MENTAL HEALTH AND CRIMINAL JUSTICE

What can we learn from liaison and diversion in the USA and Canada?

Paula Reid
Churchill Fellow
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The relationship between the mental health and criminal justice system has become increasingly complex in recent years. Cuts to community mental health services and crisis support mean the police are frequently the first point of contact if someone is distressed. They often have to respond without the necessary support from mental health services. Once in the criminal justice system, opportunities to identify a person’s mental health needs can be missed and appropriate support is not always available.

A number of national initiatives have been introduced to try and improve the interaction between the mental health and criminal justice systems. In early 2014, the Government announced a national pilot programme for liaison and diversion teams, building on previous pilots and attempting to formalise the model. These liaison and diversion teams are tasked with identifying people with mental health needs, assessing what support is required and signposting people to the relevant services. They also have a role to play in ensuring these mental health needs are being taken into account at all stages of the criminal justice system. In February 2014, HM Government published a Mental Health Crisis Care Concordat.1 This outlined commitments from national stakeholders across health and justice to improve outcomes for people experiencing mental health crisis.

It is really positive to see a focus on this issue at national policy-making level. This report hopes to contribute to work in this area by looking at examples of partnerships between mental health and criminal justice agencies in the USA and Canada. Informed by visits to a number of organisations in these countries, it highlights existing good practice models and discusses how these principles might be applied more widely in the UK.

In order to design a local system responsive to the needs of people with mental illness in contact with the criminal justice system, it is important to know what resources are already available. In the USA, a framework known as the Sequential Intercept Model has been developed to help communities map these resources. It identifies key interaction points between mental health and criminal justice agencies so local areas can better understand where the gaps in their service provision might be. Alongside robust local data collection this can help communities decide how best to support people affected by mental illness to avoid entering the criminal justice system, or receive appropriate help and treatment while in it.

One of the most challenging areas of mental health and criminal justice is police involvement where people are experiencing a mental health crisis. This has been the focus of a number of national reports in the UK and it is hoped the new liaison and diversion pilots will help improve this interaction. In the USA and Canada, responses to this issue tend to fall into one of two categories. The first of these is a police-led response, in particular the Crisis Intervention Team (CIT) approach. This involves offering an enhanced mental health training programme to certain police officers, allowing them to take the lead on mental health calls. This model relies on strong community partnerships, especially with mental health providers and local advocacy groups, to support these officers. The second model is more of a co-response model. Police and mental health professionals respond together to mental health calls, ensuring that both agencies have input at the earliest possible stage. The report looks at different ways local areas have implemented this model.

In order for any of these policing initiatives to be successful, it is essential that they have timely access to support from mental health agencies. Some of the areas visited for this report have developed local protocols for

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prioritising access to mental health services for people in contact with the police so they can receive treatment at the earliest possible opportunity. Alternatives to hospitalisation or custody are also discussed as part of a wider system responding to people experiencing a mental health crisis.

Another opportunity for better mental health input is in courts. Often people affected by mental illness get to this stage of the system without their mental health needs being identified or supported. If these needs are not taken into account, the result can be expensive and unnecessary prison sentences. These do little to reduce reoffending or support someone’s rehabilitation and recovery. In the USA and Canada, they have developed mental health courts, a diversion programme adapted from the successful drug court model that has been in operation for the past 25 years. In mental health courts, participants follow a court-mandated treatment and care plan based on their identified needs. If they successfully complete the programme, they will either have charges dismissed or will serve a short community sentence rather than a longer prison sentence. These courts are more flexible if people are struggling to engage with their treatment and participants are given time to find a package of support that is best for them. Although the model does have its critics, it demonstrates good outcomes in terms of re-arrest rates, engagement with treatment and participant experience.

This report welcomes the current focus on mental health and criminal justice at both a national and local level. It also fully supports the recommendations made in the Crisis Care Concordat. In order to further build on this work, it makes the following recommendations:

1. Local commissioners (Clinical Commissioning Groups, Local Area Teams, Police and Crime Commissioners and local authorities) should work together to map pathways for people affected by mental illness in contact with the criminal justice system in their area. This work should inform future commissioning plans.

2. Mental health service providers should work with local police and emergency services to ensure their referral processes do not create barriers to a quick and appropriate transfer of care.

3. Police and Crime Commissioners (PCCs) should commission mental health awareness training for police that is co-delivered by people with lived experience and local mental health service providers.

4. Crisis Intervention Team (CIT) model pilots should be considered as part of the ongoing national development of liaison and diversion.

5. Local areas should set up a steering group to oversee all elements of their crisis care system. This could be a function for existing Health and Wellbeing Boards, or any local bodies that form as a result of implementing the Mental Health Crisis Concordat. The steering group should include people affected by mental illness, along with families and carers.

6. The new Mental Health Intelligence Network from Public Health England should be extended to include comprehensive datasets on crisis services, section 136 detentions, police contact with people affected by mental illness and updated figures on mental health prevalence in the criminal justice system.

7. The Ministry of Justice should build on its previous mental health court pilot and look at introducing pre-prosecution or pre-sentencing models in magistrates’ courts.

8. Commissioners should consider including peer support provision in all mental health service specifications, including crisis services.

9. Local health and criminal justice agencies should develop joint protocols around information-sharing so that this can be done safely and effectively at a local level. These protocols should be developed in line with Caldicott recommendations and other guidance on safeguarding and data protection.
METHODOLOGY

This report has been produced as part of a Churchill Travelling Fellowship. It has been informed by visits to criminal justice agencies and mental health service providers across the USA (Maryland, Virginia, Tennessee, New York and Washington D.C.) and Canada (Ontario). I carried out telephone interviews with agencies I was unable to visit and attended the CIT International conference in Hartford, Connecticut (14-16 October 2013). I also visited two police forces in the UK (Leicestershire Police and Devon and Cornwall Police) to better understand liaison and diversion schemes already in operation in the UK. A full list of the agencies I spoke to as part of this project is available in Appendix 1 of this report.

I also carried out a survey of Crisis Intervention Team (CIT) stakeholders across the USA. I had 224 responses from a range of agencies involved in delivering CIT, including police and other law enforcement agencies, staff working in jails and prisons, probation, mental health service providers, advocacy organisations and other community services. A full list of questions can be found in Appendix 2.

Over the course of my Fellowship trip I also kept a blog at www.atlanticdiversions.wordpress.com. Further details on some of the organisations I visited, as well as links to references in this report, can be found on the ‘Resources’ page.

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Finally, I would like to say a huge thanks to Lizzie Blow, Ben Bransfield, Jenny Grunwald, Felicity Johnston, Tom Lintern-Mole and Susie Rush for all their feedback on drafts of this report.

2. HM Government, 2014
3. For more information on the Churchill Travelling Fellowship programme, please visit the Winston Churchill Memorial Trust website on www_wcmt.org.uk
4. For more information on CIT International, please visit http://www.citinternational.org/
INTRODUCTION

Too many people affected by mental illness are in contact with the criminal justice system in the UK. This is the consensus of numerous national reports and initiatives over the past few years. The over-representation of people affected by mental illness in prisons and the large amount of police time spent responding to mental health calls are just part of the picture.

All the evidence points to a mental health system that is stretched to the limit and only able to intervene at crisis point. In 2012/13 there were over 50,000 uses of the Mental Health Act to detain patients in hospital for assessment or treatment, not counting the use of short-term holding powers. This is the highest number of uses of the Act ever recorded.\(^5\) People affected by mental illness are more than twice as likely to access A&E and inpatient services than the general population.\(^6\) Over half of mental health inpatient wards are operating above the capacity recommended by the Royal College of Psychiatrists.\(^7\) If people affected by mental illness are not able to access appropriate mental health support in a timely way, there is a risk their condition can deteriorate and they can come into contact with the criminal justice system.

There are two key elements to this issue. The first is the criminal justice system having to intervene in mental health crisis situations, often without support from health partners. In this situation, police can use section 136 of the Mental Health Act to take the person from a public place to a ‘place of safety’ if they were concerned for their welfare. The person would then be assessed by a mental health professional under the Mental Health Act to see whether further detention under the Act was appropriate, or whether they could be referred to another service or discharged. In many local areas across the UK, there are few options open to police who are concerned for a person’s welfare other than using section 136. This is especially true if they come into contact with people outside of normal service hours.

The second element is the mental health support available to people who might need to continue through the criminal justice system if they are charged with an offence. There is often a lack of mental health services available in custody, at court and in prisons. People might also not be identified as needing this support until they have progressed a long way through the system without it. In some cases these people might already be known to mental health services, but this information is not available to criminal justice professionals. These needs are therefore not taken into account at sentencing, where there is a real opportunity to divert people away from unnecessary, and expensive, prison sentences and to ensure they get the appropriate support.

So what can be done? The first real attempt to grapple with these issues was Lord Bradley’s 2009 report looking at how the criminal justice system responded to people with mental illness and learning disabilities.\(^8\) This report set the scene for a lot of the work that has followed. It made a number of recommendations to improve the way mental health is supported within the criminal justice system. One of its key recommendations was liaison and diversion teams. These teams would work in custody, courts and other criminal justice settings to identify people affected by mental illness.

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5. Care Quality Commission, 2014
6. Health and Social Care Information Centre, 2014
8. Lord Bradley, 2009
They would advise and provide relevant information to police, judges and other criminal justice professionals to ensure a person’s mental health needs were taken into account at the appropriate points in the system. They would also signpost individuals to health and social care services as required. The ethos underpinning liaison and diversion is that people affected by mental illness should be supported in the least restrictive setting possible. In some cases this might mean diversion out of the criminal justice altogether. In other cases it might be finding a more appropriate setting within the criminal justice system, such as issuing community sentences with mental health support instead of prison sentences.

Pilot liaison and diversion teams have been in operation over the past few years in the UK and have been demonstrating success. In January 2014, the government announced extra funding to further develop these pilots, with an aim of national coverage for liaison and diversion teams by 2017. There are currently a number of street triage schemes running across the UK, which promote closer collaboration between police and mental health professionals.9

There have been a number of comprehensive reports recently that have highlighted some of these issues. These include the 2013 Independent Commission on Mental Health and Policing, which reviewed the work of the Metropolitan Police following fatal incidents involving people in crisis.10 A joint report from a number of national agencies on the use of section 136 and ‘place of safety’ provision also highlighted failings in this area.11 The recent commitment to a Mental Health Crisis Concordat, outlining how key agencies should work collaboratively to improve the wider crisis care system, is also a very positive development.12 It seems like there is finally a real momentum growing around this issue.

This report looks to contribute to work in this area by showcasing some international models of good practice, alongside examples from the UK. It focuses on two very different diversion points in the system: the initial police response and court diversion programmes. In the USA and Canada, they are facing many of the same problems we are grappling with in the UK. They too are experiencing increasing numbers of people with mental illness in the criminal justice system and a community mental health system with ever stretched resources. Although the systems in these countries are very different, the principles underpinning possible solutions are similar.

There needs to be greater emphasis on early intervention and preventing people reaching crisis point. When a person is experiencing a mental health crisis, mental health input needs to be quickly available via whichever service that person first comes into contact with. Local areas need to develop robust community partnerships involving health, criminal justice, housing etc. to offer people appropriate support. Options need to be available so people can be supported in the least restrictive setting possible and with minimal criminal justice input. All these things should be possible within the UK system, even if their implementation is different to the USA or Canada.

9. GOV.UK, 2013
11. Her Majesty’s Inspectorate of Constabulary, Her Majesty’s Inspectorate of Prisons, Care Quality Commission and Healthcare Inspectorate Wales, 2013
12. HM Government, 2014
Many of the challenges discussed in this report cannot be solved by one single agency. They require a community response, with mental health, criminal justice, housing, welfare and other support services working together to support individuals with complex needs.

At the point where police encounter someone experiencing a mental health crisis, or a judge is sentencing someone with mental health needs, there have to be options available to them and appropriate services for them to refer to.

Too often people are held in police cells under section 136 because a health-based place of safety is not available. Magistrates are unwilling to use mental health requirements as part of community sentences because they lack confidence or awareness of service provision locally. In order to tackle these problems, communities need to know what they have at their disposal. Without this it is impossible to agree on appropriate and effective joint processes and protocols for responding to people affected by mental illness.

Some people may argue that the basic building blocks of an effective mental health system are lacking in many communities, and therefore efforts to reduce the overrepresentation of people with mental illness in the criminal justice system are futile. This argument is not persuasive.

Even the most underfunded mental health systems can work to improve services to individuals with the greatest need, including the group of people with serious and persistent mental disorders who have frequent interaction with the criminal justice system. Such efforts require close collaboration between the mental health and criminal justice systems.

Dr Mark Munetz and Dr Patricia Griffin

Munetz & Griffin, 2006
Many of the initiatives introduced in the USA and Canada have not required any new resources, they have simply used existing services differently. In a time of limited finances, a creative use of existing assets is particularly important. In Toronto, for example, St Michael’s Hospital recognised that having one of its mental health nurses on patrol with the Toronto Police Service, rather than in their emergency department, would be a much better use of resources. It would reduce the burden on police responding to mental health calls from two officers to one, freeing the police up to respond to other calls. It could also reduce emergency department use if the nurse was able to make referrals to community services at the scene instead. The difficulty is that many communities do not necessarily know what is available to them and where the gaps in provision might be. They therefore cannot pool resources and plan effectively. In the USA, many areas have started using a community mapping process called the Sequential Intercept Model to help shape their local systems.

Sequential Intercept Model

The Sequential Intercept Model was developed by Dr Mark Munetz and Dr Patricia Griffin in the USA in 2006. It was designed as a framework for understanding mental health and criminal justice interactions. It has been used by a number of communities in the USA to help them understand how and where people affected by mental illness may come into contact with the criminal justice system. The model is designed to identify intervention points, the different target populations at these points and help illustrate where there might be gaps in existing services.

The model moves through the various stages of a person’s possible contact with the criminal justice system. Not everyone will go through every stage of the process. They may be diverted from the criminal justice system into healthcare settings, or have their charges dismissed. However, many communities report that it is a helpful way of thinking of the system as a whole.

Griffin and Munetz broke the model down into a series of filters, or intercepts, covering the following key stages:

The ultimate intercept: best clinical practice

Accessible community mental health services and the principle of early intervention are the foundations of any effective mental health system. Appropriate support and timely interventions could stop situations escalating to crisis point, where more intense and costly responses would be required.

If a person is in crisis, then they should be able to access services that are responsive to their needs in a timely way. This is the ambition outlined in the recent Mental Health Crisis Concordat. If the police are the first point of contact, the Concordat emphasises that they should be equipped to respond appropriately, but should also be properly supported by partner agencies.

Intercept 1. Law enforcement and emergency services (including 999)

For many people in crisis, the police are their first point of contact with any kind of support. It is therefore important that the police are properly equipped to manage these situations appropriately. This is the rationale behind some of the initiatives described later in this report, such as Crisis Intervention Teams and mobile crisis response.

In Devon and Cornwall, the police are also involved in preventing situations escalating, rather than just reacting to crises. Community Psychiatric Nurses (CPNs) work alongside neighbourhood policing teams to identify vulnerable people who might be at risk. The CPNs can then proactively offer support ensuring that people get access to help at the earliest possible point, rather than waiting for a crisis.

15. Toronto Police Service, 2013
16. Munetz & Griffin, 2006
17. Department of Health, 2014
Neighbourhood policing
Devon and Cornwall Police

Devon and Cornwall Police has three Community Psychiatric Nurses (CPNs) based across three custody suites in Cornwall. As well as working closely with custody staff, the CPNs also work with neighbourhood policing teams to proactively identify and support people who might be at risk. This outreach work uses the Force’s ‘neighbourhood harm reduction register’. If people contact the police three times in three months about the same address, for any reason, the address is flagged as needing particular support or attention. If there are mental health concerns, the neighbourhood policing team might ask the CPNs to get involved in the case and work with them to identify and offer the appropriate support.

An evaluation of this scheme shows that following intervention by a CPN, the number of police contacts with these addresses is reduced by a third. By getting help to people early, this scheme can ensure that they are signposted to appropriate support and services before they become more unwell or any offending behaviour escalates. This should lead to better outcomes for the people involved – better engagement with appropriate services and less contact with the criminal justice system. It should also reduce the amount of police resource needed to support this group.

Intercept 2. Initial detention and initial court hearings

There are opportunities here to divert people out of the criminal justice system altogether or to ensure they get the right support within the criminal justice system. Effective custody screening tools and the new custody liaison and diversion teams are a good example of this.

If people are charged and appear before a magistrate, mental health court workers could also advise the court about any mental health needs and options for assessment and treatment.

Intercept 3. Courts and prisons

One of the key examples here is the mental health court model, which will be discussed later in this report. Intensive case management, making links between relevant services and coordinating care, is a key element of this. This ensures that people are receiving the appropriate support and helps resolve any gaps in provision.

Other important interventions here include mental health provision in prisons, such as mental health inreach teams, and effective screening to inform diversion decisions.
Intercept 4. Resettlement: moving on from prison or hospital

The difficult transition from prison back into the community can be even more problematic for people affected by mental illness. Without effective support and planning, people can end up with gaps in treatment, unstable housing arrangements and struggle to access benefits and other forms of support. This can lead to a deterioration in people’s mental health, and increase the risk of reoffending.

To address this, the Department of Community Mental Health in Westchester provides transitional case managers to people leaving prison. They work with people for about a month pre-release and two months afterwards to make sure all the elements of their release plan are properly implemented. This intensive support helps make the transition back into the community a lot less overwhelming and uncertain for people.

Intercept 5. Community corrections

This includes probation supervision following release from prison or as an alternative to imprisonment. Similar to Intercepts 3 and 4, effective case management is essential here.

It is also important that community provision can offer a full range of services – housing, employment, education – and does not have any criteria excluding people who have had involvement in the criminal justice system.

Sharing information at initial detention

Westchester Department of Community Mental Health

Westchester County, New York has developed an effective system of local information sharing. The Westchester Department of Community Mental Health (DCMH) and the Westchester Department of Corrections (DoC) share records so it is easy to cross-reference and find matches between the two.

If a person is arrested and then booked into the local jail, their details are automatically checked against the DCMH records. If there is a match, an email alert is sent to the jail’s mental health team to provide continuity of care. Upon notification, the team then visit the person and do an evaluation to ensure they have everything they need. The community mental health team that work with that person are also alerted that they are in jail.

The system also works when someone is released from jail (Intercept 4). The community mental health team is alerted that the person is due to be released, along with the likely release date. The team then meets with the person in jail to actively engage the person and help them manage the transition back into the community. This support is offered 30 days pre-release and 60 days post-release to aid this transition.
Data

Robust data collection is a key part of establishing the local picture and mapping community provision. Mental health data has historically been patchy and it can be difficult to work out what is happening locally. It is crucial that commissioners have access to detailed information about their area so they can ensure appropriate services are available, especially for people with complex needs.

Access to strong local data can help inform the development of community initiatives. In Anne Arundel County in Maryland for example, mobile crisis teams have been introduced, comprising pairs of mental health workers who respond to calls from the police for support. By using local data on the rate of mental health calls to the police they determined that a full 24/7 service might not be the best use of resource, as there were significantly fewer calls in the early morning. The teams therefore operate on an on-call basis between midnight and 8am and a full time service the rest of the time. The service is therefore responsive to local need but also targeting resources effectively.

Data can also help identify where there might be problems in the existing system. For example, the high rates of A&E use among people affected by mental illness could be indicative of a lack of alternative crisis provision. Increasing numbers of detentions under the Mental Health Act might reflect a reduction in more preventative community services which would stop people becoming unwell. Without this data it can be difficult to work out where one part of the system is negatively impacting on another and take action to resolve this.

Community problem-solving

If local processes are put in place, it is important that they are effectively monitored and evaluated. This should involve all relevant stakeholders, including people affected by mental illness and their relatives and carers. This is important for community ownership of these processes.

In Hamilton, Ontario they have taken a local approach to monitoring how they support individuals with complex needs in contact with a number of different services. Across Ontario there are Human Service and Justice Coordinating Committees (HSJCC) that operate at a provincial (Ontario-wide), regional and local level. These committees were introduced to provide leadership around supporting people with specific needs, such as mental health, learning disability or substance misuse, in contact with the criminal justice system.

In Hamilton, their HSJCC serves as a problem-solving forum, using the attendees’ pooled resources to respond to complex cases. The committee has developed terms of reference and a strict protocol for information-sharing so that confidentiality is not breached. Committee members work together to come up with creative solutions for people who are in frequent contact with services, but who do not have formal care coordination. Once a case is raised, stakeholders give input and develop a support plan. Members of the committee have found that services are more receptive to accepting complex cases when they know they can draw on the support of other local agencies. They have also worked to standardise processes and language across agencies where possible, making it easier for agencies to collaborate with each other. Hopefully the joint ‘Local Crisis Declarations’ proposed in the Crisis Concordat will drive this kind of local collaboration in the UK.

19. Care Quality Commission, 2014
This section of the report looks at initiatives that have improved the way communities respond to people in crisis. As well as discussing models led by, or involving, the police, this section also highlights the importance of strengthening local mental health systems to better support people experiencing crisis. Ideally everyone experiencing a mental health crisis would have access to appropriate care and support within a health setting without ever coming into contact with the police. However we know this isn’t always the case, and it is therefore important the police are able to handle these interactions appropriately. Often police are placed in a difficult position regarding people affected by mental illness because of the lack of options available to them. Community mental health providers should work with them to design referral pathways that get people into appropriate care setting as soon as possible.

**Crisis Intervention Teams**

The Crisis Intervention Team (CIT) model was developed in Memphis, Tennessee. It started in 1988 following the tragic case of a young man who was fatally shot by police in Memphis while experiencing a mental health crisis. Public outcry followed the shooting and the incident led to the development of a better model of police response to people experiencing a mental health crisis. It is one of the key developments in the mental health and criminal justice arena in the USA in the last 30 years. While the model does have its critics, it is seen internationally as one of the most successful models of police intervention. There are now CIT programmes in 46 of the 50 states in the USA, as well as Canada, Australia and Liberia. The CIT model provides a specialised police response to mental health incidents. This report will outline the ‘best practice’ for CIT, though some areas may implement it differently depending on resource and local variability.21

The most important element of CIT is the community partnerships between police, mental health service providers, local peer and advocacy groups and other key stakeholders, such as ambulance services. Without this, CIT will never be effective. Any police-led response to mental illness will only ever be as successful as the services that support and surround it, and CIT has developed as a real community initiative. Community partners are involved in all elements of the CIT programme – planning, training, implementation and monitoring and evaluation. This local ownership means that all the different agencies are invested in the outcomes.

*The networking between law enforcement and mental health professionals has created knowledge among each discipline about the other discipline which enables each to respond together.*  
**CIT survey respondent, Ohio**

*In our case we bridge the gap between very different service providers, bringing professional mental health services out into the community to the benefit of our law enforcement services, and to facilitate the provision of services through hospital and other care providers.*  
**CIT survey respondent, Connecticut**

*It helped to pull the community together in a different way. People with a mental illness are going to the hospital instead of jail and entering the criminal justice system.*  
**CIT survey respondent, Indiana**

Recruiting the right people to become CIT officers is the next step. This should be a voluntary and competitive application process, with past disciplinary records and previous service taken into account. There should be enough officers in the programme to ensure CIT availability on each shift. The best practice guidance suggests that 25% of patrol officers in a force should undertake CIT training. There are a number of reasons for this. CIT places a strong emphasis on interpersonal skills and it is important that the selected officers are able to relate to, and empathise with, people in crisis.

Being a CIT officer has also gained real status as the programme has expanded and CIT officers talk about the pride and sense of identity they have through being involved in the programme. There is a strong leadership component as CIT officers often assume the lead officer role on mental health calls, regardless of the rank of other attending officers. Training a quarter of a force should therefore be enough to give CIT coverage on every shift, while retaining this sense of identity.

In reality, this varies significantly across forces in the USA. A survey of 224 CIT programmes conducted for this report indicates that, on average, 45% of officers in participating forces are CIT trained. A significant number of respondents said that 100% of their force was trained. This is because some police departments in the USA can be very small and need to train most or all of their officers in order to ensure CIT availability on every shift. In other cases police forces have embraced the ethos of CIT and want all their officers to have these skills. Critics of this approach feel that having 100% of a force trained erodes the identity and the specialist nature of CIT officers.

One of the core components of CIT is an intensive 40-hour training programme for officers selected to take part in the programme. In addition to the basic safety skills all officers are taught, this training includes components on mental health awareness, medications and side effects, suicide prevention, community mental health resources and de-escalation techniques. It is not designed to equip police officers to make a diagnosis or to act as mental health professionals. Instead it aims to give them greater awareness of how someone experiencing a mental health crisis might present to police officers and gives them the skills to respond to this. In many areas emergency dispatchers also receive CIT training as they are often the very first point of contact with the system. The training enables them to respond appropriately to people in crisis, but also to know what information they need to gather to support the CIT officers.

In Memphis, as in many areas across the USA and Canada, this CIT training is designed and delivered in part by people affected by mental illness, their relatives and carers, mental health providers and other community partners, as well as law enforcement professionals. Most areas involve a wide range of local agencies in their training; this is an important part of the CIT approach. It serves two purposes. Firstly, it strengthens the community buy-in to the programme and the sense of community ownership. Secondly, it starts building personal connections between police and local community partners. In most cases this training is offered free of charge by community partners so the only cost to police departments is the staff cost of officers attending the training.
The CIT approach is endorsed by the National Alliance on Mental Illness (NAMI), the largest grassroots mental health organisation in the USA. NAMI has local and regional branches, many of whom take part in and support the CIT programme. NAMI members meet with CIT police officers to talk about their own interactions with the police while they or the person they care for were unwell. This input from people with lived experience is an essential part of the CIT training curriculum. It gives officers a real understanding of the issues that people are facing and makes the police advocates for better services. NAMI also promotes CIT to its members so that they are aware of the programme and can look out for officers wearing the CIT badge, a key component of the identity of CIT officers.

A young man in his twenties, with a history of mental illness and substance abuse, was serving a community sentence (home detention). While serving this sentence under probation supervision, he had a number of encounters with a local CIT team. He reported hearing voices that would command him to hurt himself or they would tell him that he was going to be killed or harmed. He also reported severe depression and hopelessness, repeatedly stating that he just felt like dying. The subject first would only open up to mental health staff, but eventually he became comfortable enough to open up to officers and could tell them what the voices were telling him. He also talked about past suicide attempts and would talk about the suicide plans he had currently. This enabled the officers to get him the help that he needed as quickly as possible.

I consider this a success for the CIT program because the subject learned that he could rely on the police to help him, despite him having a criminal record. Instead of acting on his feelings, he himself called the police for help.

NAMI respondent, CIT survey

Research suggests that CIT is an effective police diversion programme. Although more work needs to be done, for example on cost-effectiveness of CIT and the experiences of people in contact with CIT, studies to date are positive. A comparison of three police-led diversion models found the CIT model to have the lowest arrest rate. CIT officers are not only accurately identifying individuals in need of psychiatric care, but are also referring them in to treatment earlier than might otherwise occur. They are also less likely to use physical force than their non-CIT trained counterparts.

There has been a tremendous change in how officers and deputies perceive people with mental illness in crisis. There are fewer admissions to jail, and hospitals of this population, and more appropriate visits to our local crisis services. We have also seen a marked improvement in the writing of our 72 hour involuntary holds [similar to section 136 in the UK] that are written by law enforcement.

CIT survey respondent, California

However the success of CIT is reliant on a local mental health system that allows quick and easy access for individuals in contact with the police. This gives CIT officers the confidence to make decisions about referring people to services. In Memphis, for example, police have access to a crisis assessment centre that has a no-refusal policy for police cases and acts as a triage point. These centres are discussed in more detail later in this report but the CIT survey showed that 45% of programmes had access to a centre of this kind. Other responses included a 24/7 crisis line with a special protocol for police officers and one force where officers could get mental health advice via Skype. Emergency rooms were also cited as somewhere the police could take people affected by mental illness, though many highlighted that this was not ideal.

23. For more information see www.nami.org
Mobile crisis response models

The CIT model very clearly separates the role of the police and mental health professionals. By training specialist police officers to de-escalate and contain situations, they then link the person to mental health professionals. This might be via a crisis receiving centre or another mental health service. However, some areas have decided to pair police officers with mental health professionals to respond to incidents. This is similar to the street triage schemes currently being piloted in the UK, including Leicestershire.27

Studies show that having an integrated mobile crisis team can reduce the amount of time spent at the incident and also increases the person’s later engagement with mental health services.28 CIT and mobile crisis is not an either/or scenario and many areas have both. The CIT survey shows that 61% of police forces could call on a mobile crisis response team including mental health professionals. In this scenario, a CIT officer might be the first to arrive on the scene to assess the situation. They might then request a mobile crisis team to attend for expert mental health input.

Street Triage

Leicestershire Police

The street triage model in Leicestershire is a co-response model – a police officer and a mental health nurse work together to respond to incidents. The key to this model is that decisions are informed by both the mental health and policing side jointly, leading to more appropriate responses to people in crisis. The team was originally set up to reduce section 136 detentions and A+E admissions, although the work of the team has become more wide-ranging than that. They have taken ownership of repeat and complex cases in the area and are facilitating joint professional meetings to bring mental health and criminal justice professionals in the area together.

In Leicestershire the nurses who work in the team are all crisis nurses who rotate between shifts in the street triage car, custody suites, courts and probation. They therefore have a large amount of expertise of crisis assessments and the wider criminal justice system. The team don’t just offer support in person, they also are able to advise over the phone and via the police radio. The response officer in the team keeps an eye on the incoming police calls to see where support might be needed, and the nursing staff have access to mental health records for any information that might help inform decision-making and risk-management in these situations. If the street triage car does attend an incident, the nurse is able to do mental health assessments and make referrals to appropriate services there and then.

Frontline police have really welcomed the introduction of the street triage team to help support better decision-making in mental health incidents. One of the biggest advantages is a more positive attitude to risk – mental health staff and police handle risk in very different ways and there is a feeling that a joint approach has led to less intrusive resolutions to incidents.

27. GOV.UK, 2013
28. Kisely, et al., 2010
A number of these mobile crisis response models exist in different formats across the USA and Canada. A summary of some of these different approaches can be found below:

**Police and mental health co-response models (Toronto, Ontario; Westchester County, New York and Hamilton, Ontario)**

In Toronto, the Mobile Crisis Intervention Team (MCIT) consists of a police officer and mental health nurse. This partnership came about at the initiative of the local hospital as a better way of using community resources. The team acts as a so-called secondary responder. They are not dispatched to emergency calls in the first instance but attend if requested by police officers on the scene.

The role of the MCIT is slightly wider than in some other schemes. They also do follow up calls and some proactive outreach work. However, these responsibilities need to be balanced against the demands of being part of an emergency response system. The police officers and mental health professionals involved in MCIT are trained together so that there is clarity around their different roles, particularly in regard to relevant legal frameworks. The mental health nurse can make referrals at the scene, avoiding the need for admission to hospital or the emergency department. If admission is necessary, the nurse might be able to do some initial triaging at the scene to speed up the process once they get to hospital, meaning the person can access appropriate mental health care sooner.

In Westchester County, New York, the mobile crisis team comprises a police officer and a social worker. The team operates from 8am-4pm in collaboration with the local Crisis Intervention Team (CIT). Outside of these hours, the CIT officers leave a report for the mobile crisis team so that they are aware of any activity overnight and can follow up where appropriate. The close collaboration between Westchester County Police and the Department for Community Mental Health means that the police often know the mental health case managers of people they come into contact with regularly. This allows community mental health teams to offer follow up and additional support to people after contact with police.

In Hamilton, Ontario, the Crisis Outreach and Support Team (COAST) provides a wide range of services, of which mobile crisis response is a key part. Referrals come in to the service from numerous sources, including a 24/7 crisis line, a local alert system from statutory services or police requesting attendance. The Hamilton Police Department also submit reports to COAST after any contact with someone affected by mental illness. This is governed by a strict local information-sharing protocol which allows police to share information with COAST, but mental health workers cannot share details of any follow up with police. The COAST service triages all these different referrals and works out the best response to each call. In some cases they will dispatch the mobile crisis team, comprising a plain clothes officer and a mental health worker. All the police officers in the COAST service have had CIT training.

**Mental health crisis response models (Anne Arundel County)**

In Anne Arundel County, Maryland the mobile crisis team operates differently to many other models. Instead of being paired with police officers, the mobile crisis teams in Anne Arundel County are pairs of licensed mental health professionals. They can be called out to attend any incident at the request of the police. There are no prerequisites for this; if the police call the team they will attend. Police access the mobile crisis response team via a 24/7 Warmline, a general number funded from the county mental health budget. It is promoted to the community as well as the police, but prioritises criminal justice calls.

The mobile crisis team work to divert the person to the least restrictive setting possible. This might be to the local crisis beds or an assertive outreach programme. The mobile crisis teams also support emergency department staff if required and can work at this stage to divert people from hospital admissions where appropriate.
Before this scheme was set up, a lot of work was done with police locally to find out what they wanted from a crisis response model. Police were originally concerned about the different cultures of law enforcement and health agencies. They were worried that this culture clash might complicate already difficult situations. The mobile crisis team offer mental health training and regularly attend the police’s change of shift meetings (roll call) to discuss recent calls and what could have been done differently. In return, the mobile crisis team receive training in personal safety, 911 response and other police protocols so they understand the framework within which they are operating. The mobile crisis team can also access police radios to offer advice and assistance even if their attendance is not necessary.

It is clear that real respect and trust has developed and that the police see the mobile crisis team as equal partners. The police now even bring in the mobile crisis team to support their own staff following difficult or traumatic events. All the agencies involved see this as a key part of the model’s success - both mental health and criminal justice professionals need to share learning and appreciate the other’s expertise.
Crisis Intervention Teams and mobile crisis teams are not standalone solutions. They have to be seen as part of a wider system of crisis response. These models are designed to get people out of criminal justice involvement and into health care settings as quickly as possible. They therefore rely on a local health system that offers options at the point of crisis and is able to accept referrals from police quickly and with minimal handover procedures. Any police-led response will fail if there is not support and buy-in from the mental health community.

Crisis receiving centres

Many local areas in the USA have a dedicated mental health facility to receive people experiencing a mental health crisis. These facilities are often called crisis receiving centres (CRCs) or crisis assessment centres (CACs). 45% of the CIT programmes surveyed had access to one of these centres.

These services are different to a ‘place of safety’ as defined in section 136 of the Mental Health Act in the UK. They are not solely for people detained under the Mental Health Act, but serve as a triage point for anyone affected by mental illness in contact with the police. Many of these centres have a ‘no-refusal’ policy, meaning that people cannot be excluded from them for alcohol or drug use or aggressive behaviour. In the UK, a recent report from Her Majesty’s Inspectorate of Constabulary suggested that these are often the reasons people are refused entry to healthcare settings, leaving the police with little option but to hold them in custody. 29 It is good to see this being addressed as part of the Crisis Concordat. 30

These centres are also usually able to refer people directly into a range of different services. In Memphis, for example, the CAC is able to arrange physical health assessments for people, make referrals to drug and alcohol services and can access crisis beds as an alternative to admission. If after a mental health assessment it is decided that detention under the Mental Health Act is appropriate, then the CAC can initiate this. However in Memphis, staff estimate they divert approximately 70% of people from inpatient admission through these links to other services.

Transfers of care

Another advantage of a dedicated receiving centre is the handover procedure. One of the reasons mental health incidents can be so resource intensive for police is that officers are often required to remain with the person even once they are in a healthcare setting. Police might be required to wait until the person has undergone assessment. This is particularly true if the person has been brought to an emergency department by police. In many cases this is an ineffective use of police time and it increases the stigmatisation and criminalisation of people affected by mental illness by keeping them in contact with the criminal justice system longer than necessary.

In many areas in the USA and Canada local agencies began to feel that many of these long waits were due to healthcare settings being overly-cautious. Healthcare professionals were reluctant to, or felt unable to, support the person in crisis safely and manage any related risk. They therefore became reliant on the police as a form of

29. Her Majesty’s Inspectorate of Constabulary, Her Majesty’s Inspectorate of Prisons, Care Quality Commission and Healthcare Inspectorate Wales, 2013
30. HM Government, 2014
back-up. In Hamilton, Ontario the police and local emergency department worked together on a protocol to better manage and communicate risk. This has reduced the average police wait time in emergency departments by 45 minutes.

**Care plans and information sharing**

Multi-agency working raises questions around how information can be appropriately shared, in line with relevant safeguards, to manage risk and ensure people are offered support at the earliest possible point. Effective care plans for people already in touch with secondary mental health services could play a key role in this. These individualised care plans should include information on what someone should do in a crisis. There is currently no national guidance in the UK around care plans, unless someone is on an enhanced level of support called the Care Programme Approach (CPA). Everyone on a CPA should have a care plan that is shared with them and outlines treatment plans and what to do in a crisis. This is also recommended for people not on CPA.

A recent Care Quality Commission (CQC) study showed that nearly a quarter of people on CPA do not have a care plan. This increases to 40% for people not on CPA.31 Even for those who do have care plans, a significant minority do not feel these cover what they should do in a crisis. This has a number of consequences. Firstly it means that the person experiencing crisis, or those supporting them, might not know where to turn if they become very unwell. This could

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**Transfer of care**

**St Joseph’s Hospital, Ontario**

In Hamilton, Ontario, work has been done to reduce the amount of time taken to transfer the care of people with mental illness from the police to emergency department staff. Working in partnership with the Hamilton Police Service, St Joseph’s hospital decided to make changes to their emergency department procedures to try and reduce the amount of time police are needed. A key part of this was finding common ground around the idea of risk. When they set up a working group to look at this, they found that police and psychiatric emergency staff in the hospital had quite different ideas about risk and the kind of situations that may or may not require police presence. As a result they found it difficult to communicate with each other about this risk and police were often staying a lot longer than was necessary.

They designed a short form for police to fill in with their observations of the person while they had been with them. This flagged symptoms or behaviours that might then help the emergency staff make a decision about their ability to manage them in the emergency room environment. This form has helped bridge this gap and facilitate conversations between police and the mental health professionals. It has also challenged the idea that people are automatically high risk because they arrive with police. Police will now only stay in cases that all parties deem to be high risk. In all other cases people are left in the care of the hospital psychiatric emergency team. There has been a drop in average police waiting time from 122 minutes to 77 minutes in just over a year.

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31. Care Quality Commission, 2013
lead to the situation escalating and the need for crisis interventions from the police. It also means that when that person comes into contact with services, there is no pre-agreed course of action. Having care plans with clear contingencies for crisis situations could therefore reduce this uncertainty and even reduce emergency service use if the right support was accessed earlier. In Ontario, Canada, community mental health teams are supporting people to share relevant information on crisis plans with the police, where this is appropriate. Some areas are also developing crisis cards that contain essential information, such as the person’s current treatment plan and emergency contact details. The Mental Health Crisis Care Concordat in the UK contains guidance on the type of information that might be shared on a ‘need to know’ basis among agencies involved in supporting someone in crisis. It is important that this information is shared sensitively and in line with relevant data protection requirements.

### Alternatives to admission

There is a growing movement in the UK towards providing alternatives to inpatient admission. This is something that was highlighted in *The Abandoned Illness*, the 2012 report from the Schizophrenia Commission. Community-based alternatives, such as recovery houses, offer short-term residential support in a less medical environment. These services are linked to better satisfaction and experience outcomes for people using them. There is scope to use this model more widely across the mental health system, but it could also support police-led interventions, as outlined in this example from Toronto.

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**Mental Health and Justice Beds**

**Canadian Mental Health Association, Toronto**

Toronto has developed a city-wide ‘Mental Health and Justice Safe Bed’ initiative for people in crisis and in contact with the criminal justice system. There are four providers involved in this initiative, each running a safe bed service in a different quadrant of the city. One of these providers is the Canadian Mental Health Association (CMHA), a national voluntary organisation. CMHA has done training with the Toronto police and set up a dedicated phone line for police. There is always at least one bed available for police referrals at one of the four services in the city. This bed is accessed via a dedicated phone line, which police can also call for general advice and support. The safe bed services work with people for up to 30 days in a community setting. People continue contact with their usual case manager/community team while staying at the service so there is continuity of care. Resident crisis support workers are also available 24/7 at the service for anyone who needs additional support or monitoring.

Referrals to the service are not just limited to the police but come through a range of different criminal justice channels. These are ‘priority referral sources’ and include the police, probation or court. It is used as a diversion option at different points in the process, not just as a police alternative. Sometimes people are referred to the safe bed service as a condition of their bail. In other cases people might spend time there as part of a release plan – a transitional arrangement to help them build confidence around living independently.
Peer support

Peer support is defined by the Implementing Recovery through Organisation Change (ImROC) programme as ‘offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations’.

The ImROC programme recommends embedding peer support workers within the mental health workforce to drive a greater focus on recovery across mental health organisations. Peer support workers draw on their own experiences of using mental health services to support and empower others to work towards recovery. They are currently under-utilised within the mental health system, partly because of bureaucratic barriers, a lack of adequate support within the organisation and some misunderstanding of their role within teams.

There is therefore great potential for mental health services to expand their peer support provision, particularly in the area of crisis care.

In Salt Lake City, Utah, they have embedded certified Peer Support Specialists across their crisis response system. Peer workers are paired with social workers as part of the local mobile crisis response team. They work at the local crisis receiving centre and within the Wellness Recovery Centre, the community alternative to inpatient admission in Salt Lake City. They also staff the local Warmline, a mental health support line for non-crisis situations. This focus on peer support was initiated by local commissioners who wrote mandatory peer support provision into local mental health contracts.

Peer support workers provide valuable experience and expertise and can be integral to delivering more recovery-focused models of care. It is important that they are valued as part of a team and not seen as a low-cost alternative to other types of mental health support. By building more peer support expertise into a crisis response system, there is real potential to embed recovery values within it.

32. Provincial Human Services and Justice Coordinating Committee Ontario, 2013
33. Department of Health, 2014
34. The Schizophrenia Commission, 2012
35. Osborn, et al., 2010
36. Repper, 2013a
37. Repper, 2013b
This section of the report discusses a very different interaction between mental health and the criminal justice system. The previous section considered people in crisis coming into contact with police and other emergency services and how people can be diverted into appropriate healthcare as soon as possible. However, another aspect of this is how people can be supported and diverted within the criminal justice system. This section will discuss mental health courts, which look to divert people from prison sentences and to offer the appropriate treatment and support.

Background

The prevalence of mental health problems in prison is extremely high. More than 70% of people in prison experience at least two mental health problems. Rates of self harm and attempted suicide are much higher than the general population, especially among female prisoners. People affected by mental illness often fall into what is called the ‘revolving door’ group of people who are regularly in and out of the criminal justice system. This group tend to serve short sentences of under a year and are therefore not currently entitled to any probation support and supervision on release. They return to the same situations they were in when they originally offended, with the same pressures and the same lack of support. There are plans to expand probation supervision to people serving short sentences. However, simultaneous widespread changes to how probation is commissioned and delivered raise concerns about how probation will support people with more complex needs going forward.

On top of grappling with high rates of mental illness, prisons in the UK are also currently overcrowded. Latest figures show that the prison service is currently running at 112% of its Certified Normal Accommodation (CNA), the level at which it can safely accommodate people. From a criminal justice perspective, prison is not particularly effective at reducing reoffending. Figures suggest that 47% of adults are reconvicted within one year of being released and this rises to 58% for those on short sentences. Public opinion on the effectiveness of prison in preventing crime and disorder is also changing. A Prison Reform Trust poll conducted in 2012 revealed that there is strong public support for effective community and public health measures to prevent crime. Six out of ten people surveyed thought that better mental health care would be effective.

In the UK there is currently a community sentencing option that includes mental health support. The Mental Health Treatment Requirement (MHTR) is one of twelve elements that can be mandated by the court as part of a Community Order (community sentence). This requires the person to engage with mental health treatment as part of their community sentence. As with all Community Order treatment requirements, the offender’s consent must be sought before it can be issued. The MHTR offers a real opportunity to divert people from a prison sentence and into community treatment. However the MHTR accounted for just 0.4% of all community orders started in 2012/13. This is despite changes introduced by the 2012 Legal Aid, Sentencing and Punishment of Offenders Act that simplified the process for issuing MHTRs. There are many suggested reasons for this low uptake, including a
lack of information available at the point of sentencing and uncertainty about how MHTRs can be delivered locally. Whatever the reason, this is a missed opportunity to get people access to the support they need.

Taken together, this makes a compelling case for rethinking how we respond to offenders affected by mental illness. We should be looking at more non-custodial solutions that deliver support and treatment in the least restrictive setting possible. The mental health court model, which is becoming increasingly popular in the USA and Canada, could be one answer to this.

**Mental health court model**

Mental health courts have been operating in the USA and Canada since the late 1990s and build on the successful drug court movement that started in the USA 25 years ago. These are court-based diversion schemes and their ultimate aim is to divert people from prison sentences into community-based services, although the parameters for this might vary between courts. It is a very collaborative model involving a number of different agencies within the criminal justice and mental health systems. This includes the judiciary, defence lawyers, prosecution, court staff, case managers, mental health service providers and more. All these agencies employ a problem-solving approach and work together with the mental health court participant to support them to engage with treatment in the community. If they successfully complete the treatment programme set out by the mental health court, their charges can be dismissed or reduced and a prison sentence is avoided.

Treatment programmes mandated by mental health courts are different to the Mental Health Treatment Requirement (MHTR) in the UK in a number of ways. In many cases, mental health courts operate as a pre-prosecution diversion programme. This means there is no admission of guilt in participating in the court mandated treatment programme, whereas the MHTR is a sentencing option. Mental health courts have a much higher level of judicial supervision as participants have to attend regular review hearings with a judge to report on progress. Mental health court participants are usually supported and offered case management by an independent service provider, rather than by the probation service. There is also a lot more flexibility if participants are not following the treatment programme in a mental health court than under the MHTR, where a breach can mean an instant return to prison.

In 2009, the Ministry of Justice ran a pilot mental health court scheme in two courts in the UK. While it found that the scheme led to innovative multi-agency working, it concluded that there would have to be significant changes to current information sharing and data collection arrangements to implement it more widely. Although the pilot did contain certain elements of the model used in the USA, it appeared to be more about delivering Community Orders more effectively, rather than as a pre-sentencing diversion programme.

The exact operation of mental health courts varies between local areas. However there are certain key elements that are common to all courts. This section will explore these in more detail based on visits to the following mental health courts in the USA and Canada:

- Mental Health Community Court, Superior Court of the District of Columbia, Washington DC
- Davidson County Mental Health Court, Nashville, Tennessee
- Toronto Mental Health Court, Toronto, Ontario
- Bronx TASC Mental Health Court Program, New York
- Westchester County Mental Health Court, New York

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44. Scott & Moffatt, 2012
45. Winstone & Pakes, 2010
Identification and eligibility

It is important that potential mental health court participants are identified as early as possible in the criminal justice system. Many mental health courts therefore accept referrals from a number of sources, including defence lawyers, police and other custody staff, court staff and judges. Eligibility criteria vary between courts. Some might limit the type of offences they are able to handle; in the USA many mental health courts will only handle misdemeanour cases which carry sentences of up to a year. Some courts might have strict diagnostic criteria or require proof that the mental health problem is directly related to the offending behaviour. In other areas there is more flexibility on this and courts are happy to work with people even if the link between mental illness and the offence is unclear.

The next step in the referral process is usually assessment by a mental health professional. There is then discussion with both the defence and the prosecution about the appropriateness of mental health court for the individual. It is essential that the prosecution support the diversion decision as it could result in the charges against the person being dismissed or reduced. Many mental health courts have a dedicated prosecution representative allocated to the court who understands what mental health courts are trying to achieve and takes an active role in the process. This involves inputting into the diversion agreement and any decisions about how to respond to an individual who is not following the agreed treatment programme.

Once the person is accepted on to the mental health court docket, they are assigned a case manager and work begins on developing an individualised treatment programme.

Case management

Case management is an absolutely essential element of the mental health court programme. In the majority of the programmes visited for this report, case management was delivered by an organisation independent of the court. Case managers are usually involved in designing the person’s treatment plan and coordinate community mental health and other support services for the participant. They play a key role in the regular review meetings in court, reporting on progress and contributing to discussions on any changes to the treatment plans. They need to be able to navigate the mental health system while understanding the legal framework within which the court operates. They also ensure that plans are in place for when the person completes, or ‘graduates’ from, the mental health court programme.

As with all diversion programmes, it is essential that high quality community services are available for case managers to refer participants into. This is important not only for the recovery and rehabilitation of mental health court participants, but also for the credibility of the programme itself. It is important that the judge, prosecution and defence have confidence in the treatment and support a participant is receiving in order for mental health courts to remain a robust alternative to the traditional trial process.

Many mental health court participants in the courts visited for this report also used drugs or alcohol, often to self-medicate. In both the USA and the UK, community mental health services can struggle to support people who have co-occurring mental illness and drug use. It is important that community services are able to address the full range of needs demonstrated by mental health court participants, otherwise these programmes will not be successful. In some areas, the mental health court has actually acted as a lever for making services work with people who have more challenging needs.
Mental health courts are an entirely voluntary programme. If someone chooses not to participate then their case continues to trial as usual. It is therefore very important that participants fully understand what is expected of them as part of the programme. They should receive a clear explanation of the conditions of the court, the length of time they are expected to engage with the programme and what the status of their case will be if they complete the programme. Conditions might include regular appointments with their mental health team, attending peer support groups, taking medication as required and having regular drug tests if substance use is a concern.

They must also have a full understanding of the maximum sentence they may be facing if they choose to go to trial in a traditional court, and that they will return to the regular trial process if they are not able to complete the programme. Some studies suggest that participants do not always have this understanding. One found that 60% of participants had not been told that the court was voluntary until they enrolled and many did not know that they could leave at any time.\textsuperscript{46} This has worrying implications for the ethics and ethos of mental health courts.

Diversion courts tend to fall into one of two categories. Some of them are pre-prosecution programmes. This means that they divert people before a trial takes place. By taking part in the programme, the participant is not making any admission of guilt. This format tends to be used for low-level offences, and often the charge is fully dismissed on successful completion of the programme. The majority of courts (67%) operate as a form of pre-sentencing diversion.\textsuperscript{47} This means that the participant must plead guilty to participate in the court but sentencing is deferred until the end of the mental health court programme. It is therefore even more crucial that participants are fully aware of what they are giving up by pleading guilty without a trial. Pre-sentence diversion is often used for more serious offences and charges are not always dropped entirely at the end of the programme. Instead, a prison sentence might be downgraded to a community supervision order for a period of time after graduation from the court.

\textsuperscript{46} Redlich et al., 2010
\textsuperscript{47} Redlich et al., 2010
Judicial supervision

A key element of the mental health court model is regular review hearings in court, chaired by the sitting judge. Most mental health courts have a dedicated judge who oversees them. These judges often have a background or particular interest in mental health and are keen to support the participant in their recovery. These review hearings tend to be weekly at the beginning of the programme and then less frequently as the participant is making progress. The reason for these hearings is twofold. They are a way of checking progress and making sure that the person is able to follow the conditions set down by the court. If the person is struggling, then amendments might be made so they receive more support as part of their treatment plan. This should be done in agreement with the judge, defence, prosecution, case manager and participant. In some courts, problem-solving meetings are held before the court session begins. These are an opportunity for key professionals to review problematic cases and develop alternative support options to put to participants.

These review hearings are also an opportunity for the judges to offer encouragement and positive reinforcement to the participant. Anecdotally, a number of people working in mental health courts believe that this engagement between the judge and participant is a huge part of the success of the programme. This is supported by a study that suggests that judges hold a pivotal role in conveying legitimacy to participants and helping them to recognise the norms of the law.48

Sanctions

On the whole, mental health courts are more flexible in responding to people who are struggling to follow the conditions of court. The problem-solving nature of the mental health court model means that there is a focus on trying to work out what extra support people might need in order for them to fulfil the court’s requirements. This is not to say that sanctions do not occur. However, people tend to be given a few chances before this action is taken.

The prosecution also plays a role in determining how flexible the court can be as they have to consent to sanctions not being used. They understand that it might not always be in the best interests of the public to sanction someone for a small slip in following the programme. They therefore tend not to look for a sanction unless there have been numerous instances of someone not meeting the terms of the court, or if someone commits an offence while participating in the mental health court programme. In the latter case, this often results in the person being removed from the mental health court programme altogether.

As it is a voluntary programme, the participant is also free to opt-out of the mental health court at any time and return to the original court docket. In some cases people feel the conditions of court are too onerous. Participation in mental health court can also result in lengthier contact with the criminal justice system than if they just served a prison sentence. In Washington DC, for example, the average diversion agreement lasts around six months. However in the other courts, it is commonly over a year and in the Bronx it can be up to 24 months (usually for more serious cases). There are therefore a number of reasons why people might not want to pursue the mental health court route.

48. Wales, Hiday, & Ray, 2010
Outcomes

The mental health court model does have its critics. Some feel that it is a very paternalistic model and that there is a risk that the line between rehabilitation and punishment can get blurred if sanctions are not managed properly. Diversion of this kind takes twice as long as processing offenders affected by mental illness through the traditional justice system. It could therefore keep people under judicial supervision for a lot longer than would otherwise be the case.

However, this has to be balanced against the benefits. Mental health participants value the voice and validation they are offered as part of the mental health court programme. They view the programme as fair and impartial.

Participants also have better criminal justice outcomes than people who go through the traditional criminal justice system. Reoffending is reduced and participants have fewer jail days. These positive outcomes are still evident two years post-graduation from mental health court. The re-arrest rate at this stage is 18% for those who completed the mental health court programme, compared to 81% of people who were ejected from the programme. Research has also shown that rates of reoffending and programme failure are lower among participants facing violent felony charges. This demonstrates that the mental health court model is effective even when handling more serious offences.

49. Redlich, Lie, Steadman, Callahan, & Robbins, 2012
50. Wales, Hiday, & Ray, 2010
51. Goodale, Callahan, & Steadman, 2013
52. Hiday & Ray, 2010
53. Reich, Picard-Fritsche, Cerniglia, & Wonsun Hahn, 2013
CONCLUSION

Although we are making progress, it is clear that some people affected by mental illness will continue to come into contact with the criminal justice system. Mental health is now seen as core police business and the introduction of the new liaison and diversion teams and street triage pilots show that this is acknowledged at all levels of policy-making. Ideally early intervention and preventative care would stop situations escalating to a point where criminal justice agencies need to get involved. However, where this does not happen it is important that the criminal justice system is supported to get an individual to the appropriate care and support as quickly as possible.

In many cases, people affected by mental illness reach crisis point because they have been let down by other services in the past. They deserve access to the right support at the right time, just like those with a physical health condition. This requires willing on the part of all agencies to make this happen. Too often criminal justice professionals are left in difficult positions because they are not getting the support they need from health colleagues. They are trying to balance public safety considerations with the individual’s wellbeing with few options available to them. This has to change and criminal justice agencies cannot do it alone.

Although the case studies from the USA and Canada are operating in a very different context to the UK, there are some key principles that are very relevant for practice here. What is clear from all the examples outlined in this report is that no one part of the system can solve all these problems without support from others. Real community-level collaboration is at the heart of all these new approaches and initiatives. This relies on a robust system for mapping community resources and identifying the gaps in provision so that a locally appropriate system can be developed. Commissioners from all parts of the system should be taking a lead in making sure this happens. Mental health services need to become more responsive to the unique needs of people in contact with the criminal justice system. They also need to be more accessible to criminal justice agencies trying to refer people into appropriate care.

Introducing a more problem-solving approach and effective case management into the traditional criminal justice system could also lead to better outcomes. This is true even if a full mental health court model is not implemented. These principles could underpin a real change in how people affected by mental illness are supported through the system. Court-based liaison and diversion teams could play a role in embedding some of these elements in the wider court process.

Looking to other systems for good practice examples is a positive way of constantly improving and refining our own systems. Hopefully this summary of models in the USA and Canada can add to the current focus on mental health and the criminal justice system. Long may the momentum on this issue continue.
RECOMMENDATIONS

No single agency can fix all the challenges discussed in this report. They require collaborative working across a number of community partners. At their heart is an urgent need for high-quality mental health support in the community, which might help prevent people reaching the criminal justice system at all. The Crisis Care Concordat has made a number of strong recommendations around crisis care provision, and this report fully endorses these.

In addition, this report makes further recommendations to strengthen local community partnerships. These are outlined below. This report will be shared with the key agencies named in the recommendations, as well as wider stakeholders at both the local and national level.

1. Local commissioners (Clinical Commissioning Groups, Local Area Teams, Police and Crime Commissioners and local authorities) should work together to map pathways for people affected by mental illness in contact with the criminal justice system in their area. This work should inform future commissioning plans.

2. Mental health service providers should work with local police and emergency services to ensure their referral processes do not create barriers to a quick and appropriate transfer of care.

3. Police and Crime Commissioners (PCCs) should commission mental health awareness training for police that is co-delivered by people with lived experience and local mental health service providers.

4. Crisis Intervention Team (CIT) model pilots should be considered as part of the ongoing national development of liaison and diversion.

5. Local areas should set up a steering group to oversee all elements of their crisis care system. This could be a function for existing Health and Wellbeing Boards, or any local bodies that form as a result of implementing the Mental Health Crisis Concordat. The steering group should include people affected by mental illness, along with families and carers.

6. The new Mental Health Intelligence Network from Public Health England should be extended to include comprehensive datasets on crisis services, section 136 detentions, police contact with people affected by mental illness and updated figures on mental health prevalence in the criminal justice system.

7. The Ministry of Justice should build on its previous mental health court pilot and look at introducing pre-prosecution or pre-sentencing models in magistrates’ courts.

8. Commissioners should consider including peer support provision in all mental health service specifications, including crisis services.

9. Local health and criminal justice agencies should develop joint protocols around information-sharing so that this can be done safely and effectively at a local level. These protocols should be developed in line with Caldicott recommendations and other guidance on safeguarding and data protection.
REFERENCES


Her Majesty’s Inspectorate of Constabulary, Her Majesty’s Inspectorate of Prisons, Care Quality Commission and Healthcare Inspectorate Wales. (2013). A Criminal Use of Police Cells?


APPENDIX 1

List of organisations visited (7th September - 19th October 2013)

**Virginia**
- Supreme Court of Virginia
- Department of Human Services

**Washington, DC**
- Pretrial Services Agency
- Mental Health Community Court, Superior Court of the District of Columbia
- Mental Health America

**Maryland**
- Anne Arundel County Mental Health Agency, MD

**Tennessee**
- Memphis Police Department
- Memphis Police Training Academy
- CIT Resource Center, University of Memphis
- VA Medical Center, Memphis
- Southeast Mental Health Center, Memphis
- Davidson County Jail, Nashville
- Davidson County Mental Health Court, Nashville
- Knoxville Police Department
- Helen Ross McNabb Center, Knoxville

**Ontario, Canada**
- Canadian Mental Health Association, Toronto
- Toronto Mental Health Court
- Toronto Police Service
- Legal Aid Ontario, Toronto
- COAST, Hamilton

**New York**
- Bronx TASC Mental Health Court Program
- Westchester County Mental Health Court, White Plains
- White Plains Police Department, White Plains
- Westchester Department of Community Mental Health, White Plains
- Policy Research Associates Inc., Albany
APPENDIX 2

Crisis Intervention Team survey questions

Which of the following best describes the agency you work for?
- Law enforcement
- Corrections
- Courts
- Probation
- Mental health service provider
- Other health service provider
- Consumer/family advocacy organisation
- Other community organisation
- Other _____________________________

Are you answering on behalf of an organisation that operates on a:
- Local level
- Regional level
- State-wide level
- Other _____________________________

How long has your CIT programme been running?
- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 10+ years

Approximately what percentage of your personnel are CIT trained?

Which of the following best describes your local CIT training programme?
- 40 hour programme in one week
- 40 hour programme over multiple weeks
- Training programme with more than 40 hours
- Training programme with less than 40 hours

Are you involved in delivering elements of the CIT training programme?
- Yes
- No

Are you involved in evaluating or monitoring your local CIT programme?
- Yes
- No

If yes, how is this evaluation/monitoring organised? (formal steering group, frequency of meetings etc.)

Which of the following mental health services are available to CIT officers in your local area?
- Mobile crisis response team with mental health professionals
- A dedicated crisis assessment centre
- Other mental health service
- Emergency department

Is there any information available on the impact of your CIT programme?
- Yes
- No

How is your local CIT programme funded?

What do you see as the biggest benefit of the CIT programme?

What do you see as the biggest challenge of the CIT programme?
The Winston Churchill Memorial Trust was established when Sir Winston Churchill died in 1965. Thousands of people, out of respect for the man and in gratitude for his inspired leadership, gave generously so that a living memorial to the great man could benefit future generations of British people. This fund now supports 100 Travelling Fellowships and ten Bursaries at Churchill College Cambridge, each year based on the Trust’s charitable Object of:

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