at out-patient clinic etc
- remand to hospital under section 35 of the Mental Health Act 1983

If it proves impossible to find an alternative to remand into custody, the solicitor should as a minimum draw the Court’s attention to para 1.305 of Stone’s Justices’ Manual. If the client is suffering from mental illness or severe mental impairment and is in urgent need of medical attention, the solicitor should discuss with the prison medical officer the possibility of transfer to hospital under section 48 of the Mental Health Act 1983. Where difficulties
develop, the solicitor may find it helpful to contact C3 Division of the Home Office (see also Section 6).

On receiving the medical report, the solicitor should consider sending a copy to the Crown Prosecution Service (CPS) to enable the CPS to consider whether to discontinue the proceedings. However, attention must be given to ensure that mentally disordered people receive the same rights and opportunities as any other suspects to clear their names against wrongful allegations and also, in appropriate cases, to take responsibility for their actions. There should be no assumption that mentally disordered people are necessarily in need of in-patient treatment which may involve an indeterminate period of detention in hospital. A criminal justice disposal may be more appropriate if treatment or care needs can also be met. It should also be remembered that where a prosecution takes place, it is still possible for the client to gain access to the health or social care services.

The solicitor should discuss with the psychiatric services where a plea of ‘Not guilty by reason of insanity’ may be appropriate, if the client fulfilled the criteria set out in the M’Naughten Rules at the time of the offence. In cases where the client is considered unfit to plead at the time of the trial, a committal to the Crown Court should be considered. In both these types of cases, the range of disposals under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 will become available to the court.

Disposals

The solicitor should make representations to the court to consider the disposal most suitable to meet the client’s need. The following may be considered:

- an order for psychiatric treatment without conviction under section 37(3) of the Mental Health Act 1983.

- a probation order with a condition of residence or psychiatric treatment (as an alternative to a hospital order under the Mental Health Act).

- a hospital order under section 37 of the Mental Health Act (as an alternative to a restriction order under section 41 or a custodial sentence).

- an interim hospital order under section 38 of the Mental Health Act (where the court is undecided whether a hospital order is appropriate).

- a guardianship order under section 37 of the Mental Health Act.

- bind over.

- a community service order.

- conditional or absolute discharge.

After Conviction/Sentence

The solicitor should discuss with the client whether to lodge an appeal against conviction and/or sentence. If a hospital order has been made, with or without a restriction order, the solicitor should explain to the client his/her right to apply to the Mental Health Review Tribunal.

If the client is sentenced to imprisonment and his/her condition deteriorates, the solicitor should discuss with the prison medical officer the possibility of a transfer to hospital under section 47 of the Mental Health Act 1983. In cases of difficulty, C3 Division of the Home Office may be contacted (see also Section 6).
8. Homeless and Ethnic Monitoring

Homelessness

Homelessness is a serious problem among mentally disordered offenders, as the presence of mental disorder may undermine a person’s ability to cope and may lead to the loss of his or her home, and the stress of homelessness may exacerbate mental disorder. Circular 66/90 set out the Government’s view that mentally disordered people have the same right to bail as other accused people and that they should not be denied bail either by the police or by the courts simply on account of their homelessness. The final summary report of the Reed review includes (at Annex F to that report) a paper on the needs of homeless mentally disordered offenders.

Ethnic Monitoring

Services for people from black and ethnic minority groups were considered by the Reed Committee which identified a range of concerns and, in particular, took note that studies have indicated that people from the ethnic minorities are more likely than white people to be brought within the scope of the Mental Health Act or detained in a Special hospital (Volume 6 of the Review reports concerning Race, Gender and Equal Opportunities, available from HMSO). The Committee recommended that all agencies involved with mentally disordered offenders should establish strong proactive equal opportunities policies relating to race and culture which should be reflected in staff training and allow for consultation with representatives of ethnic minority groups in the planning, development and monitoring of services.

In addition, the Committee recommended that a co-ordinated system of ethnicity data collection should be established by all relevant agencies. The Department of Health has already taken steps towards this end by announcing in December 1991 that it would be seeking to include in the patient data collected by health authorities information on the ethnic origin of patients to enable effective monitoring of services. Pilot projects have been undertaken in Bristol and Manchester prior to country wide implementation. Section 95 of the Criminal Justice Act 1991 requires the Home Secretary to publish information enabling people engaged in the administration of the criminal justice system to avoid discriminating against any person on grounds of race. The first of these documents, “Race and the Criminal Justice System” was published in September 1992.
Annex:
Extract from final report of Reed Committee (chapter 10)

THE WAY FORWARD

“It eluded us then, but that’s no matter - tomorrow we will run faster, stretch out our arms farther…”
- F SCOTT FITZGERALD, The Great Gatsby, Ch 9

The fundamental issues

10.1 Each of the recommendations in Chapter 11 is a piece 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.

10.2 The planning and development of services must reflect the guiding principles of the review, which, as set out at paragraph 3.3, are that patients should be cared for:

- with regard to the quality of care and proper attention to the needs of individuals;
- as far as possible, in the community, rather than in institutional settings;
- under conditions of no greater security than is justified by the degree of danger they present to themselves or to others;
- in such a way as to maximise rehabilitation and their chances of sustaining an independent life;
- as near as possible to their own homes or families if they have them.

We see the fundamental issues as being:

- a positive approach to individual needs
  a positive approach to the needs of individual patients, many of whom, including women and people from ethnic minorities, may have special or differing needs;
- joint working
  a flexible multi-agency and multi-professional approach whose aim is to identify and meet most effectively the needs of mentally disordered offenders;
- the complementary role of mainstream and specialised services
  the role of general mental health and learning disability services, with access to more specialised services, in providing care and treatment for most mentally disordered offenders;
- the police
  closer working between the police, health and social services to avoid unnecessary prosecution of mentally disordered suspects;
• **the probation service**

the development of the probation service to:
- facilitate effective co-operation at local level between criminal justice agencies and health and social services;
- ensure that prosecutions are not initiated where they could be avoided; and
- to help divert from custodial disposals mentally disordered people who have to be prosecuted;

• **community care**

an improved range of community care services, including accommodation and day services that are suitable as alternatives to prosecution and will meet the needs of homeless mentally disordered offenders;

• **secure and associated services**

the expansion of medium secure and associated "outreach" services, including in particular those to cater for people with learning disabilities and longer-term medium security needs;

• **health care for prisoners**

the improvement of mental health services for prisoners, to be contracted in mainly from the NHS;

• **the academic and research base**

a stronger academic and research base to underpin service improvements and the general and specialised forensic training of staff to work with mentally disordered offenders.

**Evidence of progress**

10.3 There is widespread evidence of a more positive approach by a number of agencies to services in this area. This includes specific follow-up to Circular 66/90 (as shown, for example, by the growth in diversion schemes) and other joint initiatives (such as policy agreements and practice guidelines established at both strategic and working levels, as well as locally organised multi-agency conferences to stimulate awareness and co-ordinated action).

10.4 There is also a growing range of innovative service developments and, to judge by visits and responses to our earlier reports, much enthusiasm and interest. This progress is greatly welcomed, but it represents only a start – taken nationally, a fairly modest start – which needs to be nurtured and supported from the top. In this respect, the responses to the recent needs assessment exercise have been valuable in pointing to those parts of the country where agencies are acting positively and in concert those where they are doing so more haphazardly or, compared to others, less effectively.

10.5 We welcome the sponsorship by the Home Office of a forthcoming series of high-level conferences for health and social services in every Region (including Wales). These events, which are being organised by the Mental Health Foundation, should help to raise further the profile of mentally disordered offenders and seek to stimulate, as an adjunct to formal action that may stem from this review, the multi-agency approach.

**Joint working nationally and locally**

10.6 At the national level, the review itself has contributed to a closer working relationship between the Department of Health and the Home Office. We welcome Ministers' commitment to continue this beyond the review (House of Commons written answers, 13 Nov 1992 and 2 June 1992), but we believe strongly that it requires a continuing formal framework to ensure that awareness of the needs of mentally disordered offenders is sustained and translated into action (OV 32)!

10.7 The new Criminal Justice Consultative Council and the area committees established in the light of the Woolf report will in future provide multi-agency foci for the criminal justice system. These bodies are not designed to provide the focus for health and social services for mentally disordered offenders, although they have an important role to play in some areas (such as health care for prisoners).
Comparable arrangements are needed for mentally disordered offenders. This requires the active participation of all the local agencies concerned, guided and monitored at Regional and national levels. We have already suggested the appointment of consultant advisers in forensic psychiatry as one possible contribution to ensuring that regional Health Authorities have access to clearly identified sources of advice.

The Health of the Nation White Paper

We welcome the priority accorded to mentally disordered offenders in the Health of the Nation (1992, op cit);

The essential task here is to ensure that mentally disordered offenders who need specialist health and social care are diverted from the criminal justice system as soon as possible, this requires close co-operation between all the local agencies concerned. Authorities' strategic and purchasing plans should include the necessary range of health and social services (both secure and non-secure) to enable them to respond to people's special needs.

This is the essential complement to the diversion and discontinuance arrangements promoted in circular 66/90 and could be matched on the social services side by implementation of our recommendation that services for mentally disordered offenders should form part of local authorities' community care plans for 1993-1994.

Effective follow-up of the review

We think that effective follow-up of this review will require an action plan which sets out clearly the key tasks to be performed and the times by which they are to be achieved. This will need the active involvement of the NHS Management Executive and the Social Services Inspectorate which have formal monitoring responsibilities for health and social services authorities, as well as that of Regional Health Authorities, which have their own monitoring and strategic function. With regard to the criminal justice system, the Home Office would need to spearhead work with the probation, police and prison services and the courts. Other Departments, including the Lord Chancellor's Department, the Department of the Environment and the Department of Education, may also need to be involved.

The implementation programme must need to be co-ordinated with the work of the recently formed mental illness task force (see paragraph 5.18), bearing in mind particularly that we expect most mentally disordered offenders to be cared for and treated within mainstream services.

It is vital that the medium secure programme is firmly managed and monitored. In this respect we recognise that the monitoring arrangements that the Department of Health now has in place are far more sophisticated than existed in the mid-1970s. The increased capital for medium secure places above the current target of 1,000 and a requirement for more local secure places in lower security.

Continuing work

In many areas, the development of effective diversion arrangements and complementary services for mentally disordered offenders will be starting from a narrow base (CR 4.26). We envisage the developmental process having the following fundamental stages:

i. the agreement of a local framework for inter-agency co-operation. Unless this is in place, services are likely to develop haphazardly, if at all, and will almost certainly fail a number of users;

ii. a local assessment of need. This process has begun, but must be broadened to include all health and social services with need, identified on a multi-agency basis;

iii. a. the inclusion of multi-agency plans for mentally disordered offenders in purchasing, service development and other strategies;

b. early action taken centrally, and by local agencies, to determine training requirements and to ensure the development of an adequate academic and
research base. This is a prerequisite for achieving the necessary service changes and ensuring that they lead to real health and social service gains for patients;

iv. a. the development of a more effective range and level of health and social services, a process which includes the contracting in of mental health care to prisons and must move on a broad front in tandem with;

b. the development of effective arrangements for:
   the identification of mentally disordered people by the police and their obtaining advice from the health and social services as to suitable care and treatment; diverting mentally disordered offenders to health and social services care at the pre-court stage, we favour the earliest possible development of assessment and diversion schemes to achieve nationwide coverage;
   the identification by the prison service of mentally disordered prisoners who require health or social services care and their transfer to suitable placements.

And finally...

10.17 What happens from now on is subject to the decisions and efforts of others. In 1990 we were offered what the then Parliamentary Secretary for Health described as “an excellent opportunity”. As we said in our earlier Overview, it was one we have welcomed and which we have endeavoured to seize effectively. It has been a great encouragement to us that those who have commented on our reports have very largely endorsed the broad direction we have proposed and our vision of a much more diverse and sensitive range of services, predominantly non-institutional and non-custodial, which effectively and promptly meets individual needs. Fortunately there seems to be widespread agreement about what needs to be done – in itself a helpful base from which to move forward.

10.18 Mentally disordered offenders and others requiring similar services are a vulnerable and, as we have said, too often neglected group of people. Justice for them, as well as our wider interests as a society, demand a more effective response than in the past. We hope that our work has helped to build the foundation on which that response can be given.