



**Adverse
Childhood
Experiences**

Be the Change

Applying the Sequential Intercept Model to the Northern Ireland Context

A selective review of practice innovations to improve the life chances
of justice-involved young people and adults with complex needs

**Main
Report**



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List of abbreviations

A&E = Accident and Emergency Department

ACE = Adverse Childhood Experiences

ACCT = Assessment, Care in Custody and Teamwork

ASW = Approved Social Worker

ATC = Alcohol Treatment Centre

CBT = Cognitive Behavioural Therapy

CYP = Children and Young People

DE = Department of Education NI

DfC = Department for Communities NI

DfE = Department for Environment NI

DoH = Department of Health NI

DoJ = Department of Justice NI

ED = Emergency Department

EITP = Early Information Transformation Programme

FMO = Forensic Medical Officer

GP = General Practitioner

HSCT = Health and Social Care Trust

LDS = Liaison and Diversion Schemes

MCT = Mobile Crisis Team

MH = Mental Health

MHC = Mental Health Court

MHIRT = Mental Health In-Reach Team

MHIRS = Mental Health In-Reach Service

MHPO = Mental health probation officer

MoJ = Ministry of Justice

NHS = National Health Service

NI = Northern Ireland

NIAO = Northern Ireland Audit Office

NICE = National Institute for Health and Care Excellence

NICTS = Northern Ireland Courts and Tribunals Service

NIPS = Northern Ireland Prison Service

NISRA = Northern Ireland Statistics and Research Agency

NOMS = National Offender Management Service

OoCD = Out-of-Court Disposal

PBNI = Probation Board for Northern Ireland

PD = Personality Disorder

PHE = Public Health England

PIPE = Psychologically Informed Planned Environment

PPO = Prisons and Probation Ombudsman

PRA = Policy Research Associates

PRT = Prison Reform Trust

PPS = Public Prosecution Service

PSNI = Police Service of Northern Ireland

QUB = Queen's University Belfast

RCT = Randomised Controlled Trial

SAMHSA = Substance Abuse and Mental Health Services Administration

SBNI = Safeguarding Board for Northern Ireland

SEHSCT = South Eastern Health and Social Care Trust

SIM = Sequential Intercept Model

SMHC = Specialised Mental Health Caseload

SMI = Serious Mental Illness

TIC = Trauma Informed Care

TIP = Trauma Informed Practice

UK = United Kingdom

US = United States of America

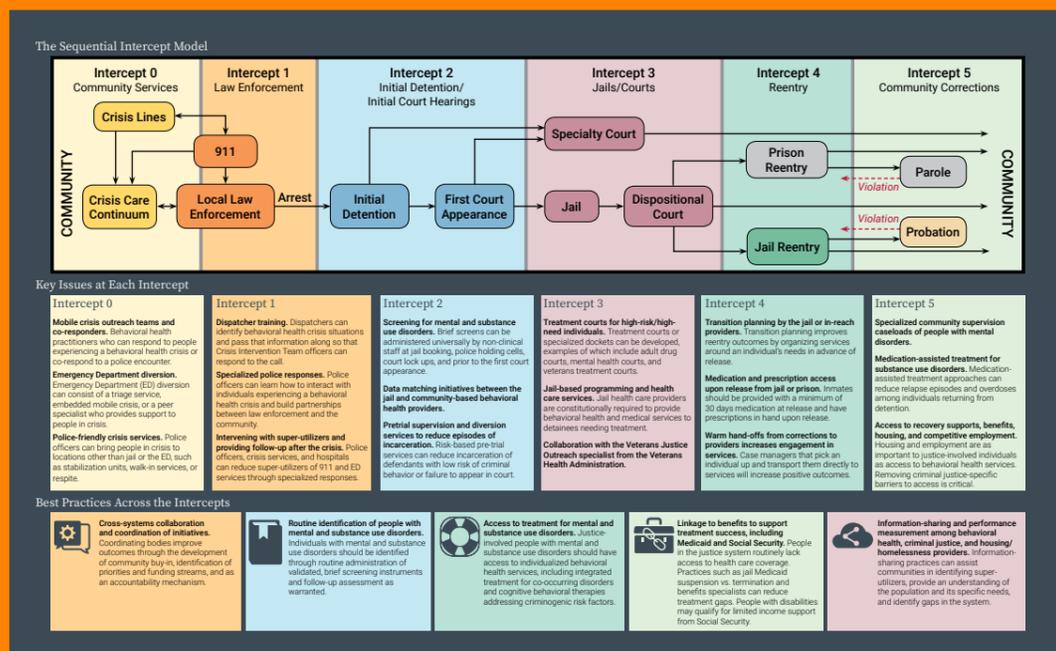
YJB = Youth Justice Board

YJS = Youth Justice Agency

YOT = Youth Offending Team

CHAPTER 1

REPORT PURPOSE AND OVERVIEW



1.1 Developing Trauma Informed Practice in Northern Ireland

This report uses the 'Sequential Intercept Model' as a framework for a selective review of practice innovations at different stages of the criminal justice process as a means to identify good practice to improve the life chances of young people and adults with complex needs in Northern Ireland (NI) who interface with the criminal justice system (CJS)³. Commissioned by the Safeguarding Board Northern Ireland (SBNI), the report makes a contribution to the Early Intervention Transformation Programme's (EITP) Trauma Informed Practice developments for health, social care, education, justice systems and the voluntary and community sectors in Northern Ireland (NI). The EITP aims to improve life chances and outcomes for children and young people in NI, embedding early intervention approaches. The EITP initiative is part of Delivering Social Change/Atlantic Philanthropies Signature Project, jointly funded by the NI Department of Health (DoH), Department of Justice (DoJ), the Department for Communities (DfC), Department for Environment (DfE), the Delivery Social Change Fund and Atlantic Philanthropies.

As part of the EITP Trauma Informed Practice initiative, academics from Queen's University Belfast (QUB) undertook a rapid evidence review in 2018 to support the adoption of trauma informed practice across NI care systems. A series of reports were produced focused on the implementation of trauma informed care in the child welfare, health, education and justice systems in addition to a key messages report which provided an overview of the principles of trauma informed care and summarised the evidence review findings across multiple systems and settings (Bunting et al., 2018a-e).

1.1.1 Trauma Informed Care

Trauma informed care (TIC) is a whole system transformation process that seeks to embed coherent models of practice across diverse settings and roles. Originating from the seminal US Adverse Childhood Experiences (ACE) study (Felitti et al., 1998) and extended by subsequent international and UK research, study findings established a strong graded relationship between the number of childhood adversities experienced (inclusive of physical, sexual and emotional abuse; neglect; and household adversities), and a wide range of negative outcomes, across multiple domains over the life course (Anda et al., 2006; Anda et al., 2010; Bellis et al., 2015; Hughes et al., 2017; Van der Kolk et al., 2005). Recognising the impact of childhood adversity on child and adult health and

³ Reference to the criminal justice system in this report is inclusive of policing (Police Service of Northern Ireland - PSNI), the judiciary including the Public Prosecution Service (PPS) and Northern Ireland Courts and Tribunals Service (NICTS), the prison service (Prison Service Northern Ireland), probation services (the Probation Board for Northern Ireland - PBNi), the Youth Justice Agency (YJA) and prison healthcare services provided by the South Eastern Health and Social Care Trust (SEHSCT).

wellbeing outcomes, trauma-informed service delivery strives to build collaborative relationships with children and adults, improving consistency and communication across linked organisations and sectors. The aim is to mitigate the impact of adversity by supporting and enhancing child, adult and family capacity for resilience and recovery, while reducing organisational practices that may inadvertently exacerbate detrimental effects of severe adversity and impede service engagement. Although most widely implemented in the USA, trauma informed care is gaining momentum as a comprehensive practice framework across the UK, Europe, Australia and New Zealand with a growing body of context-specific implementation guidance and associated evaluation generating evidence of positive effect.

1.1.2 Trauma-informed justice systems

Increasing recognition of the strong connections between trauma history and involvement with the justice system (Bellis et al., 2015), continued traumatic experiences within the justice system (Kubiak et al., 2017), and the relationship between harsh punishments and continued offending on release (Ko et al., 2008) has led to the adoption of trauma-informed approaches in adult and youth justice settings. These developments are reviewed and discussed in detail in the justice report commissioned by the SBNI as part of the Trauma Informed Practice project in NI (Bunting et al., 2018c). Although not specifically identified by its developers as a trauma-informed approach, the Sequential Intercept Model (SIM) was identified by this evidence review as a promising framework promoted by the US federal government Substance Abuse and Mental Health Administration Agency (SAMHSA) to inform the work of the justice system, highlighting opportunities to implement community-based treatment for justice-involved individuals suffering mental ill health and/or substance misuse conditions as a means of minimising involvement in the criminal justice system (Munetz & Griffin, 2006, p320). It is argued that such diversion has the potential to reduce costs to society and deliver appropriate services without increasing the risk to public safety (Heilbrun et al., 2015). This framework is described in detail below. Implementation of the SIM framework is the focus of this follow-up report, which seeks to explore the relevance for justice-involved young people and adults in NI impacted by adversity and trauma, highlighting the evidence for emerging good practice.

1.2 Vulnerability and the Justice System: the prevalence of complex needs in justice-involved persons

The Northern Ireland justice system objectives strive to ‘protect the public, bring offenders to justice, support victims and support the rehabilitation of offenders to reduce the overall level of offending’ (NIAO, 2019 p.2). Given the overarching aim of public protection, it may appear rather counter-culture to consider the vulnerabilities of those who offend or are at risk of offending. Offender vulnerability is however a vital consideration if we are to understand the complex factors that influence how people serially come to the attention of the criminal justice system. Evolving a system of justice that fully and fairly takes offender vulnerability factors into account may best assist as many people as possible navigate away from offending behaviour patterns toward lives where they can thrive and contribute positively to society. The complex links between health, social inequality and crime are increasingly recognised (for example Public Health England, 2018). Justice-involved persons are known to suffer significantly worse health than the general population and are more likely to be the victims of crime (Anders et al., 2017). By working to address social exclusion and health-related problems connected to criminal behaviour, it is recognised that crime can be prevented (PHE, 2018).

Recent justice system developments in the UK and NI recognise these challenges. Adult and youth justice processes are striving to take effective account of these intersecting influences on offending behaviour and promote cross-sector partnership working to enable and prioritise upstream intervention to prevent or mitigate underlying causes and impact of offending behaviours (see for example PHE, 2018; Improving Health in Criminal Justice Strategy and Action Plan, 2019). This report has emerged from one such effort in NI – the move towards trauma informed practice to mitigate the deleterious influence of childhood adversity and trauma.

1.2.1 The trouble with language and definition: the case for complex needs

When attempting to name and quantify the vulnerabilities of justice-involved populations, problems of language and definition emerge. Reports and studies apply a range of terms to such vulnerabilities including ‘mental health issues’, ‘emotional wellbeing problems’, ‘mental health disorders’, ‘substance use problems/disorders’, ‘complex needs’, ‘social and health issues’, ‘adversity’ and ‘trauma’. While language can be inclusive, terms often seek to define by excluding potentially similar issues which are *not* being addressed. Definition variability is noted in the recent report by the Northern Ireland Audit Office (NIAO, 2019) which reviewed ‘mental health in the criminal justice system’ urging establishment of ‘consistent definitions’ enabling collection of good quality justice system data and partner agencies about ‘mental health and other key vulnerabilities’ (p.4) among offenders. Shared consistency of vulnerability definition is recognised as an issue of some significance to enable effective data analysis and policy decision-making. Researching this report, efforts have been made to find inclusive terminology as a means to capture the range of vulnerabilities that many justice-involved young people and adults experience and in doing so, explore a wider range of practice initiatives. As a result, the overarching term of ‘complex needs’ is used throughout this report, with more specific terms such as ‘mental health disorders’ applied where a particular term or definition is present in the literature cited.

1.2.2 The prevalence of complex needs in justice-involved persons

It is well established that young people and adults involved with the justice system are disproportionately affected by adversity and trauma (Miller et al., 2011), with exposure to childhood adversity identified as a key risk factor for subsequent justice involvement (Kerig & Becker, 2010). UK research indicates the scale of the increased risk with recent population-based ACE surveys demonstrating that English adults exposed to 4 or more ACEs were 11 times more likely to be imprisoned at some time in their lives (Bellis et al., 2014) while Welsh adults experienced a 20 times greater likelihood of imprisonment (Bellis et al., 2015). The NI Audit Office (2019) note that people who repeatedly encounter the justice system often live ‘chaotic lives’ (p.2). While noting the lack of authoritative evidence, higher rates of a range of social and health issues in this population is noted, including mental ill health, alcohol and substance misuse, homelessness, lack of educational attainment and employment opportunities and psychological harm caused by prior traumatic experiences. This range of vulnerabilities is also

noted as present for many young people close to, or in contact with the Youth Justice System, having missed opportunities for early identification and intervention. Justice-involved young people are recognised as ‘more likely than their peers to have a mental health or neuro-disability problem, and may often have more than one mental health problem in combination with a range of vulnerabilities from adverse childhood experiences. A common feature of this cohort is that they do not always fit into clear diagnostic categories, and as a result, some of their mental health needs are not being met’ (Twitchett & Sylvester, on behalf of NHS England, 2018 p.160). The significant presence of multiple vulnerabilities and the links between victimisation and offending in justice-involved persons, both young people and adults, is starkly evidenced by the sample of UK and NI statistics presented below (Table 1). Regional and national statistics provide a reminder of the multiple challenges driving the need for integrated and collaborative working across traditional system boundaries of justice, mental health, physical health, social care and housing, to ensure that basic and more complex needs of justice-involved persons are identified and addressed systematically.

Table 1. Complex needs prevalence in justice-involved persons

Complex needs prevalence in justice-involved persons	UK statistics	NI statistics
Mental health problems	<p>26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody (MoJ, 2013).</p> <p>25% women and 15% men in prison reported symptoms indicative of psychosis (MoJ, 2013) – the rate is 4% in the general public (Wiles et al., 2006).</p> <p>8 in 10 women in prison (79%) reported that they had mental health issues compared with 7 in 10 men (71%) (HM Chief Inspectorate of Prisons, 2018).</p>	<p>Initial arrest: 64% of cases in a sample of 240 arrests in 2017-18 indicated that the arrested person had, or had previously had, a mental health issue (NIAO, 2019 p.16).</p> <p>Prison population: NIAO reviewed 4 years of committal data (2014-18) to gain an indication of the mental ill health prevalence in NI prisons. Over one third (36%) reported they had been engaged with MH services at the time of committal (NIAO, 2019 p.20).</p> <p>Community sentences: 42% offenders assessed by NI Probation Service were determined to have some level of mental health problem (i.e. been diagnosed and prescribed medication) and 72% had a 'general emotional wellbeing problem' (NIAO, 2019 p.23)</p>
Suicide & self harm	<p>Self-inflicted deaths are 6.2 times more likely in prison than the general population (MoJ, 2018a).</p> <p>Current rates of self-harm are at the highest ever recorded (MoJ, 2018b)</p>	<p>44% of prison population have history of self-harm at committal (NIAO, 2019 p.20).</p> <p>Self-harm is a near daily occurrence, with more than one incident recorded on most days in 2017 and 2018 – on just over one third of days, 3 or more self-harm incidents were recorded across the NI prison estate (NIAO, 2019, p.33)</p>
Substance Use	<p>It is estimated that 33-50% of all acquisitive crime is committed by drug users (National Treatment Agency for Substance Misuse, 2009).</p>	<p>Over half of the NI prison population indicated drug use prior to committal (58%) (NIAO, 2019 p.20).</p>
Learning disabilities	<p>34% of people assessed in prison in 2017-18 reported they had a learning disability or difficulty (Skills Funding Agency, 2018)</p>	
Basic needs	<p>Prisoner Needs Profile questionnaires completed in 2017 reported that 9% of prisoners who responded said they were not registered with a General Practitioner (NIAO, 2019 p.38)</p>	

Complex needs prevalence in justice-involved persons	UK statistics	NI statistics
Employment	<p>Only 17% of people are in PAYE employment one year after leaving prison (MoJ, 2018c).</p>	
Homelessness	<p>Prisoner Needs Profile questionnaires completed in 2017 reported that 19% were homeless or living in a hostel when they entered prison; 26% stated that they had no accommodation to go to upon release (NIAO, 2019 p.38)</p> <p>Nearly 2 in 5 women (37%) left prison without settled accommodation – around 1 in 7 (14%) were homeless and nearly 1 in 20 (4%) were sleeping rough on release in 2017-18 (MoJ, 2018d).</p> <p>One in 7 people who left prison in the year to March 2018 were homeless. This increases to 1 in 5 people serving a sentence of less than six months (MoJ, 2018e).</p>	
Children and young people	<p>Fewer than 1% of all children in England are in care, but around two-fifths of children in secure training centres (44%) and young offender institutions (39%) have been in care (HM Inspectorate of Prisons, 2019)</p>	<p>While looked after children represent less than 1% of the under 18 population in NI, they accounted for between 9 and 17% of referrals to PSNI Youth Diversion Officers between 2009-10 and 2013-14 (NIAO, 2017)</p>
	<p>It is estimated children with care experience are 5 times more likely to become involved with the justice system than those outside the care system (Prison Reform Trust, 2017)</p> <p>A profile of young people in the youth justice system in Wales with a history of reoffending (Youth Justice Board Cymru, 2012) found that:</p> <ul style="list-style-type: none"> • 48% had witnessed family violence • 55% had been abused or neglected • 79% had social services involvement • 81% were without qualifications • 95% had substance misuse issues 	
Women	<p>More than half of women prisoners in England (53%) report having experienced emotional, physical or sexual abuse as a child compared to 27% of men (MoJ, 2012)</p> <p>57% of women in prison report being victims of domestic violence as adults (MoJ, 2014). This is likely to be an underestimate (Gelsthorpe et al., 2012). The charity Women in Prison report that 79% of the women who use their services have experienced domestic violence and/or sexual abuse (House of Commons Justice Committee, 2013).</p> <p>Of young women offenders in custody, 40% have suffered violence at home and 30% have experienced sexual abuse at home (Prison Reform Trust, 2012).</p>	

1.2.3 Trauma and the justice process

In addition to the prevalence of a trauma history for individuals prior to their involvement with the criminal justice system, the potential for the justice process itself to evoke a trauma response or re-traumatise is well evidenced and widely accepted. Trauma triggering experiences may occur in the innumerable interactions and processes that make up the justice pathway – from initial attendance at an incident to arrest, investigation, trial, detainment and release into the community. While practices frequently utilised in justice settings may be considered necessary to maintain order, manage difficult behaviours and increase safety for staff and others (e.g. use of restraint, seclusion, invasive searches, movement restriction), these interpersonally restrictive practices are recognised as potentially traumatic in their own right, and can have a re-traumatising effect on people impacted by early life trauma (Covington, 2008; Owens et al., 2008). For example, Kubiak et al. (2017) note that while negative responses by female prisoners to ‘pat down’ searches or medical examinations may be perceived by staff as evidence of resistance or non-compliance, they may also reflect fears about invasive, inappropriate touch emanating from prior life experience. Similarly, Pickens (2016) notes that young people’s resistance to showering may be as a result of previous traumatic experience. It is noted that the level of safety for prisoners is often compromised. Physical and sexual victimisation of prisoners while incarcerated remains a significant risk (Beck et al., 2013; Beck & Johnson, 2012). Current Ministry of Justice incident recording indicate that restraint and assault rates amongst children in custody in England and Wales remain high (2019a), with assaults and serious assaults in adult prisons currently at the highest levels ever recorded (2019b). Recorded sexual assaults in prison are reported to have quadrupled since 2012 (MoJ, 2019b).

1.3 The Sequential Intercept Model

1.3.1 Rationale: inappropriateness and lack of effectiveness of criminal justice system for persons with complex needs

It is abundantly clear from the statistical records tabled here that the criminal justice system currently interfaces with many individuals who have experienced early life trauma, as well as people suffering current mental health and substance misuse problems. In addition to a high cost response, it is recognised that the justice system is often poorly positioned to provide effective treatment and care to this vulnerable population or reduce re-offending rates, given the connection with other complex vulnerability factors in people’s lives. Not only is the criminal justice system often ineffective in meeting the multi-faceted needs of people impacted by multiple adversities, it is also recognised that justice involvement can exacerbate the difficulties of this already vulnerable population making it harder to rehabilitate, to become full and valued members of society. As a result, government bodies and communities are increasingly seeking alternatives that *safely* divert people with behavioural health needs⁴ towards cost-efficient and effective community-based treatments and services that produce better life chances and enhanced outcomes for the individual, the community and the justice system (Abreu et al., 2017).

1.3.2 Development of the Sequential Intercept Model

The Sequential Intercept Model (SIM) is a cross-systems framework which was developed in the US over a number of years in the early 2000s by Mark Munetz, Patricia A. Griffin and Henry J. Steadman as a conceptual model to inform community-based responses to the involvement of people with mental health and/or substance use disorders in the criminal justice system (see Griffin et al., 2015 for further detail). The underlying philosophy of the SIM is that while people with mental health and/or substance misuse problems should be held accountable for any criminal behaviour (assuming their actions are not directly caused by mental illness), they should not be arrested or detained in the criminal justice system simply because of illness or lack of access to appropriate treatment (Munetz & Griffin, 2006). The SIM framework was designed to assist stakeholders and communities of interest consider the interface between the criminal justice and mental health systems as a mean to address the unnecessary criminalisation of people with mental illness (Munetz & Griffin, 2006). It is predicated on the ideal that ‘the presence of mental illness should not result in unnecessary arrest and

⁴ Much of the criminal justice literature from the US refers to ‘behavioural health’. This is not a term that is used routinely in the UK. While the terms behavioural health and mental health are often used interchangeably, there are some differences (see <https://therehab.com/news/behavioral-health-vs-mental-health> for further details). As these differences are not the focus of this report, the term ‘mental health’ and ‘behavioural health’ are used interchangeably in this report.

incarceration’ and that stakeholders across multiple systems (including justice, mental health, addiction, housing etc.) share responsibility for developing viable alternatives (Munetz & Griffin, 2006 p.544). The SIM framework particularly highlights opportunities to implement community-based treatment for justice-involved individuals suffering mental ill health and/or substance misuse conditions as a means of reducing further involvement in the criminal justice system (Munetz & Griffin, 2006, p320). It is argued that such diversion has the potential to reduce costs to society and deliver appropriate services without increasing the risk to public safety (Heilbrun et al., 2015).

While the SIM framework was designed to address issues of mental health and/or substance misuse, it does not specify the programme or limit the interventions to a specific population. As conceived, it is quite feasible to use the framework when designing programmes that would meet the needs of adults and young people with various challenges (e.g. mental health, substance misuse, intellectual disability, social care issues), SIM would simply guide the programme development in terms of its most effective placement within the overall system (Munetz & Griffin, 2006, p.322). This flexibility proves useful in order to consider how to address the needs of vulnerable justice-involved young people and adults with complex needs.

1.3.3 The Sequential Intervention Model (SIM)

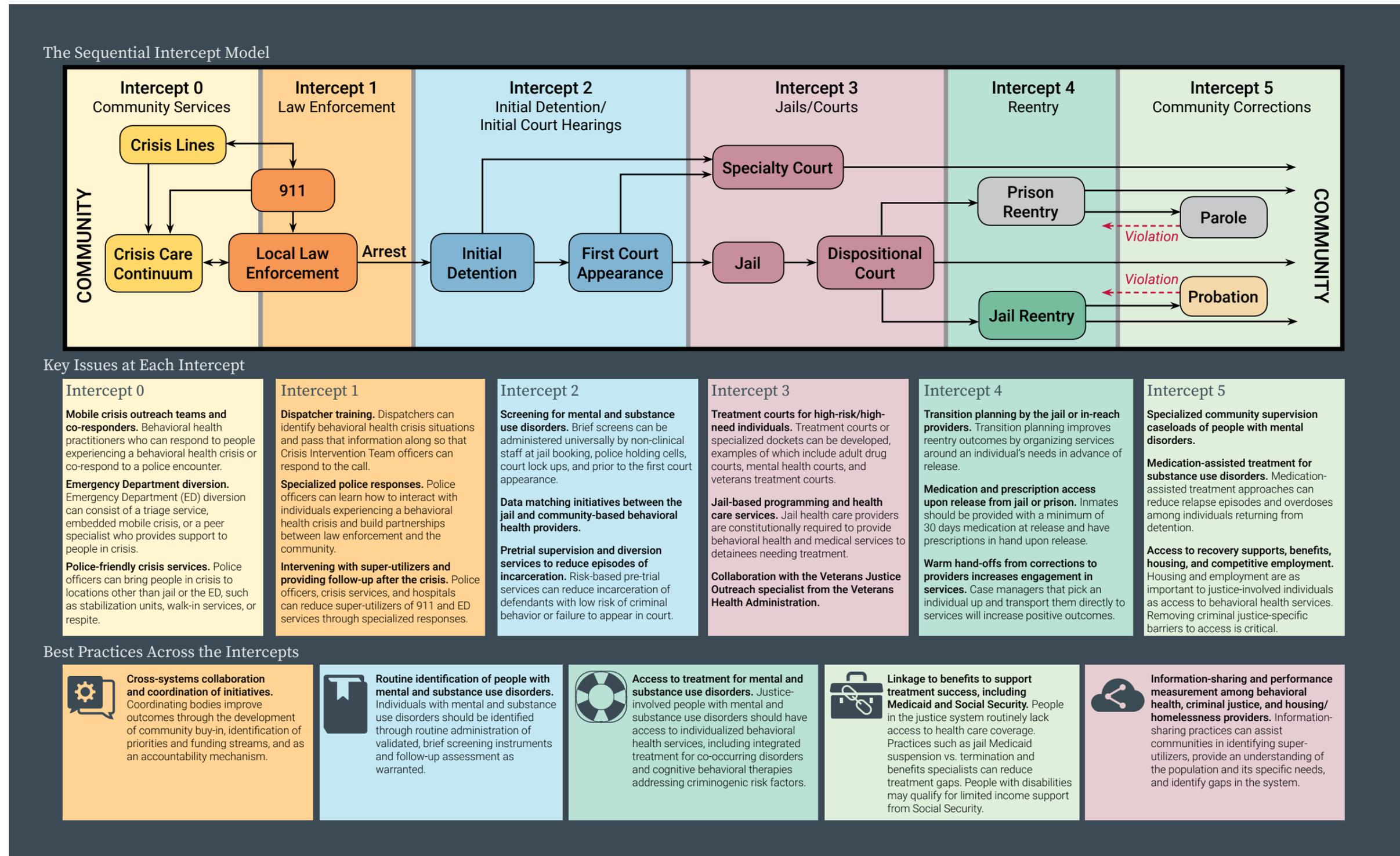
After years of piloting and refinement, several SIM versions evolved. These include the ‘filter’ or ‘revolving door’ versions (Munetz & Griffin, 2006), and an early version of the ‘linear’ model used in this report (see Figure 1) which was first published by Policy Research Associates (PRA) in 2005 by contract to operate the National GAINS Centre on behalf of the US federal policy and best practice funding agency, SAMHSA, which focusses on expanding access to services for people with mental health and/or substance disorders who come into contact with the justice system (see <https://www.samhsa.gov/gains-center>). SAMHSA prioritised this population for research and practice innovation investment given the high rate of people with mental health and/or substance misuse disorders involved with the justice system. Over the past 20 years, the model has gained prominence in the USA as an effective systematic framework (i) assessing available community resources (ii) determining critical service gaps (iii) identifying opportunities to safely divert people from unhelpful involvement in the criminal justice system and (iv) implementing reforms at 6 distinct justice decision points or ‘intercepts’ (Policy Research Associates, 2018).

Originally, the SIM delineated five intercepts (labelled 1 to 5 in Figure 1) corresponding to key criminal justice processing decision points (law enforcement; initial detention/initial court hearings; jails/courts; re-entry; community corrections). These decision points are thought to represent junctures where people with mental health issues could be prevented from ‘entering or penetrating deeper into the criminal justice system’ (Munetz & Griffin, 2006 p.544) and diverted to alternative treatment or programming that is more appropriate to their needs. Each intercept is thought to function as a filter, with interventions ideally ‘front-loaded’ to ‘intercept’ people early in the pathway (Willison et al., 2018) and therefore curtail criminal justice involvement to its lowest level. An additional intercept was formally added in 2017 in recognition of the dual roles played by the police in protecting public safety and serving as emergency responders to people in crisis (Abreu et al., 2017). Intercept 0 is entitled ‘community services’ and recognises early intervention points *before* arrest for people in crisis who come into contact with law enforcement. The goal at intercept 0 is to prevent people from becoming involved in the criminal justice system by connecting them with more appropriately tailored services to meet their needs. The fluidity between intercept 0 and 1 is depicted by the two-headed arrow. At intercept 0 and 1, there exists the possibility of ‘step down’ to community services only or ‘step up’ to some level of involvement in the criminal justice system depending on the presenting concerns.

1.3.4 The SIM mapping process as a strategic planning tool

Over recent years, the SIM is considered most effective when used as an applied community strategic planning tool to assess available resources, determine service gaps and develop priorities for action (Willison et al., 2018). Many communities in the USA have used the SIM to ‘map’ the various pathways by which people with behavioural health needs encounter the justice system and the range of response – both inside and outside the justice system – applied to those people (Willison et al., 2018). Facilitated mapping workshops are thought to be best accomplished by bringing together stakeholders that cross multiple systems (including policing and emergency services, mental health, substance use, courts, prison service, probation, relevant voluntary sector providers as well as people with lived experience) to develop a comprehensive picture of how vulnerable people move through the criminal justice system and identify service and policy gaps, resources, opportunities and devise action plans for each of the six distinct intercept points. Recent research has confirmed that this sequential mapping process is well-received by stakeholders with potential to improve cross-sector collaboration, enhancing community policy and practice for adults and young people with mental illness (Bonfine & Nadler, 2019).

Figure 1: The Sequential Intercept Model (Policy Research Associates, 2018)



1.4 Report Structure, Process and Limitations

This report provides a selective review of SIM-related practice innovations as a means to highlight emerging good practice with regard to initiatives targeted toward young people and adults with complex needs and their engagement with the criminal justice system.

1.4.1 Report Process

The literature detailing different policy and practice developments at various stages of the criminal justice process is vast. This report is not intended as an exhaustive review of the literature but rather an up-to-date focused and selective review of key criminal justice themes and developments relevant to the application of the Sequential Intercept Model. The report was structured by an initial search of multiple academic databases [SCOPUS, MedLine, the International Bibliography of the Social Sciences (IBSS) and the Social Sciences Citation Index] to identify review articles specifically focusing on the Sequential Intercept Model. This search identified several relevant academic papers which were used to classify the types of initiatives included within each intercept and relevant search terms for a selective review of both the academic and practice literature within each intercept.

1.4.2 Report Structure

The report is structured using the six SIM intercepts, with each intercept afforded a chapter to explore in-depth. Each chapter commences with a brief overview of the specified intercept, setting out key issues and challenges for practice affecting persons with complex needs at this point in the criminal justice pathway. Relevant statistical information is provided where available. A summary of the key features of the primary initiatives trialled at the particular intercept is provided. This is followed by an overview of the effectiveness research evidence and common measurable outcomes from the literature with the intention of facilitating groups of stakeholders to engage in mapping and planning exercises in a focused way. In order to provide greater insight into the implementation of practice initiatives, examples are provided of promising initiatives sourced in the literature. Where possible, US example and UK/Ireland/international examples are included. Practice examples were selected to provide perspective to the range of initiatives located across both adult and youth justice settings within each intercept. Each chapter concludes with an overview of the key messages for service developments at each intercept emerging from the literature. The report concludes by discussing over-arching cross-intercept best practice principles.

1.4.3 Report Limitations

A number of limitations deserve mention. It should be noted that this report presents a selective review of the available literature as a means to highlight key features of effective practice implementation across the SIM. Given time constraints and the identified purpose of this report, a comprehensive systematic search was neither possible nor desirable. The limited scope of the report is particularly evident when looking at practice innovations in relation to specific populations such as young people and women, as it has not been possible to review these in the detail warranted. While the over-representation of some groups in the justice system has been noted throughout the report (such as children with care experience, women with domestic violence history, and Black, Asian and minority ethnic groups) as a means to assist service providers consider targeted initiatives to address the complex needs of these notably vulnerable populations, these issues are not addressed in any depth in this report. Caution should also be applied when drawing comparisons between practice initiatives in other jurisdictions where significant differences exist in the legislative and policy contexts and the availability of services (e.g. the need for health insurance to enable payer access to certain mental health services in the USA). When considering youth justice practice examples, the age of criminal responsibility is of primary importance. Set at 10 years in NI, England and Wales; 12 years in Scotland; 15 years in Sweden, Finland and Norway; and varying between states in USA, as low as 6 years in South Carolina and 7 years in 35 US states. It becomes apparent how early-life criminalisation can set an event sequence with lasting traumatic impact across the life course. Inconsistency in terminology used in the literature reviewed has also been noted, making it difficult to draw conclusions on effectiveness. This remains an ongoing challenge.

However, despite evident limitations, this report has highlighted key messages for consideration by service providers and policy makers in their efforts to improve the outcomes for justice-involved young people and adults with complex needs who are impacted by early life trauma, mental ill health and/or substance use problems.

1.5 Northern Ireland Policy, Practice and Legislative Context – Challenges and Opportunities

There are a number of NI service provision and policy contextual issues that are important to mention which present both operational challenges and opportunities when designing new initiatives to improve the life chances of justice-involved young people and adults with complex needs.

1.5.1 Challenges

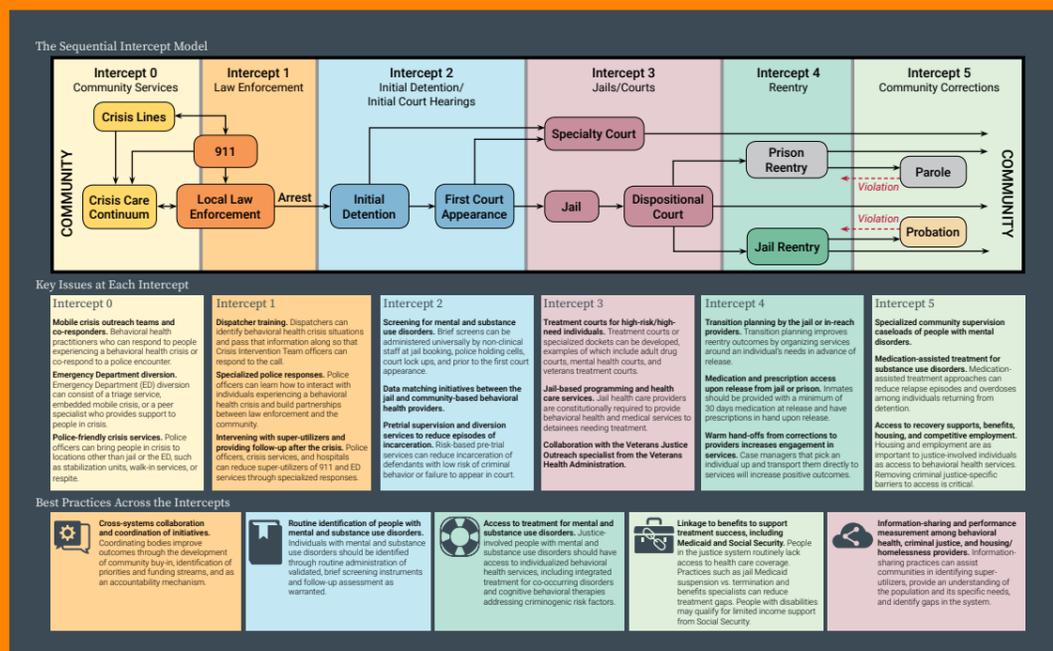
One such structural challenge to effective interagency working includes that while the PSNI, PBNI, NIPS and the judiciary have a regional remit, they must interface with five different Health and Social Care Trusts (HSCs) in their efforts to meet the needs of people for whom they have a duty of care. Each HSC Trust has different working practices, processes, and variable local service availability. Statutory provision inconsistencies are further compounded by multiple, patchy local and regional voluntary and community sector services available to each Trust area. Examples of innovative local initiatives, can also be undermined by short term funding cycles and the absence of robust built-in concurrent and end of project evaluation processes. It is recognised that these multiple organisational and departmental culture and practice interfaces complicate meeting the needs of justice-involved persons with complex needs (NIAO, 2019). These barriers are exacerbated by the long-standing underfunding of mental health services across NI which has led to services not keeping pace with demand (Commission on Acute Adult Psychiatric Care, 2016), as well as a general reduction in resources available to justice organisations. It is also of note that the general prevalence of mental health problems in NI is considered to be 25% higher than in England and Wales (Department of Health, 2014) due to a range of economic and social factors (NIAO, 2019 p.6). This is likely to be replicated in the NI justice-involved population. In addition to interface and resource challenges, NI's contested political history has meant that law enforcement is perceived differently in different communities (Hayes & McAllister, 2013). This adds additional complexity to safe, effective PSNI involvement with people in crisis.

1.5.2 Opportunities

However, there are also opportunities. While the Mental Health (Northern Ireland) Order 1986 excluded Personality Disorder and Substance Misuse Disorders from the mental disorders that could enable detention, the incoming Mental Capacity Act (NI) 2016 offers opportunities to consider how best to address this gap. This legislative omission has significant resource, culture and understanding implications for the justice system. It is widely recognised that the prevalence of Personality Disorder is relatively high amongst justice-involved individuals, presenting significant management challenges for justice organisations (NIAO, 2019). In addition to legislative change, a range of reforms are already underway within the justice system to improve the quality of working relationships and build cross-sector collaborative practices to better meet the needs of vulnerable people who are in contact with different parts of the justice system. Justice developments are detailed in the NIAO (2019) report (p.40-41) and include piloting of Mental Health Courts, Community Support Hubs and Mental Health Triage. Similarly, there are examples of promising projects in the voluntary sector which led to preliminary good outcomes (for example, the ADJUST project, 'Adolescents leaving the justice system', Venture Network, 2016), albeit that the projects were not always successfully sustained or evaluated. It is anticipated that this report will aid the development of initiatives already underway in NI and encourage others. In NI, unlike other parts of the UK, we are in the fortunate position of all justice services remaining in the public sector. For our relatively small regional population, with further concerted collaborative efforts, there are therefore opportunities to make significant system-wide positive contribution to improving the life chances of justice-involved persons with complex needs through greater understanding and more systematic cooperation and support.

CHAPTER 2

INTERCEPT 0: COMMUNITY SERVICES



2.1 Overview of Intercept 0

INTERCEPT 0: COMMUNITY SERVICES

Intercept 0 focuses on ‘community services’ and identifies early intervention points to intercept people with complex needs *before* they engage with the criminal justice sector or are placed under arrest. It is based on the assumption that *interventions should always be at the lowest level of criminal justice involvement*, with optimal support to meet identified needs.

The goal of Intercept 0 is to connect individuals with complex needs with appropriate assessment, treatment and services and prevent further involvement with the criminal justice system where possible. Intercept 0 and 1 recognise that police officers have dual roles, both protecting public safety and also acting as first responders to people in crisis. Police officers and emergency services therefore form an essential part of the ‘crisis care continuum’. At intercepts 0 and 1, there exists the possibility of ‘step down’ to community services only or ‘step up’ to some level of involvement in the criminal justice system depending on the presenting concerns. The fluidity between intercept 0 and 1 is depicted by the two-headed arrow.

Common strategies at Intercept 0 include the development of *community-based crisis services across the crisis care continuum* including:

- ▶ **Crisis Lines** provide free and confidential telephone counselling, assess suicide risk, develop safety plans with people in crisis, liaise with health and social care providers, and refer callers to appropriate support services including mobile crisis teams or emergency services where on-site assistance is required.
- ▶ **Crisis stabilisation services** provide short-term supervised care (outside of emergency departments) to individuals in crisis to de-escalate acute symptoms, safety plan and avoid further contact with emergency services or unnecessary hospitalisations where possible.
- ▶ **Mobile crisis teams** provide acute mental health crisis stabilisation and assessment services to individuals in crisis within their own homes and in other sites outside clinical settings.
- ▶ **Peer crisis services** offer short-term alternatives to psychiatric emergency department or inpatient hospitalisation and are facilitated or co-facilitated by people with lived experience of mental illness or crisis.
- ▶ **Specialised police responses** such as the development of crisis intervention teams. These initiatives are examined in Intercept 1.

Key stakeholders: emergency services; crisis services; mental health and social care community-based providers (statutory, voluntary and community sectors); police

2.2 Key Issues and Challenges at Intercept 0

Responding to the needs of people with complex needs requires a range of specialised responses, and good collaboration and coordination across multiple stakeholders. Effective practice at this intercept in NI is complicated by the following issues and challenges, in addition to those outlined in chapter 3.

2.2.1 High prevalence of people with complex needs encountering the justice system

The research evidence presented in chapter 1 confirms that there are higher rates of a number of social and health issues amongst those who encounter the justice system than in the general population. These include mental health issues, alcohol and substance abuse, homelessness, limited educational attainment or employment opportunities, and trauma-related psychological problems (NIAO, 2019 p.2). This is particularly evident at Intercept 0/1 with the Police Service in NI (PSNI) reporting a large increase in the number of non-criminal incident reports often resulting in police officers attending incidents in response to a mental health or emotional crisis *where no crime has been committed* (over 20,000 per year in 2019) (NIAO, 2019 p.14). Police involvement in such events is recognised as having a negative impact on police time, limiting their availability for other duties as well as being highly costly (NIAO, 2019 p.27). These statistics give an indication of the scale of the challenges for early intervention community service provision to intercept people who have a history of trauma, mental ill health and who are victims of violence, who may inappropriately enter the criminal justice system with all the longer term negative consequences of involvement in criminal justice.

2.2.2 Over-representation of some vulnerable groups

Research has indicated that across the UK, there is a significant over-representation of some vulnerable groups within the justice system. These include children with experience of significant childhood adversity and involved with the care system; women with experience of domestic or sexual violence as children and adults; the homeless population; and people from Black, Asian and ethnic minority groups. For example, children with care experience are estimated to be 5 times more likely to be involved with the justice system than those outside the care system (Prison Trust Reform, 2017). Many young people in the youth justice system are also known to have experienced a wide range of adverse childhood experiences including abuse, neglect and witnessing domestic violence (Youth Justice Board Cymru, 2012). More than half of women prisoners in England (53%) report having experienced emotional, physical or sexual abuse (MoJ, 2012) while 57% of women in prison report being victims of domestic violence as adults (MoJ, 2014). This is thought likely to be an underestimate (Gelsthorpe et al., 2012).

One in 7 people who left prison in the year to March 2018 were homeless. This increases to 1 in 5 people serving a sentence of less than six months (MoJ, 2018e). Over a quarter of the prison population (27%) are from a minority ethnic group in England and Wales (MoJ, 2019c). While 4% of people in prison in England state they are Gypsy, Roma or Traveller, these communities are estimated to make up less than 0.1% of the English population (Prison Reform Trust, 2019). Research has found a clear direct association between ethnicity and the odds of receiving a custodial sentence (Hopkins et al., 2016; Prison Reform Trust, 2019). These statistics serve to identify populations who would benefit from enhanced and early intervention services to mitigate against justice involvement.

2.2.3 Mental health prevalence in NI and definition of terms

Northern Ireland has high levels of mental ill health issues across the population, with general prevalence estimated to be 25% higher than in England and Wales due to a range of socio-economic factors, including higher rates of deprivation, rurality and the impact of the Troubles (DoH, 2011; DoH, 2014). NI suffers the highest regional UK suicide rate with a 19% increase recorded from 2014 to 2015. A total of 305 suicide deaths were recorded in 2017 (NISRA, 2017). Although mental health is a high profile issue for the NI Assembly, there is often a lack of precision in public discourse (NIAO, 2019 p.6). It is noted that a person may have a mental health issue yet fail to meet diagnostic criteria for a specifically diagnosed condition. The relative ambiguity of such terms is thought to make defining mental health difficulties challenging within the operational context of the justice system (NIAO, 2019 p.7).

2.2.4 System-wide problems in provision of adult mental health services

It is widely recognised that funding pressures on the health and social care systems throughout Europe have negatively impacted the ability of services to meet the needs of many vulnerable people with complex needs (Evans-Lacko, et al., 2013). This has also been the case in NI, where expenditure on mental health services has not increased in line with other UK regions and a number of key strategic issues continue to negatively affect mental healthcare provision (Commission on Acute Adult Psychiatric Care, 2016; Montgomery et al., 2018). These include inadequate availability of acute and specialist inpatient care and community-based alternatives. A number of other limitations in the provision of mental health services in NI have been identified, exposing limited resources and the lack of parity with physical health care in resource allocation (Montgomery et al., 2018). As a result, it is thought that much needed developments, such as improvements to therapeutic services and early intervention services, are unlikely to be realised (Montgomery et al., 2018). It is recognised that many people with

complex health and social care needs enter the justice system without prior involvement with key services in the health and social care sector (NIAO, 2019 p.2). As a result, 'where such individuals offend, the justice system can become the service of last resort' (NIAO, 2019 p.2).

2.2.5 Emergency Departments and people experiencing mental health or substance use crises

The pressure on mental health services is experienced across the continuum of care in the UK but perhaps most acutely in Accident and Emergency (A&E) Departments which deal frequently with people experiencing mental health or emotional crises who may present with risk behaviours including self-harm and suicidality, and/or alcohol and drug use. Within the UK, the National Institute for Health and Care Excellence (NICE) and NHS England have established a pathway for liaison mental health services to ensure that adults and older adults presenting in crisis to emergency departments or physical health general wards will have access to high-quality NICE-recommended care, any time of the day or night, every day of the week (National Collaborating Centre for Mental Health, 2016). The problem of alcohol-related attendances at acute hospital emergency departments, and their often disruptive nature, has been well established in the research literature with some evidence of useful diversions to bespoke community services (Irving et al., 2018). Irving et al. (2018) identify that in the UK, alcohol-related presentations are greatest on Friday and Saturday evenings when up to 70% of all patients presenting at A&E departments can be alcohol related. Waiting times at A&E departments are recognised as times when the behaviour of people experiencing mental health crises can become agitated and erratic. Long waits can inadvertently lead to volatile situations which can on occasion result in assaults on staff or police officers and entry into the criminal justice system (NIAO, 2019 p.27).

2.2.6 Historical structural barriers and current opportunities to promote service integration

Limitations in mental health services in NI have been compounded by the disconnected nature of the wider public services with people's needs not well met particularly when they cross organisational and departmental boundaries (NIAO, 2019). This is often the situation for people with complex needs who can present with co-occurring mental health and substance use issues, as well as experience of childhood adversity and related challenges including homelessness or relationship breakdown. Recent strategic efforts seek to address these structural barriers and promote public service organisations working collaboratively across boundaries to meet the needs of vulnerable people with complex needs.

This includes intervening early before people have become significantly involved with the justice system (see current Programme for Government). The provision of addiction services in NI and consideration of social deprivation and its links to educational attainment are areas currently under review by the NI Audit Office Public Reporting Programme. Early contact with the criminal justice system is therefore recognised as representing an opportunity to engage or re-engage children, young people and adults with the services or treatment they need (DoJ and DoH, 2019, Improving Health within Criminal Justice).

2.3 Key features of Intercept 0 initiatives

The underlying philosophy of the Sequential Intercept Model (SIM) recognises that people with complex needs should be held accountable for criminal behaviour, yet should not be arrested or detained in the criminal justice system simply because of their illness or lack of access to appropriate treatment or services (Munetz & Griffin, 2006). Heilbrun et al. (2015) position the SIM within a paradigmatic shift away from a focus on *how to* process individuals with mental illness within the criminal justice system to *whether to* process them at all. This shift is based on the suggestion that appropriate treatment resources can simultaneously better address a person's rehabilitative needs, public safety concerns and economic costs. This shift is most apparent at Intercept 0 where frequently police attend scenes where no crime has been committed.

The addition of Intercept 0 to the SIM continuum was first mooted in 2016 by Steadman and Morrisette, and developed further by Abreu et al. in 2017 as a means to recognise the role played by the police as emergency responders to people in crisis and an essential component of the 'crisis care continuum'. The SIM is based on the assumption that interventions should always be at the lowest level of criminal justice involvement commensurate with presenting issues. Intercept 0 is entitled 'community services' and recognises early intervention points *before* arrest for people in crisis who come into contact with law enforcement. The goal of Intercept 0 is to connect people in need with appropriate assessment, treatment and services before a crisis develops. Intervention therefore begins at the earliest possible stage with commitment to develop and enhance upstream responses (Steadman & Morrisette, 2016). At intercepts 0 and 1, there exists the possibility of 'step down' to community services (Intercept 0) or 'step up' to some level of involvement in the criminal justice system depending on the presenting concerns (Intercept 1). This interface is depicted by the two-headed arrow on the SIM diagram. It is therefore advised that this chapter is read in conjunction with chapter 3 (Intercept 1).

Within the available literature, a variety of ‘core’ components of early interventions that meet the goals of Intercept 0 have been identified. In addressing the overlaps between Intercepts 0 and 1, Abreu et al. (2017) identify four primary Intercept 0 components (Crisis phone lines; Crisis care continuum; 911 call centres and law enforcement dispatches; Law enforcement specialised responses), but suggest that only the first two are distinct to Intercept 0, with the remaining two bridging Intercept 0 and 1. This chapter therefore reviews the literature and initiatives related to the crisis care continuum with specialised policing strategies and initiatives examined in chapter 3 (Intercept 1).

2.3.1 Crisis care continuum

A key concept at Intercept 0 is the ‘crisis care continuum’ which refers to a variety of crisis services, which, when brought together create a continuum of care for people experiencing a mental health emergency. The primary goal of crisis care services is to stabilise mentally unwell persons, improve their psychological symptoms of distress and engage them in treatment (Abreu et al., 2017).

The US federal government Substance Abuse and Mental Health Administration Agency (SAMHSA) (2014) has described five core crisis services which are part of the ‘crisis care continuum’, all of which are conceptualised as core components of Intercept 0:

- i. **Crisis observation or stabilisation (23 hour)*** provides people suffering severe distress with up to 23 consecutive hours of supervised care to help de-escalate the crisis severity and the need for urgent care and to avoid unnecessary hospitalizations.
- ii. **Crisis residential stabilisation (short-term)*** is designed to prevent or ameliorate a behavioural health crisis and reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for people who do not require inpatient services.
- iii. **Mobile crisis teams*** provide acute mental health crisis stabilisation and psychiatric assessment services to people within their own homes and in other sites outside clinical settings. The main objectives are to provide a rapid response, assess the person, and resolve crisis situations with mentally unwell individuals. These teams may include combinations of mental health service providers, peers with lived experience or police representation and are discussed in greater detail in chapter 3 (Intercept 1).

- iv. **Crisis Lines*** provide free and confidential counselling via telephone-based conversation, web-based chat, or text message to persons in crisis, often those with severe mental health concerns including suicidal thoughts. Crisis line counsellors provide emotional support to callers, assess suicide risk, and refer callers to resources including counselling, social services, and emergency services.
- v. **Peer crisis services*** are an alternative to psychiatric emergency department or inpatient hospitalisation and are operated by people who have experience living with a mental illness (i.e. peers). Services are intended to last less than 24 hours but may extend up to several days, if needed. Peer crisis services are generally shorter-term than crisis residential services.

Emergency Department Diversion: Emergency Department (ED) diversion is also identified in some papers as an important component of Intercept 0 initiatives. ED diversion can consist of a triage service, embedded mobile crisis, or a peer specialist who provides support to people in crisis. Within the UK, bespoke services have been established to divert and safely manage people with acute alcohol intoxication away from A&E. These include Alcohol Intoxication Management Services (AIMS), Drunk Tanks, Safe Havens and Alcohol Treatment Centres (ATCs) (Irving et al., 2018).

Specialised police responses: In addition, a range of proactive police response models have been developed to assist police officers at Intercepts 0/1 to engage effectively with vulnerable individuals and groups (Abreu et al., 2017). These are outlined in Chapter 3 (Intercept 1).

2.4 Intercept 0 Initiatives: Crisis Lines

Crisis lines are a common strategy developed to strengthen access to support services for people in crisis, including those with significant mental health concerns such as self-harm and suicidal thoughts. Hotline services provide free and confidential counselling via the telephone, online-chat or text messaging. Crisis line counsellors offer emotional and practical support to people in distress. They assist in developing plans for coping or safety plans in the context of risk presentation and may facilitate access to community-based services, such as referrals to health providers or mobile crisis outreach teams if on-site assistance is required. In the USA, the National Suicide Prevention Lifeline (NSPL) funded by SAMHSA provides telephone-based hotline and online crisis chat services to anyone in suicidal crisis or emotional distress across a national network of 164 local crisis centres in 49 states.

'Lifeline' is the NI crisis response service for people who are experiencing distress or despair. It was developed as part of the NI Protect Life Strategy (2012) to reduce the rates of suicide and has been modelled on the US crisis line model. Lifeline is available 24 hours a day, 7 days a week. In addition to the telephone service, Lifeline also provides short-term face-to-face counselling for people across the life course.

2.4.1 Evidence of effectiveness for Crisis Lines

There is a robust evidence base for the value of crisis lines. Assessments of crisis lines indicate that callers experience reductions in suicidal thoughts, self-harm ideation, distress, and hopelessness at the end of their call (Gould, 2007). Crisis 'hotlines' have been shown to provide de-escalation and containment on the telephone when people are in crisis and to link with core services or referral to appropriate low level interventions. Importantly, a survey of the National Suicide Prevention Lifeline (NSPL) suggests that 50% of those who call a suicide hotline and are referred to mental health services access those services (Gould, 2012). An evaluation of the NSPL's initiative that provides *follow-up calls* to high-risk callers and individuals discharged from inpatient or emergency department settings suggest that follow-up calls may reduce the risk of future suicide attempts (Gould, 2017; NSPL, 2014). Research suggests counsellor training, integration with health care systems, and creation of protocols for call monitoring and suicide risk screening are needed to increase crisis line effectiveness (Ramchand et al., 2017).

2.5 Intercept 0 Initiatives: Emergency Department Diversion & Crisis Stabilisation

Hospital Emergency Departments (EDs) are frequently used by individuals seeking care for a wide range of crisis and behavioural health needs. However, what the outcomes are for people presenting at EDs who do not meet the eligibility criteria for admission is not always well understood by stakeholders (GAINS, 2019). Furthermore, many communities serve a population often referred to as 'high utilizers' who have frequent and costly patterns of ED attendance showing little to no connection to community-based services and stabilisation post-discharge (GAINS, 2019). Review of the literature at Intercept 0 identified a range of diverse practice initiatives which sought to address these concerns, diverting people experiencing a mental health crisis or using alcohol and drugs from EDs to alternative crisis stabilisation services or sobering sites. Two UK initiatives are presented below.

2.5.1 Alcohol Intoxication Management Services (AIMS) – Manchester Safe Haven (UK)

Difficulties associated with alcohol-related attendances at acute hospital emergency departments have been identified in the research literature (Irving et al., 2018). There is however more limited research evidence on projects which seek to address this problem. One significant exception to this trend is a current large mixed-method multicentre study funded by the UK National Institute for Health Research, which seeks to evaluate the impact of a UK wide Alcohol Intoxication Management Services (AIMS). The AIMS project seeks to divert acute alcohol intoxicated individuals away from emergency departments to supportive community facilities (Irving et al., 2018). The project evaluates the acceptability, effectiveness and cost-effectiveness of AIMS. AIMS has a number of diverse projects throughout the UK, offering a sustained and regular service open to the general public. One such example is the Manchester Safe Haven.

MANCHESTER SAFE HAVEN (UK)

Greater Manchester Police identified several issues when dealing with perpetrators and victims of crime who are made vulnerable through alcohol use, including a number of incidents in the city centre which resulted in fatalities.

The Manchester Safe Haven was a police-led initiative funded by the Manchester City Council Community Safety Partnership Team. The service ran from May 2015 to March 2017 and was based in the city centre Nexus Art Café. Café staff and Greater Manchester Police volunteers ran the service on Saturdays from 23:00 to 6:00. The space included an open plan café with a coffee bar, seating and a 'relaxation area'. Most referrals to the café were acutely intoxicated individuals found by police in the local area. The Safe Haven provided a space where lone or vulnerable persons were brought in for practical assistance or to make arrangements for their safe travel home.

Source - Irving et al., 2018

2.5.2 Leeds Survivor Led Crisis Service – Dial House (UK)

The inclusion of people with lived experience of mental health services in the development of peer crisis services is identified by SAMHSA (2014) as a key component of crisis services at Intercept 0. One such example is presented below of a UK project which provides services to people in acute mental health crisis, with frequent occurrence of repeat self-harm and suicidality.

LEEDS SURVIVOR LED CRISIS SERVICE – DIAL HOUSE

The Leeds Survivor Led Crisis Service was established in 1999 by a group of service users who wanted an alternative to hospital admission for people in acute mental health crisis. It is funded by Leeds Adult Social Care, NHS Leeds and the Leeds Personality Disorder Clinical Network. While the organisation works in partnership with these agencies and liaises frequently with the local statutory crisis resolution teams, it remains firmly outside mainstream mental health services where it provides a viable alternative to the medical model of care for people in acute mental health crisis.

Visitor presenting issues – self harm & suicidality: Up to 75% of visitors to Dial House are suicidal. Self-injury is a presenting issue in up to 51% of visits. Much of the organisation's work is with survivors of trauma and commonly sexual abuse. The organisation is particularly effective for people who have been excluded from services or who have been difficult to engage. Many visitors have violent or forensic histories, and many have been diagnosed with personality disorder.

Services

i. Connect telephone helpline: The helpline is open from 6pm to 10.30pm offering emotional support and information to people in distress. The helpline also has funding to provide support to carers. It is staffed by volunteers, many of whom have had mental health problems and each shift has a paid supervisor.

ii. Dial House: This is a place of sanctuary for people in acute mental health crisis who may otherwise present to statutory crisis or emergency services. It is open from 6pm to 2am Friday to Sunday. Visitors can relax in a homely environment and receive one-to-one support from a crisis worker. There is a family room to enable parents in crisis to access the service.

iii. Group work: The organisation provides six to ten week 'coping with crisis' groups. These use a person-centred approach and are aimed at people who are frequently in crisis. The purpose is to support people to recognise what is a crisis for them, identify trigger points, and support them to develop alternative coping strategies for dealing with crises.

iv. Weekly Social and support group: There is also a weekly Dial House visitors' social and support group held on one afternoon (12noon to 3pm). The aim is to provide social contact and support to people whose crisis is due to chronic isolation and loneliness.

Approach to risk management

There is a perception that there is a culture of fear and blame in statutory mental health services which drives people away from them and causes workers to practice defensively. Service users are reported to experience a lack of control in mental health services which can elicit self-harm. This survivor-led organisation works in a risk-embracing way which supports user empowerment and reduces risk to self and others. The service's approach to managing risk is summarised as 'not living in fear', trusting people and giving them as much control as possible.

Staff support & supervision: This approach to risk management is only possible if staff are well supported. After support sessions, in person or on the phone, staff debrief. All team members have regular supervision and there is a monthly reflective practice group where risk issues are discussed.

Source – Venner, 2009

In a report commissioned by the Leeds Survivor Led Crisis Service, Beckett et al. (2012) considered the experiences of people who repeatedly self-harm and attend Accident and Emergency (A&E) and evaluated services provided within the NHS and those in the third sector mental health crisis service Dial House (see case study above). This population frequently interface with crisis mental health teams and police services acting in their capacity as first responders. The evaluation aimed to (i) elicit the views and experiences of this population (ii) identify the barriers and facilitators to accessing Dial House (iii) identify what people find helpful/unhelpful in their journey through A&E/NHS services and/or Dial House. The project interviewed 20 people who had repeatedly attended A&E as a result of self-harm, 10 of whom also used Dial House. The project team estimated that up to a quarter of participants were attending A&E at least once a week. A wide range of recommendations were put forward to improve the experience for this vulnerable repeat self-harm population. These included recommendations for A&E services; NHS Self-Harm Teams; NHS staff training; the police service; improving out of hours provision; and Dial House. In relation to the police, these included more support and training in relation to mental health and self-harm; for routine monitoring to pick up on the extent of police involvement in the individual's journey through services; and better liaison with the police in relation to mental health and individuals who repeatedly self-harm.

2.6 Data collection at Intercept 0

SIM proponents argue that tracking and understanding data across the intercepts is a critical part of developing an effective continuum of health services and reducing justice system involvement for people with mental health and substance use problems (GAINS, 2019). Identifying and tracking individuals who make frequent use of emergency department and crisis services across systems is therefore considered essential to enable comprehensive planning to stabilise and appropriately support those individuals and reduce their use of crisis services. The following data collection variables are suggested for Intercept 0.

2.6.1 Data collection for crisis lines

It is recognised that gathering data regarding calls to national crisis call organisations presents challenges, however efforts should be made to understand the call volume and nature of calls to local call systems. Gathering data regarding use of crisis lines can be complex as jurisdictions often have multiple disconnected 'crisis lines'. Coordination and collaboration is therefore required to bring data from these multiple sources together to create a comprehensive understanding of services requested by the community through call lines. Stratifying calls for services by crisis, emergency, specialised (such as suicide prevention) or other categories can help clarify service demand, improve access to appropriate services and reduce unnecessary utilization of public resources, resulting in a more streamlined, accessible service delivery system (GAINS, 2019). Key data to collect include:

- ▶ Number of crisis and support lines in operation
- ▶ What kinds of behavioural health services are most often requested by callers?
- ▶ During which days and times of the week are most people seeking services or support?
- ▶ Are certain individuals calling multiple lines repeatedly within a similar time frame?
- ▶ Across all calls:
 - ▶ Type of caller (family member, self, social worker, etc.)
 - ▶ Type of call or service requested (need related to mental illness, suicidality, substance use et.)
 - ▶ Number of times someone from this location has called the line
 - ▶ Type of outcome (e.g. referral to emergency service, community provider follow-up scheduled, stabilised with no further follow-up etc.)

2.6.2 Data collection regarding use of emergency department

It is recognised that while some of the recommended variables regarding individuals' use of emergency departments may be available in hospital electronic records, such data may be embedded in large databases and its extraction may require a substantial time commitment from hospital information technology staff and data analysts. Obtaining the needed permissions to extract data can also be a lengthy process (GAINS, 2019). Recommended variables and measures regarding use of emergency departments include:

- ▶ Number of people experiencing mental health or substance use crisis attending A&E Departments?
- ▶ Of this cohort:
 - ▶ How many meet criteria for hospital admission?
 - ▶ Average and median length of A&E Department stay and inpatient unit stay, if admitted?
 - ▶ Discharge outcome (to home, warm hand-over to community provider, shelter, release prior to being seen etc.)
 - ▶ Mode of arrival (e.g. walked in alone, brought by family, ambulance, mobile crisis team, police etc.)
 - ▶ % of individuals who left prior to being evaluated or against medical advice

2.6.3 Data collection regarding crisis stabilisation services

Community-based crisis stabilisation or detoxification and withdrawal management services provide a resource for people who need a safe space to stabilise mental health symptoms, become sober or manage drug withdrawal symptoms. They are also opportunities to initiate services for a range of mental health, substance use or social care needs (GAINS, 2019). Gathering data regarding persons who frequently use such services may improve stabilisation, increase access to or facilitate warm handover to community-based treatment and support services, and decrease the frequency and costs associated with crisis service use. Data is therefore required to ensure that available services meet current demand, and examine how they relieve the burden on other facilities such as hospitals or emergency services (GAINS, 2019). Recommended variables for collection include:

- ▶ Number of beds/places available by type of crisis stabilisation service
- ▶ Number of individuals presenting for crisis stabilisation services
- ▶ Across all individuals:
 - ▶ Type of service required
 - ▶ Average and median length of stay if admitted?
 - ▶ Discharge outcome (to home, warm hand-over to community provider, shelter, release prior to being seen etc.)
 - ▶ Mode of arrival (e.g. walked in alone, brought by family, ambulance, mobile crisis team, police etc.)

2.7 Intercept 0 initiatives: Juvenile Justice

In the field of youth justice, a wide range of preventative, diversionary and welfare-orientated initiatives have been developed to address the often complex needs of children and young people who offend or who are at risk of offending. Welfare-orientated initiatives present good examples of intercept 0 initiatives to prevent young people from entering the juvenile justice system. At this intercept, it is important to note the age of criminal responsibility which sets the parameters for state actions. It is notable that in NI, England and Wales, the age of criminal

responsibility is 10 years old which is lower than almost all other European jurisdictions. In the US, the age varies between states, being as low as 6 years in South Carolina and 7 years in 35 states. A Ministry of Justice commissioned review of the youth justice system in the UK (Taylor, 2016) called for:

‘a new system in which young people are treated as children first and offenders second, and in which they are held accountable for their offending, but with an understanding that the most effective way to achieve change will often be by improving their education, their health, their welfare, and by helping them to draw on their own strengths and resources’.

2.7.1 Welfare-orientated initiatives – Finland case example

Juvenile Justice in Finland

In Finland the overwhelming majority of children who have engaged in criminal behaviour are dealt with by the child protection system because such behaviour is regarded primarily in terms of the risks it poses to their health and development. As in other Nordic countries, most children growing up in Finland will have benefitted from high quality family support services including accessible day care, provided by the state. They will then have attended a school with in-built support services, including child mental health practitioners. If a child does develop behavioural problems, this is seen as a manifestation of a collective failure which should be addressed through support rather than punishment.

The age of criminal responsibility in Finland is 15 years. Thus, children who have engaged in problematic behaviour before that age cannot be prosecuted in the criminal justice system. Instead, the families of such children are offered child welfare or health services, and additionally some reparation work may be undertaken with any victim. Children aged 15 or older who are referred to a criminal court, are most likely to receive a community disposal or suspended sentence. Consequently, from 2005 to 2011, there were on average only six 15-17 year olds in custody in Finland at any one time, and most of these had been subject to pre-trial remand rather than sentenced to imprisonment.

Source – Jacobson & Fair, 2016

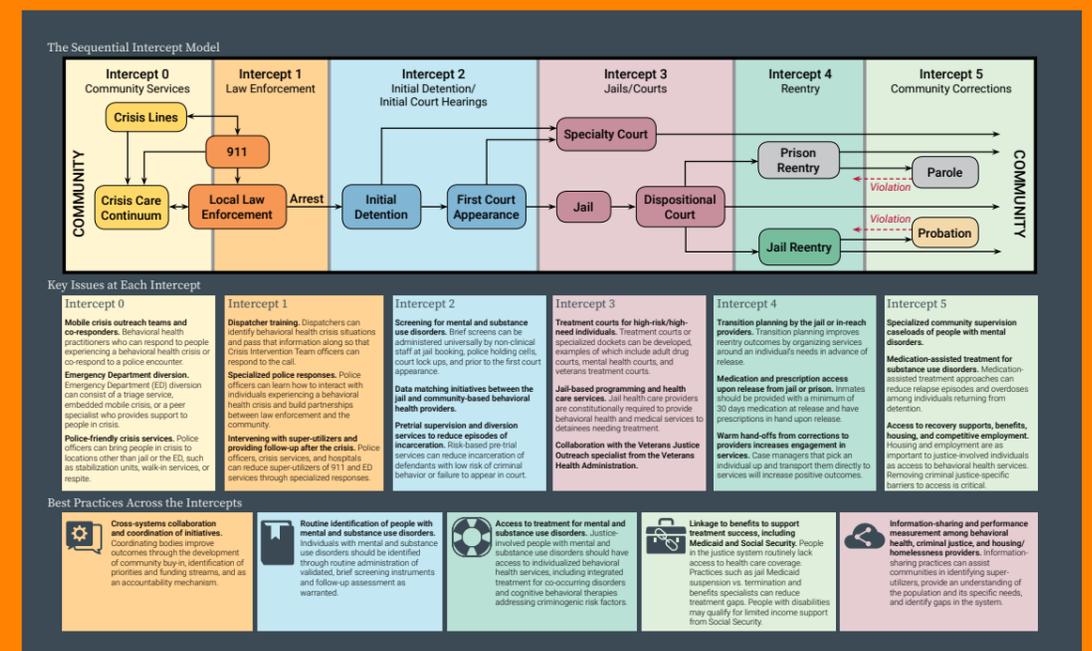
2.8 Intercept 0: Key Messages

Although the boundaries between Intercept 0 and 1 are fluid, both intercept points focus on diverting people with complex needs who are not a danger to the community away from criminal justice processing toward community-based mental health and social care services which can provide more appropriate treatment and support. Developing and resourcing a range of collaborative community-based services across the crisis care continuum is therefore considered essential to effective diversion at Intercept 0 and 1. The literature reviewed suggests the following key messages:

- i. A range of community-based crisis services are required to provide early intervention points for people with complex needs outside of the criminal justice system which can facilitate more appropriate access to mental health and social care treatment and support. These include co-ordinated crisis lines, mobile crisis teams, emergency department diversion services and crisis stabilisation services.
- ii. Community-based crisis stabilisation and sobering/detoxification services and access to mobile crisis teams are frequently noted as service gaps at Intercepts 0/1.
- iii. Involvement of people with lived experience of mental health issues or crisis (peers) can assist service planning and delivery.
- iv. Collaborative relationships and networks are required across health, social care and policing, including statutory, voluntary and community sector initiatives to align crisis services and ensure that individuals in need are connected with the most appropriate assessment, treatment and support at the earliest point.
- v. Information-sharing protocols are required between services and sectors in order to facilitate access to the most appropriate services.
- vi. Data collection across crisis services is essential to service planning to meet the needs of frequent users of crisis services.
- vii. Stakeholders should identify vulnerable populations at risk of justice-involvement and develop bespoke initiatives to address over-representation.
- viii. Public investment in early intervention health and social care services for vulnerable children, families and communities is required to promote more timely service response for those identified as at risk of justice system involvement.

CHAPTER 3

INTERCEPT 1: LAW ENFORCEMENT



3.1 Overview of Intercept 1

INTERCEPT 1: LAW ENFORCEMENT

Intercept 1 involves law enforcement and emergency services. It is the initial point of contact between an individual and police officers or other emergency responders.

The goal of diversion at intercept 1 is to reduce further contact with the criminal justice system by implementing alternatives to arrest, such as connecting individuals with complex needs to an appropriate range of mental health and/or social care services.

Intercept 0 and 1 recognise that police officers have dual roles, both protecting public safety and also acting as first responders to people in crisis. Police officers and emergency services therefore form an essential part of the 'crisis care continuum'. At intercepts 0 and 1, there exists the possibility of 'step down' to community services only or 'step up' to some level of involvement in the criminal justice system depending on the presenting concerns. The fluidity between intercept 0 and 1 is depicted by the two-headed arrow on the SIM diagram. As a result, this chapter should be read in conjunction with chapter 2 (Intercept 0).

Common strategies at Intercept 1 include:

- ▶ **Emergency dispatcher training** to identify behavioural health crisis situations so that relevant information can be relayed and crisis intervention teams can respond
- ▶ **Police officer training** - the facilitation of additional approaches for police officers to interact with individuals with behavioural health concerns such as crisis intervention teams
- ▶ **Specialised police responses** - including the development of mobile crisis teams and other outreach or diversionary initiatives

Key stakeholders: police; emergency services; crisis services; mental health and social care community-based providers (statutory, voluntary and community sectors)

3.2 Key Issues and Challenges at Intercept 1

3.2.1 Police involvement in responding to people in crisis

Across much of the developed world, the police are the service often called upon to respond to individuals in crisis. There are ongoing concerns about the numbers of people with serious mental illness and complex needs who come to police attention and about the appropriateness or adequacy of police response. Within NI, the Police Service of Northern Ireland (PSNI) is the main interface between the justice system and the community. In this 'front-end' role, officers interact regularly with people with complex needs and interface with mental health and social care services.

Increase in demand: The PSNI have identified a very large increase in the number of *non-criminal incident* reports often resulting in police officers attending incidents in response to a mental health or emotional crisis where the person is deemed to be a risk to themselves or others. The recorded number of such incidents in NI increased from 9,000 in 2013 to over 20,000 per year in 2019 (NIAO, 2019 p.14). In addition, officers also frequently encounter people with mental health issues when they arrest and detain a subject *following a criminal offence*. Each year, officers arrest over 20,000 subjects for interview, two-thirds of whom are identified as having a mental health or potential mental health issue (NIAO, 2019 p.14).

Impact on police service availability: Responding to mental health crises is recognised to impose significant operational demands upon the PSNI, including the call management system and reduces the PSNI's operational capacity. It is estimated that police officers responding to non-criminal events can be involved for between 18 and 30 hours on each occasion (NIAO, 2019 p.14). The significant impact of preliminary assessments by the PSNI on service availability is consistent with the experiences of other UK police services, but is thought to be further increased in the NI context as a result of additional security concerns which mean additional officers are required in some circumstances (NIAO, 2019 p.27). Historically, these issues have been compounded by the disconnected nature of the wider public service network, and by the limitations in the provision of mental health services in NI (Commission on Acute Adult Psychiatric Care, 2016; Montgomery et al., 2018).

Concerns regarding police involvement in responding to mental health crises:

Research evidence suggests the role of the police in the context of responding to people experiencing mental health crises in NI can have unanticipated negative consequences. Using a mixed methods approach, Davidson and Campbell (2010) examined the standard practice of Approved Social Workers (ASWs) in adult mental health services in NI. They found that police officers were directly involved in 44% of the ASW assessments reviewed, the majority of which were completed in the patient's own home. ASWs identified a number of issues associated with police involvement. These included views from some ASWs that at times, police involvement created additional problems. For example, one ASW said that the use of the 'PSNI [police] would be more stressful for the client who was not in any way a risk to others—'I agreed to family members taking her to hospital' (p.1618). Other ASWs thought that delays in arrival or excessive use of coercion by the police were problematic. One ASW recalled an 'overuse of force until [I] intervened. They wanted to handcuff a very elderly man who was no threat to them' (p1618.). Good working relationships between professionals are identified as of fundamental importance in the assessment process with recommendations that good communication is standardised in all such situations (Davidson and Campbell, 2010). Police involvement in responding to crisis events may be further complicated in the NI context due to historical issues related to the political conflict which impacted how the police are perceived in some communities (Hayes & McAllister, 2013).

Police training: Police practices in the context of responding to someone in crisis have also been identified as an issue of concern by the Northern Ireland Audit Office (NIAO, 2019) in a recent report which looked at mental health in the criminal justice system. It was noted that officers receive little training in relation to these events with officers interviewed stating that there is 'no consistent approach amongst officers to responding to such incidents' (NIAO, 2019 p.27).

3.2.2 Justice-involved young people – prevalence of mental health and social care needs

Within the juvenile justice sector, the behavioural health needs in justice-involved adolescents are an increasing concern to the US legal system and wider society (Heilbrun et al., 2017). It is estimated that two-thirds of young people in the justice system in the US meet the criteria for one or more psychological conditions (Grisso, 2004). In addition, a large research study in Florida found that justice-involved young people were four times more likely to report four or more adverse childhood experiences (ACEs) than the adults in the original ACE study (Baglivio et al., 2015). More generally, the presence of mental health problems or a trauma history are thought to increase the risk of offending or re-offending, such as running away from the family home or using drugs to deal with distressing experiences or memories (DeHart & Moran, 2015; Ford et al., 2006; Heilbrun et al., 2012). These statistics compare with those from the UK context, where it is recognised that young people who come into contact with the youth justice system are more likely to have a mental health or neurodisability problem than their peers, and may often have more than one mental health problem in combination with a range of additional vulnerabilities from adverse childhood experiences (Twichett & Sylvester, 2018). Although the number of first time offences committed by young people aged 10-17 years in NI have reduced significantly in recent years, it is notable that more than 1 in 4 young offenders go on to reoffend within one year (NIAO, 2017 p.6; DoJ, 2018b). Three quarters of young people involved with the PSNI are boys, with the majority of both boys and girls between the ages of 14 and 16 years. Repeat offenders account for a disproportionately high percentage of all youth offences (72%), with 44% of all incidents carried out by the 10% most frequently recorded young people (NIAO, 2017 p.6). Looked after children are disproportionately represented amongst youth offenders (Prison Reform Trust, 2017). Despite representing less than 1% of the under-18 population, children with care experience accounted for 17% of the referrals to Youth Diversion Officers in the PSNI between 2009 and 2014 (NIAO, 2017 p.7). It is notable that a profile of young people in the youth justice system in Wales with a history of reoffending (Youth Justice Board Cymru, 2012) found that 48% had witnessed family violence; 55% had been abused or neglected; 79% had social services involvement; 81% were without qualifications; 95% had substance misuse issues.

These statistics give stark insight to the complex lives of young people who offend, suggesting the need for a wide range of health, social care and educational services to meet their needs and their family's needs to mitigate early, repeat involvement with the justice system. Clearly, early intervention at the youth interface with the criminal justice system presents opportunities to engage young people and their families with the most appropriate health and social care services.

3.3 Key features of Intercept 1 initiatives

Intercept 1 involves law enforcement and emergency services. It is the initial point of contact between an individual and police officers or other emergency responders. The goal of diversion at this intercept is to reduce further contact with the criminal justice system by implementing alternatives to arrest, such as treatment for individuals who appear to be exhibiting mental health disorders (DeMatteo et al., 2013). Given the inclusion of police responding as first responders to crisis situations, this chapter should be read in conjunction with chapter 2 (Intercept 0).

The first entry point of Intercept 1 focuses on the interface between law enforcement and emergency services. It refers to the initial contact between the individual and police officers or other first responders seeking to divert mentally unwell individuals away from the criminal justice sector by implementing alternatives to arrest (Heilbrun et al., 2012). Intercept 1 initiatives include approaches to specialised police responding (Compton et al., 2008), and the facilitation of additional approaches for police officers to interact with individuals with behavioural health concerns.

In addition to the range of community-based crisis services which are conceptualised as core components of Intercept 0 initiatives (see chapter 2 – Intercept 0 for exploration), a number of proactive police response models have been developed in the US to assist police officers at Intercepts 0/1 to engage effectively with vulnerable individuals and groups (Abreu et al., 2017):

- i. Crisis Intervention Teams:** This approach exists across much of the USA, whereby frontline police officers are provided with the skills and knowledge to deal effectively, in the course of their regular duties, with individuals in mental health crisis.
- ii. Homeless Outreach Teams:** Multi-agency collaborations and multidisciplinary teams seek to support individuals living on the street, often with severe disabilities. These teams promote harm reduction and are based on strength-based recovery philosophies.
- iii. Serial Inebriate Programmes:** These outpatient programmes support homeless individuals with addictions. Such programmes seek to divert individuals off the street, out of jails, emergency departments and the criminal justice system and into treatment options which promote stability.

iv. Mental Health Assessment Response Teams: An alternative model for integrated provision involves various forms of multi-agency teams established to respond to mental health crises. These teams tend to be made up of police officers working together with mental health practitioners.

v. Police-friendly crisis services: Police officers can bring people in crisis to locations other than jail or the Emergency Department, such as stabilisation units, walk-in services, or respite centres.

3.4 Intercept 1 initiatives: Crisis Intervention Teams

A key strategy at Intercept 1 is the Crisis Intervention Team (CIT) specialised policing model, which was first developed in Memphis, Tennessee in 1988, and has since been applied, with modifications, in many parts of the US, and beyond. The CIT model involves providing self-selected frontline police officers with the skills and knowledge to deal effectively with individuals in a mental health crisis in the course of their normal duties.

Training: A core component of the CIT model is the provision of training in active listening and de-escalation skills through role-play and information on mental health. Experiential learning with people who have lived experience of mental health problems is also a central aspect of CIT training. In many contexts, officers are selected for training through a voluntary and competitive application process (Jacobson & Fair, 2016).

Partnership: One of the CIT model's reported strengths is that a range of stakeholders (such as mental health service providers, service users and advocacy groups) have direct involvement in the design and delivery of the training. In these ways, the CIT model actively encourages inter-agency working, partnership and community ownership. CIT has been introduced in adapted forms outside the USA, including by New South Wales Police in Australia (Heilbrun et al., 2012). In New South Wales, the Mental Health Intervention Team programme entails a four-day residential course provided through a partnership between the police and various health, welfare and academic bodies. Themes covered in the training include the needs of differing cultures with regard to mental health provision; personality disorders; and the roles and responsibilities of non-police agencies (Jacobson & Fair, 2016).

Heilbrun et al. (2015) identify two additional forms of crisis intervention teams:

- (i) **Co-responder teams** which combine *police officers and mental health professionals* into teams who respond to mental health crises. These co-responder teams are likely to handle calls that take more time to resolve, or possibly involve transportation to a crisis centre
- (ii) **Follow-up teams** consist of specially trained officers who work alongside mental health partners to identify and *help resolve problems of individuals who frequently come to the attention of police.*

3.5 Intercept 1 initiatives: Mobile Crisis Teams

On review of the literature, it is clear the concept of crisis intervention policing teams has been taken on in a variety of locations across the world and adapted accordingly. A range of co-responder mobile crisis initiatives have been developed with different titles (such as crisis response teams, mobile crisis teams, street triage, mental health assessment teams, crisis outreach teams) which include different combinations of mental health, social care and justice (statutory and non-statutory) partners depending on the context and targeted outcomes.

A number of mobile crisis initiatives are detailed below, all of which involve some form of specialised policing service. It should be noted however that in the US literature the term ‘mobile crisis teams’ refers also to teams that do not include a policing presence, but rather refer to teams made up of mental health professionals (statutory and voluntary sector) and peers with lived experience (Intercept 0) which can call for police back-up if required. The literature reviewed suggests that a diverse range of mobile crisis outreach initiatives have the potential to improve inter-agency collaboration and efficiency, enhancing the response to people with mental illness or complex needs at the point of crisis (Intercept 0) or their first engagement with the criminal justice system (Intercept 1) (Heilbrun et al., 2012; Lancaster et al., 2016).

3.5.1 Mobile Crisis Outreach Team - Canada

MOBILE CRISIS OUTREACH TEAM: NOVA SCOTIA MOBILE CRISIS PARTNERSHIP

Within the Canadian province of Nova Scotia, the Capital District Health Authority provides adult services to 395,000 people, 40% of the province’s population. Here a partnership was established between mental health services, the Halifax Regional Police and the EHS (the province’s ambulance service). The service offered short-term crisis management, with mobile interventions attended by a plain clothes police officer and a mental health professional.

The integrated service offered:

- ▶ **Telephone support 24 hours a day** backed by teams of mental health professionals and police officers
- ▶ **A clinician managed all incoming calls** with a call-back response within 30 minutes.
- ▶ **Crisis visits:** When crisis visits were required, plain clothes officers accompanied the clinician, allowing the team to respond to more severe or acute situations. An ambulance also attended, if necessary.
- ▶ **Information dissemination to front-line officers:** The introduction of the integrated teams was accompanied by information for all front-line police officers on how and when to access the crisis team.

While the Capital District Health Authority (CDHA) had access to 24-hour telephone support, the integrated mobile crises teams were only available to the part of CDHA that was covered solely by the Halifax Regional Police. The remainder of the Capital District was covered by police officers from other forces who did not have access to the mobile component of the crisis team. As the partnership project was only available to those areas covered by the Halifax Regional Police, this facilitated a quasi-experimental comparison of areas with and without access to the service.

Evaluation: Using a mixed-methods design, a controlled before-and-after quantitative comparison of the intervention area with a control area without access to such a service was conducted for 1 year before and 2 years after program implementation. Additionally, qualitative assessments of the views of service recipients, families, police officers and health staff at baseline and 2 years afterward were also conducted.

Outcomes: The findings suggested that integrated services resulted in *increased use by people in crisis, families, and service partners* (for example, from 464 to 1666 service recipients per year). *Despite increased service use, time spent on-scene and call-to-door time were reduced.* At year 2, *the time spent on-scene by police (136 minutes) was significantly lower* than in the control area (165 minutes). These findings were supported by the qualitative results of focus groups and interviews. Participants felt that a 30-minute call back for telephone interventions was reasonable and had been achieved. However, participants wanted greater availability and timeliness of response for mobile interventions.

Other positive outcomes included:

- ▶ greater accessibility on the telephone
- ▶ better understanding of mental health issues by police officers
- ▶ improved partnering on the ground.

Source - Kisley et al., 2010

3.5.2 Mobile Crisis Team developments in the UK

A key initiative in the UK context was the *Mental Health Crisis Care Concordat* which was launched in February 2014. This was a joint statement, agreed by health, social care, police, justice, and local government agencies, setting out how public services should work together to respond to people, including those within the criminal justice sector with mental health problems (HM Government, 2014). The establishment of mobile crisis teams, as outlined below, provide an example of a collaborative approach to people experiencing mental health crisis across mental health and policing sectors.

Mobile Crisis Teams (MCTs) in the UK provide joint responses by the police and mental health services to community crisis. Here police officers responding to individuals who may be experiencing a mental health crisis may refer to mental health professionals such as crisis resolution home treatment teams (Onyett et al., 2006) for assessment. However, many police officers reported a lack of skills and knowledge to do so accurately. Various approaches to joint assessments by the police and mental health professionals have been developed in the UK and elsewhere in efforts to overcome these issues (Wood et al., 2011). Lancaster et al. (2016) reviewed the evidence on Mobile Crisis Teams and suggested that the UK is behind other countries in the development and implementation of MCTs and that there are significant differences between the services provided in the UK and other countries. However, the review of available research identifies positive outcomes for MCTs with evidence of:

- ▶ improved outcomes for people in mental health crisis
- ▶ reduction in inappropriate use of mental health legislation and hospital admissions
- ▶ increased user engagement
- ▶ a strengthening of relationships between the police and health services
- ▶ potential reduction in costs to public services.

3.5.3 Street Triage - UK

STREET TRIAGE

Street Triage is a joint mental health service and policing approach to crisis care. Based on locally agreed protocols, the aim is to:

- i. support access to appropriate crisis care**
- ii. provide more timely access to other health, social care and third sector services**
- iii. reduce the use of police cells as places of safety for mental health detentions.**

The Department of Health provided funding for *nine pilot schemes* each of which established an operating model for Street Triage that was *appropriate and relevant to local circumstances*:

- ▶ The British Transport Police C Division developed a Control Room model of service provision, whereby a mental health professional was based in a police Control Room and was able to share information with police controllers to assist front-line officers.
- ▶ In Sussex, Thames Valley and Derbyshire, a police officer and a trained mental health nurse, using a patrol car, responded to all calls with a mental health aspect.
- ▶ The West Midlands model was similar but also included a paramedic.
- ▶ In Devon and Cornwall, with the Metropolitan Police Service, a team of mental health nurses was based in the police Control Room or a Mental Health NHS Trust gave advice over the telephone to police officers at the scene but did not attend incidents in person.
- ▶ In both West and North Yorkshire, a team of mental health nurses provided telephone support and if required responded to incidents face to face.

Evaluation: The evaluation of the scheme consisted of gathering quantitative data on the operation and outcome of the Street Triage teams and qualitative data from interviews with health and police staff, service users and family members involved in the pilot schemes.

Outcomes: The Street Triage schemes reported significant progress in care planning and coordination and effective inter-agency relationships:

- i. Reduction in the use of mental health detentions:** All but two of the nine Street Triage schemes resulted in a reduction in the use of mental health detentions, when compared with an equivalent timeframe from the previous year; mental health data for one scheme were not available.

ii. Police/Health service partnerships: Feedback from interviews with key stakeholders highlighted that strong partnerships between police and health services was an essential foundation. Key features included:

- ▶ *Co-locating police and health staff* helped to assure joint working and establish the collaborative nature of the service.
- ▶ The value of *information sharing* between police and health care staff was seen as one of the great successes of the schemes.
- ▶ The ability to *access detailed information early in the process* was thought to allow police to make more informed and appropriate decisions for service users.

iii. Enhancement of police knowledge and practices:

- ▶ an increase in mental health knowledge
- ▶ an improvement in the management of people with mental health problems
- ▶ increased awareness of appropriate outcomes for people with mental health problems
- ▶ greater familiarity of related legislation.

iv. Feedback from key stakeholders including service users identified that:

- ▶ the quality of care provided had improved
- ▶ the scheme supported a more effective response for the service user
- ▶ a more consistent approach to mental health situations was offered than had been previously in place.

Overall, 'the impact on pathways into care, as well as care planning and effective inter-agency relationships, were felt to be notable areas of improvement across the pilot areas' (Reveruzzi & Pilling's, 2016 p.62).

Source - Reveruzzi & Pilling, 2016

3.6 Intercept 1 initiatives: Diversionary substance use programmes

An additional form of initiative found in the literature at this intercept, includes diversionary practices where police officers have the discretion to divert the person to treatment and services early in the justice process rather than proceed to arrest. The US drug recovery policing programme detailed below is one such initiative.

3.6.1 Police Assisting in Drug Recovery – US diversion initiative

With increased understanding of the benefits of early intervention in drug rehabilitation and the increase in alcohol and drug-related deaths, Bensalem Police Department, Bucks County, US, has introduced a programme offering an option of treatment to individuals who use drugs and had presented themselves to the local police.

BENSALEM POLICE ASSISTING IN RECOVERY PROGRAMME (USA)

Bensalem Police Assisting in Recovery programme offers individuals who use drugs, treatment instead of incarceration. It seeks to *exploit the opportunity presented at the time of a crisis to link individuals with substance abuse problems with the appropriate services* and thus prevent their further engagement with the criminal justice system.

Key features include:

- ▶ **Offer of treatment rather than arrest:** As first responders, police officers who come into contact with an individual who is using drugs can *offer the individual help as opposed to arresting them.*
- ▶ **Individual Support:** If the individual turns the drugs in their possession over to authorities and agrees to seek treatment, they are not arrested. Instead, they are *paired with a Volunteer Navigator* who will accompany the person to a nearby treatment centre. The Navigator can choose to stay at the assessment centre and offer support.
- ▶ **Training in addiction:** Navigators are trained community volunteers, who along with the police officers are educated on aspects of addiction. They work in partnership to offer support and encouragement for individuals to seek appropriate treatment.

These programmes have become increasingly important in many states in the US including Bucks County where there has been a steady increase of accidental drug and alcohol related deaths. These deaths have been linked to increases in prescription medication misuse, heroin use, overdoses, underage drinking, co-occurring disorders, and corresponding physical and mental health concerns.

Source - Finello, 2017

3.7 Evidence of Effectiveness and Data Collection Intercept 1

3.7.1 Evidence of effectiveness of crisis intervention teams

Heilbrun et al. (2012) conducted a systematic review of the research evidence in relation to the SIM approach. Much of the reported research evidence for Intercept 1 initiatives focuses on the crisis intervention team (policing) approach, with 11 original studies and a review by Compton et al. (2011). The majority of these studies focus on the measurement of effectiveness of the CIT approach and address three key areas:

- (i) the characteristics and knowledge of CIT trained police officers
- (ii) the characteristics of individuals who have been engaged by the CIT
- (iii) the “effectiveness” of specialised police response, for example, in relation to numbers of individuals diverted from the criminal justice sector, or the services delivered to diverted individuals.

The findings are generally supportive of the effectiveness of CIT or other specialised police response in redirecting mentally ill individuals in crisis from arrest and linking them with services. Additionally, notwithstanding regional variations, police trained in CIT reported feeling more prepared to manage crises relating to mentally ill persons in crisis (Borum et al., 1998), although it should be noted that officers’ knowledge base was found to decline in the months following training (Compton & Chien, 2008). CIT-trained officers were found to be more likely to link individuals to psychiatric services (Compton et al., 2008) and less likely to use physical force (Compton et al., 2011). Physical force was still used conservatively by CIT-trained officers (Skeem & Bibeau, 2008), but more often with individuals who appeared at higher risk for violence themselves. However, Heilbrun et al. (2015) caution that although Specialised Police Responding (Intercept 1) has ‘essential elements, widespread popularity, and face validity’ (p.9), there is currently limited empirical evidence supporting its effectiveness at changing police behaviour or community-level indicators. While research in this area therefore shows clear effects on the attitudes of officers toward engaging people with mental health problems, the impact of these attitudinal shifts on officer behaviour in terms of lower rates of arrest or less use of force, are less clear.

3.7.2 Data collection regarding Intercept 1 initiatives

SIM literature suggests that early informed decisions by emergency dispatch, mobile crisis teams or specialised policing crisis intervention teams can route people in crisis or those with mental health or substance use conditions to the most appropriate care setting, reduce the number of police transports, improve outcomes for the individuals in question, and better align services (GAINS, 2019; Heilbrun et al., 2012 & 2015). It is important therefore that stakeholders understand how many people are diverted from a higher level of care by mobile crisis services or specialised policing crisis intervention teams, what crisis services are engaged, what services are provided by these teams, and where services are needed. In order to understand the impact of such services, it is recommended that key data is collected in relation to police dispatch, crisis intervention policing responses and mobile crisis teams.

Emergency dispatchers need to have the information and skills to respond efficiently and effectively to behavioural health-related calls, including the ability to route calls to the appropriate services or responders. Data collection and call analysis can help stakeholders understand the types of mental health, substance use and crisis-related needs impacting the community and their pathways into services (GAINS, 2019). Recommended data collection variables include:

- ▶ What % of emergency dispatchers are CIT trained?
- ▶ What proportion of calls are related to mental health, substance use or crisis concerns?
- ▶ What locations generate such calls?
- ▶ Of calls related to mental health, substance use or crisis:
 - ▶ Number forwarded to or triaged by a crisis line representative
 - ▶ Number dispatched to a specialised response (e.g. CIT-trained officer, mobile crisis etc.)
 - ▶ Number dispatched to emergency medical services
 - ▶ Number dispatched to police service
 - ▶ Number dispatched to fire service

Outcomes to monitor with regard to **specialised police responses such as crisis intervention team** officers include:

- ▶ Number of police officer calls or encounters which involve persons with a mental health, substance use or other related need
- ▶ Time spent by police officers acting as first responders in crisis situations
- ▶ Outcomes of specialised crisis intervention teams versus non-specialised teams

Data to be collected regarding use of **mobile crisis teams** across all persons accessing services include:

- ▶ Primary and secondary presenting problems
- ▶ Location of service delivery
- ▶ Primary service provided (e.g. medication management, stabilisation etc.)
- ▶ Type of outcome (e.g. stabilised at scene, transported to A&E etc.)
- ▶ % that required police involvement
- ▶ % with repeat usages in past year

3.8 Juvenile Justice Initiatives at Intercept 1

The SIM can also be used when designing programmes that meet the needs of young people with mental ill health or behavioural challenges. In this context, Intercept 1 provides a pre-arrest diversion, often occurring in school-based settings (Heilbrun et al., 2017). This entails the provision of school-based alternatives to zero tolerance punishments for behaviour that could be viewed as juvenile offending, such as fighting or bringing weapons to school. Such programmes are designed to reduce the number of students who enter the justice system and consequently improve young people's long-term outcomes. Intercept 1 initiatives also provide an early opportunity to screen young people for behavioural and mental health needs before official involvement in the justice system and to prevent the trauma, stigma, and negative consequences of justice system involvement, including exacerbation of existing mental health issues (Heilbrun et al., 2017).

3.8.1 Evidence of effectiveness of Intercept 1 youth justice initiatives

A number of research studies focused on the application of Intercept 1 initiatives to Juvenile Justice (Heilburn et al., 2017). For example, Intercept 1 of the SIM was found to provide a critical opportunity to prevent young people who do not present a danger to their communities from entering the Juvenile Justice system and, instead, to divert them to community-based services. It was also noted that many young people who are diverted never return to the justice system (Moffitt, 1993; Reyes, 2006).

3.8.2 Intercept 1 Youth Justice initiatives: School Diversion Programme (USA)

Based in the US, the Philadelphia Police School Diversion Programme provides one example of an Intercept 1 initiative to prevent young people from unnecessarily entering the Juvenile Justice system.

THE PHILADELPHIA POLICE SCHOOL DIVERSION PROGRAMME – USA

Philadelphia Police School Diversion Programme was introduced in all city schools in 2014 in an *attempt to reduce the number of school-based arrests and provide supportive services to young people who would otherwise become justice-involved*. The Police School Diversion Programme was established as a cross-system collaboration among the Philadelphia Police Department, School District of Philadelphia, and Philadelphia Department of Human Services.

The Programme aim is to spare eligible students the traumatic experience of arrest and the short and long-term negative consequences of justice system involvement. Prior to the implementation of the Police School Diversion Program, approximately 1,600 young people were arrested in Philadelphia schools annually, experiencing the trauma of arrest and post-arrest processes as well as the ongoing negative consequences of Juvenile Justice involvement.

Key features include:

- ▶ **Offences excluded from arrest:** Under a memorandum of understanding among key agencies, police officers are prohibited from arresting young people for specific *'summary and misdemeanour delinquent'* offences such as marijuana possession, disorderly conduct, or weapons on school property other than firearms.

- ▶ **Eligibility:** If a student commits one of these designated offenses, is at least 10 years old and has no current or previous involvement, he or she is eligible for the Diversion Program and is immediately enrolled. Consequently, the student is not arrested and may remain in school, subject to the school administrator's discretionary policies. The individual therefore maintains a history free of justice system involvement. If, however, the student is ineligible for the Diversion Program because of the type of offense or criminal history, he or she is placed under arrest and subject to standard juvenile justice processes.
- ▶ **Young person and family assessment:** The Programme social worker conducts an initial screening of the young person and their family in the family home to evaluate service needs and to ascertain what services they may wish to obtain.
- ▶ **Access to support services:** The young person and their family are assessed for supportive services such as housing assistance, education support, mental health services such as individual treatment or family therapy, and other treatments such as substance use treatment or anger management. These interactions involve restorative and supportive practices that recognise and are responsive to the issues and challenges underlying the student's behaviour. If the student and family accept services as part of the programme, the young person is assigned to an Intensive Prevention Service provider.
- ▶ **Voluntary participation:** Participation in the Diversion Programme services is completely voluntary.
- ▶ **Staff training:** The programme also provides front-line staff with training in de-escalation techniques, such as conflict management and mediation, to help resolve situations that might otherwise lead to arrest. Additionally, school police officers completed trainings on adolescent development, mental health first aid, Individualized Education Programmes, and trauma-responsive policing.

Outcomes

The Philadelphia Police School Diversion Programme has demonstrated positive outcomes in the first 2 years of operation:

- ▶ **More than 1,000 young people in Philadelphia have been diverted,** spared the experience of arrest, and *connected with service providers.*
- ▶ **Drop in school-based arrests:** In the first full school year (2014–2015) of the programme's operation, the number of school-based arrests *dropped 54% city-wide.*
- ▶ **Youth and family service engagement:** Approximately 90% of *diverted youths and families accepted the voluntary services* through the programme. Most of those families who declined services did so because they were already receiving services elsewhere.
- ▶ **Low rate of arrest:** Perhaps most significantly 1.5 years into the programme's operation, *only 36 (4.5%) of the nearly 800 young people diverted had been arrested* for committing an offence in school or in the community following diversion.

Overall, the Philadelphia Police School Diversion Programme prevents arrest for low-level offences, promotes school retention, avoids unnecessary trauma, and involves proportionate responses – all of which have been associated with lowering the risk of future offending, as well as improving adjustment in the school environment (Cornell & Heilbrun, 2016; Daly et al., 2016).

Source - Heilbrun et al., 2017

3.8.3 Intercept 1 Youth Justice initiatives: Youth diversion programme (Netherlands)

THE HALT PROGRAMME – NETHERLANDS

The HALT programme offers young people a last chance before they enter the youth justice system. The programme is run by a private sector organisation, is enshrined in the Dutch penal code and has been in existence for over 25 years. Each year some 22,000 children and young people are referred to HALT.

Key features include:

- ▶ **Eligibility:** Children and young people aged between 12 and 18 years, who have been apprehended by the police for minor offences such as theft or nuisance behaviour.
- ▶ **Referral:** Children and young people can be referred directly by the police or the public prosecution for a 'Halt penalty'.
- ▶ **Interventions:** Participation on the HALT programme involves a mixture of unpaid work (between 6-20 hours), support to change their behaviour of concern, and restorative justice.
- ▶ **Criminal Justice Outcomes:** Those who accept a HALT penalty do not receive a criminal record.
- ▶ **Programme participation exclusion:** It is not possible to go through the HALT programme more than twice.
- ▶ **Parent and family involvement:** Parental involvement from the point at which their children are first referred to HALT is seen as key to the work of the programme. Parents are helped to develop skills to prevent their children from engaging in criminal behaviour in the future, and are expected to be involved when their children offer apologies for their behaviour and make amends for any damage done.

Source – Jacobson & Fair, 2016

3.9 Intercept 1: Key Messages

Responding to people with complex needs requires specialised police responses, coordination and collaboration across multiple stakeholders. To a large extent, the research evidence suggests that collaborations between the police, the mental health system and essential social services has positive, long-term benefits for adults and young people in diverting individuals away from criminal justice involvement (Steadman et al., 2000). The following key messages from the literature reviewed seek to implement the core components of Intercept 1:

- i. **Training front-line police officers** in how to respond to people in crisis and greater knowledge of mental health and substance use issues appears to lead to improved experience for the person with a greater likelihood of service engagement:
 - ▶ It appears important to consider the content of the training and how officers would be selected to participate.
 - ▶ A target for the number of officers to receive such training is also advised.
 - ▶ Inclusion of peers with lived experience enhances training content.
 - ▶ Partnership with relevant statutory, voluntary and community sector agencies in the development and delivery of training for police officers enhances cross-sector and cross-agency relationships and working.
- ii. **The development of various forms of mobile crisis teams** holds potential to provide more appropriate responses to young people and adults with complex needs and connect them with mental health and social care services:
 - ▶ Depending on the target population, these teams could be made up of different personnel with justice and mental health expertise across statutory and voluntary sectors and may include people with lived experience.
 - ▶ Such initiatives promote collaborative working and effective partnerships across traditional boundaries by developing joint ownership of cross-sector/agency initiatives at a senior management level
 - ▶ Regular review of joint working arrangements is recommended
 - ▶ Joint training programmes for all staff involved promote enhanced cross-sector understanding and effective working relationships
 - ▶ Effective information sharing protocols between services are required

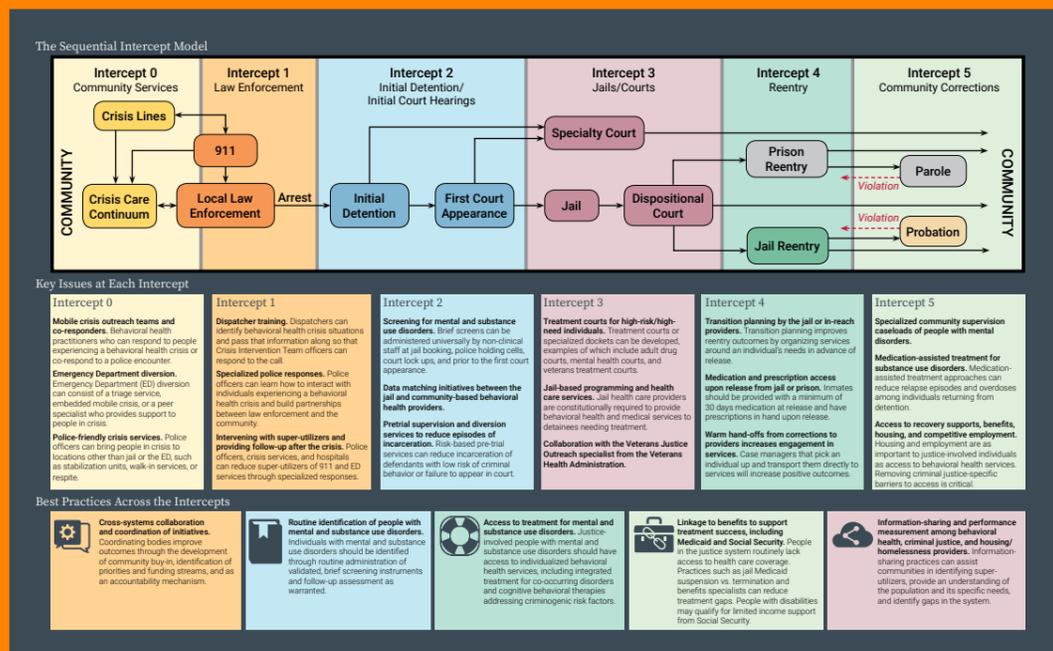
iii. **For young people at risk of justice-involvement**, the following factors are identified as important for intercept 0 and 1 initiatives:

- ▶ Given the very high rates of childhood adversity in the youth offending population, it is important to recognise young people's offending behaviours as health and wellbeing concerns.
- ▶ The development of cross-sector initiatives is recommended for low level offences that are proportionate and avoid young people receiving a criminal record which can negatively impact their life chances.
- ▶ Justice system engagement at these early intercepts should be recognised as opportunities to connect or re-connect children, young people and families with the required range of services.
- ▶ Avoid school exclusion where possible.
- ▶ Consider the young person's behaviour in the context of their family and community, and engage the family/adult caregivers in interventions as pivotal resources to mitigate against re-offending.
- ▶ Where children and young people re-offend, step up the intensity of contact between the young person and their family with supportive services as a means to mitigate against further involvement with the justice system.

Common identified gaps at intercepts 0 and 1 include lack of sufficient mobile crisis response; lack of mental health or crisis intervention training for emergency dispatchers; training needs regarding substance use service linkages for first responders; lack of crisis stabilisation units and/or sobering sites in the community.

CHAPTER 4

INTERCEPT TWO: INITIAL DETENTION/ INITIAL COURT HEARING



4.1 Overview of Intercept 2

INTERCEPT 2: INITIAL DETENTION/INITIAL COURT HEARING

Even with optimal mental health services and effective pre-arrest diversion programmes in place, some vulnerable individuals with complex needs will nevertheless be arrested. Intercept 2 occurs after an individual has been arrested and largely focuses on efforts to interrupt the standard prosecution process *after* the person had been arrested but *before* he/she proceeds to trial or enters a plea. It includes efforts to divert vulnerable individuals from formal prosecution pathways as well as decision-making on initial release/detention and conditions of release pending trial for those arrested. The aim is to avoid pre-trial detention as well as reduce the likelihood of subsequent conviction and incarceration.

Strategies used at this intercept commonly include:

- ▶ **use of validated screening** to identify mental health issues, substance use disorders, and co-occurring vulnerabilities/needs to ensure the availability of suitable services/treatment and that any identified issues are taken account of in subsequent criminal justice proceedings;
- ▶ **pre-trial diversion for low-level offences** with treatment as a condition of probation to reduce prison-use for low risk behaviour and enhance the likelihood of more appropriate service engagement; and
- ▶ **data-sharing between involved systems** to link people to appropriate services

Key stakeholders: police, health and social care providers, judiciary, probation, community services

4.2 Key Issues and Challenges at Intercept 2

Common challenges at intercept 2 include effective screening and assessment processes for mental health and other key vulnerabilities on arrest, as well as the availability of pre-trial diversion opportunities, specialised supervision for people with substance use and/or mental health conditions and the inappropriate use of remand. These have also been noted in the NI context.

4.2.1 Effective assessment

Comprehensive and effective mental health assessment at this stage in the justice process is noted as important as it offers an opportunity for early identification of complicating vulnerabilities or needs, and the involvement of other agencies upstream to address those needs. Assessment documentation will also be available to other service providers at later stages in the justice process and so will influence subsequent service provision.

NI Criminal Justice statistics covering young people and adults (DoJ, 2018a) indicate that in 2017/18, 98,000 crimes were reported to PSNI and 22,000 suspects were arrested. The prevalence of mental health difficulties at this stage in the justice process in NI are noted as high, with a review of assessments of 240 newly detained persons in 2017-18 (NIAO, 2019 p.16) evidencing current or previous mental health issues in 64% of cases. Difficulties for police in engaging in effective health assessment and facilitating access to wider healthcare provision for individuals who are arrested have been identified in a recent report by the NI Audit Office (2019). These refer specifically to the process by which a Custody Sergeant summons a Forensic Medical Officer (FMO) to attend the custody suite to make an assessment where there are physical or mental health concerns. This process is highlighted as costly and not always effective, with nurse-led models currently being trialled (NIAO, 2019).

4.2.2 Use of Remand

The use of remand as a 'place of safety' in NI, where there are concerns about an individual's vulnerability and no effective alternatives, has been identified as problematic, leading to poor outcomes for the individual concerned (NIAO, 2019 p.31). In NI in 2017-18, just under 2,800 individuals were held in custody during the prosecution of their case (DoJ, 2018a). Instances where remand has been utilised specifically for a mental health assessment to be conducted have been specified by the NI Audit Office (2019) as 'entirely inappropriate and does not service the health needs of those individuals' (p.30). The basic structure of prison life, both in terms of the physical environment and the daily social regime imposed, can pose a threat to an individual's mental wellbeing and many of the strategies recommended to a person in the general community to help manage their condition are recognised as hard to apply within a prison environment (NIAO, 2019). As noted in chapter 1, the standard of safety in prisons is also recognised as a cause for concern with high levels of assault and restraint (MoJ, 2019 a&b).

In addition to safety and wellbeing concerns, pre-trial detention has been connected to re-offending. A study of pre-trial detention in Kentucky involving 155,000 persons found that detention, even for a short period, increased the risk of low and moderate risk defendants committing new crimes (Lowenkemp et al., 2013). When held 2-3 days, low risk defendants were found to be 40% more likely to commit crimes before trial. This increased to 51% for low risk defendants when held 8-14 days.

4.3 Key Features of Intercept 2 initiatives: Pre-trial diversion

Formal pre-trial diversion programmes are some of the key interventions developed in both the USA and UK to address the needs of vulnerable individuals arrested and/or charged.

4.3.1 The US Context - Practice Developments

Programmes in the USA date back to the 1967 President's Commission on Law Enforcement and Administration of Justice (Entry, 2013) and, while they fell out of favour in the 1980's, concerns over extremely high incarceration rates, overburdened courts, crowded jails and prisons and strained government budgets, as well as increasing awareness of the negative and residual impacts of justice involvement on individuals, families and communities, has led to a dramatic increase in their use. While earlier programmes developed in the 1970s in the US tended to prioritize defendant rehabilitation and recidivism reduction, these goals have been less pre-eminent in modern diversion programmes. In more recent programmes, improved administrative efficiency and cost savings have been prioritised to the same extent as reduced convictions and collateral consequences for defendants. Equally, while programmes in the 1970s focused almost exclusively on the lowest level misdemeanour cases, current models target both felonies and low-level crime.

Various diversion models have been developed and implemented in the USA and, while they span the continuum of the criminal justice system, they can be broadly organized under two categories: pre-booking (or pre-charge) diversion programmes (Intercept 1) and post-booking diversion programmes (Intercept 2).

Pre-booking programmes involve diversion before the laying of a criminal charge while post-booking programmes involve diversion after an individual has been arrested and remanded in jail or charged with a criminal offence (Siroitich, 2009). Post-booking diversion programmes are characterized by three primary components: (i) initial screening for vulnerability, (ii) healthcare assessment, and (iii) negotiation between diversion staff and criminal justice personnel to create a mental health treatment disposition and to waive or reduce charges or time spent in jail or prison (Broner et al., 2004). Post-booking diversion programmes may be administratively and physically housed in different configurations: jail-based diversion, prosecutor-led or court-based diversion, and specialised diversion courts (see Miama-Dade Diversion Initiative case example).

4.3.2 Miami-Dade Diversion Initiative (USA)

MIAMA-DADE DIVERSION INITIATIVE, FLORIDA - THE ELEVENTH JUDICIAL CIRCUIT CRIMINAL MENTAL HEALTH PROJECT (CMHP)

Background: An estimated 15,000 people in need of mental health treatment are arrested each year in Miami-Dade County, primarily for misdemeanours and low-level felonies. The county spends \$80 million a year to house and treat these individuals.

Aim: The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was established to divert people with serious mental illnesses (SMI) or co-occurring SMI and substance use disorders from the criminal justice system into community-based treatment and support services. Funding was secured from a local philanthropic organization to conduct a planning study for the project, which was then used to secure a three-year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand the project and staff.

Programmes Provided: The Criminal Mental Health Project (CMHP) currently operates four different diversion programmes which operate at different levels of the SIM: A Pre-Booking Jail Diversion programme; a Post-Booking Jail Diversion- Misdemeanour program; a Post-Booking Jail Diversion - Felony Program; and a Forensic Alternative Centre for those individuals who are found incompetent to proceed to trial.

The Post-Booking Jail Diversion Misdemeanour Programme:

People charged with a misdemeanour who meet programme admission criteria (SMI diagnosis and need for acute care services) and are in custody, are transferred from the jail to a community-based crisis stabilization unit within 24 to 48 hours of booking. Upon stabilization, legal charges may be dismissed or modified based on treatment engagement. Individuals who do not meet criteria for hospitalization are released from custody and may also be referred to the programme. Programme participants meet with court case management specialists that will explain the programme and offer linkages to a comprehensive array of community-based treatment, support and housing services that are essential for successful community re-entry and recovery outcomes. Peer specialists, many of whom have already completed the programme, assist participants with re-entry to the community. They also provide the “hands on” support that increases the likelihood of successful recovery outcomes. Participants are monitored by CMHP for up to a year after re-entry to ensure ongoing linkages to supports and services.

Services include:

- ▶ **Risk and Need Screening:** The programme utilizes evidence-based screening tools in the Post-Booking Jail Diversion Programme in an effort to determine individual risks and needs to develop an appropriate transition plan to the community.
- ▶ **Housing:** The programme works closely with the Homeless Trust and other community housing organizations to ensure that adequate housing is available for program clients.
- ▶ **Entitlements:** The Court collaborates with the local Social Security Administration Office and health providers to facilitate and expedite program clients' access to benefits.
- ▶ **Contingency Funds:** Funds are available for clients for housing, treatment, medication and other ancillary needs through the Florida Department of Children and Families.

The Post-Booking Jail Diversion Felony Programme:

Due to the initial success of the misdemeanour diversion program, it was expanded to include people with non-violent felonies. Participants in the felony diversion program are referred to the CMHP through a number of sources including the public defender's office, the state attorney's office, private attorneys, judges, corrections health services and family members. All participants must meet diagnostic and legal criteria. At the time the person is accepted into the programme, the state attorney's office informs the court of the plea he or she will be offered contingent on successful program completion. Similar to the misdemeanour programme, legal charges may be dismissed or modified based on treatment engagement, participants are assisted in accessing community-based services and supports, and their progress is monitored and reported to the court by CMHP staff.

Outcomes:

- ▶ The Misdemeanour Jail Diversion Program receives approximately 300 referrals annually. Recidivism rates among programme participants have decreased from roughly 75% to 20% annually.
- ▶ Individuals participating in the Felony Jail Diversion Program demonstrate reductions in jail bookings and jail days of more than 75%, with those who successfully complete the program demonstrating a recidivism rate of 6%.
- ▶ Since 2008, the Felony Jail Program alone is estimated to have saved the county over 15,000 jail days, or more than 35 years.

Source: National Association of Counties (n.d)

4.3.3 UK Context – Practice Developments in Adult and Youth Justice

Similarly to the USA, the UK has a longstanding interest in better addressing the needs of mentally ill offenders in contact with the criminal justice system with the Reed Review (Department of Health and Home Office, 1992) recommending nationwide provision of properly resourced court assessment and diversion schemes to support this goal. Liaison and Diversion Schemes (LDS) were subsequently introduced to identify and assess people with vulnerabilities as they passed through the criminal justice system and to ensure their needs were appropriately identified and addressed. While many LDS were initially developed to cover diversion at the court stage, they later expanded to include triage services at both police stations and court, as well as other sites such as probation and bail hostels. Sixteen years later, Lord Bradley's 2009 report highlighted the on-going relevance of the recommendations of the Reed Review, noting how the lack of a centralised strategy meant that LDS had developed at different rates and in different ways with not all areas being serviced by an LDS. The Bradley Report (2009) recommended that existing LDS be used as a framework on which to build a national model of Criminal Justice Mental Health Teams to be rolled out across England and Wales.

Following the Bradley Report (2009), the Government created the Liaison and Diversion Programme, a Cross-Government initiative aimed at building an active network of LDS guided by a new standard LDS programme specification (NHS, 2014a) which outlined four key aims:

- ▶ 'Improved access to healthcare and support services for vulnerable individuals and a reduction in health inequalities.
- ▶ Diversion of individuals, where appropriate, out of the youth and criminal justice systems into health, social care or other supportive services.
- ▶ To deliver efficiencies within the youth and criminal justice systems.
- ▶ To reduce re-offending or escalation of offending behaviours' (p7).

The accompanying Liaison and Diversion Operating Model (NHS, 2014b) outlined a three stage process of:

- ▶ **initial case identification** - a lay activity carried out by youth or criminal justice practitioners to identify an initial cohort of individuals who are potentially vulnerable;
- ▶ **secondary screening** – conducted by a liaison and diversion practitioner with either a relevant professional qualification or recognised training
- ▶ **assessment (including specialist assessment)** – to be completed by someone with a specific professional mandate, namely someone with the requisite professional skills

This process forms the basis for decisions by Liaison and Diversion (L&D) Practitioners to refer a person to health or social care services as well as informing police, the Crown Prosecution Service and the Courts to make better decisions about how to deal with that person within the criminal justice context. The National Model for L&D was implemented in ten trial sites in England in April 2014 and rolled-out to a further 13 sites in April 2015. Additional funding was released in 2016 to enable further expansion of L&D in 2016/17 and 2017/18 with a view to reaching LDS coverage across at least 75% of the English population by April 2018.

Alongside the roll-out of LDS, there has been growing interest in the development of *pre-court diversion* for adults within the UK. Pre-court diversion has been a mainstay of the youth justice system since the 1980's when initiatives to reduce the number of young first-time entrants into the CJS first emerged. Over time, legislative changes, reorganisation of service structures, operational guidance and targets have led to what has been termed a 'rehabilitation revolution', with increasing emphasis on the flexible and widespread use of a wide range of diversionary options (Bateman, 2014). In particular, the Legal Aid, Sentencing and Punishment of Offenders introduced a more flexible system of Out-of-Court Disposals (OoCDs) such as statutory 'Youth Cautions' and 'Youth Conditional Cautions', as well as non-statutory 'Community Resolutions', which can be used by police to divert young people from more formal court processes (see Suffolk Youth Offending Service Diversion Programme case example below). In a recent survey (Centre for Justice Innovation, 2019a), 115 of 152 Youth Offending Teams in England Wales indicated they operate a point-of-arrest diversion scheme.

While commonplace in the youth justice system, the development of specific pre-court diversion programmes for adult offenders is less widespread. As with young offenders, police in England and Wales have the ability to divert adult offenders who commit low-level offences from formal prosecution processes using a variety of OoCDs. The Crown Prosecution Service promotes the use of OoCDs when appropriate, based on the severity of the offence, the results of the offending behaviour, the antecedents of the offender and the likely outcome at court (Crown Prosecution Service, 2013). However, concerns about the complexity of these diversionary options and lack of transparency regarding how they are applied have led the Ministry of Justice (2014) to propose a revised two-tier OoCD framework (MoJ, 2014) to simplify the process and better ensure meaningful and appropriate consequences for the offender. The Lammy Review (2017) also highlighted the tendency for the CJS to reward those who admit to crimes when charged, noting that many OoCDs are open only to those willing to admit guilt. The review, noting the positive impact of initiatives such as Operation Turning Point in the West Midlands, and CheckPoint in Durham (see CheckPoint case study below), recommended a 'deferred prosecution' model be rolled out for both adult and youth offenders across England and Wales.

4.3.4 Suffolk Youth Offending Diversion Programme (UK)

SUFFOLK YOUTH OFFENDING SERVICE DIVERSION PROGRAMME

Aims:

- ▶ More efficient and effective targeting of resources at an early point in the process
- ▶ An elimination of unnecessary processing of young people through the criminal justice system (First Time Entrants)
- ▶ Significant improvements in the life prospects for young people involved in offending behaviour, victims of crime and the wider community
- ▶ Increased use of restorative approaches to reduce conflict and repeat offending.

Eligibility: All young people who are considered for an OoCD by police or a prevention referral (via other services such as school or children and young people's services) should be referred to Suffolk Youth Offending Service (SYOS) for consideration for the following outcomes:

- ▶ **Diversion Non-crime:** These referrals relate to children/young people who may be at risk of offending, are below the age of criminal responsibility (10 years old), or are not in the public interest to prosecute. Police, Children and Young People's Service (CYPS), education or a parent/carer can all make non-crime Diversion Programme referrals.
- ▶ **Diversion Crime:** These referrals divert children and young people away from formal out-of-court processes. The crime strand is an informal measure and offences with a gravity score of three or below, or with a higher gravity score and mitigating factors, are considered for diversion. Young people who receive a Community Resolution from police should be referred to the Diversion Programme and receive a diversion non-crime outcome if intervention work is considered appropriate. Young people who are referred for a first or second Youth Caution may also be eligible, subject to consent, to undergo intervention on the Diversion Programme. Those with a Youth Conditional Caution must comply with the intervention plan as part of their conditions, otherwise they may face prosecution. Both Youth Caution and Youth Conditional Cautions are recordable statutory disposals.

Intervention

Those deemed suitable for an intervention will undergo a level 1 or level 2 intervention based on their assessed level of risk:

- ▶ Level 1 – Where there is a low risk of offending/re-offending, the intervention will concentrate on a short intervention plan, which may include, among other things, a restorative element.
- ▶ Level 2 – Where there is a medium to very high risk of offending/re-offending, a risk of harm/serious harm to others and the child/young person presents a risk to themselves or their safety and well-being; requiring a more detailed assessment followed by an intervention programme to address risk factors and strengthen protective factors.

Those with a Youth Conditional Caution will automatically receive a level 2 intervention, as will cases where there is risk of gang involvement or harmful sexual behaviour.

Outcomes

- ▶ A total of 819 referrals were made to SYOS for out-of-court disposals (OoCD) and prevention from October 2016 to September 2017
- ▶ A total of 468 (56%) OoCD and preventative referrals received non-statutory diversion (crime or non-crime) disposal outcomes with only 12% going on to offend, thus potentially reducing the number of first time entrants into the Youth Justice System
- ▶ Young people on the Diversion Programme who completed the intervention or whose Intervention was on-going were less likely to offend after referral than those who declined intervention or received a No Further Action
- ▶ The Centre for Justice Innovation estimated that the programme led to approximately £146,741 in costs avoided by the police and, based on calculations for approximately 242 young people who avoided criminal disposals, the programme avoided approximately £158,415 in justice system processing costs.

Source - Tyrell et al. (2017)

4.3.5 Checkpoint, Durham (UK)

CHECKPOINT, DURHAM

Aims:

- ▶ To provide an alternative to criminal prosecution for low level offenders
- ▶ More efficient and effective targeting of resources at an early point in the process
- ▶ An elimination of unnecessary processing of young people through the criminal justice system (First Time Entrants)
- ▶ Significant improvements in the life prospects for young people involved in offending behaviour, victims of crime and the wider community
- ▶ Increased use of restorative approaches to reduce conflict and repeat offending.

Eligibility Criteria:

- ▶ Subject must live within County Durham and Darlington and the offence must have taken place within these counties
- ▶ Subject must be over 18
- ▶ Offence must be suitable for an Out of Court Disposal
- ▶ Subject must not be subject to an order imposed by the courts or be on police/court bail
- ▶ There must be admissions OR sufficient evidence to charge
- ▶ Offence must not be more than 3 months' old
- ▶ Subject must have committed three offences or less
- ▶ Presenting offence must be eligible

Intervention

- ▶ **Shared decision to participate:** When a suspect is arrested and brought to police custody and booked into detention, the custody sergeant assesses whether they meet the project criteria and, if so, asks if the offender wishes to take part in Checkpoint or be dealt with via standard Criminal Justice processes. If agreed, then the offender is bailed under the provisions of the Bail Act to re-attend the police station to meet a Navigator, and they are reported for summons.

- ▶ **Timely meeting with Navigator:** A meeting with a Navigator is scheduled at the earliest opportunity, usually within 24–72 hrs. If the subject fails to comply, the report for summons, they will not need to be brought back into custody and they are instead called before the court.
- ▶ **Comprehensive Needs Assessment and Relationship-Building:** During the first meeting the Navigator completes an in-depth risk and needs assessment with the person. The focus of this is to build a relationship, trust, and confidence in order to elicit any needs which may contribute to the person's offending ('critical pathways'). These 'critical pathways' are used to determine the needs of the individual and the actions which will form the interventions as part of the 'contract' to engage. The 'critical pathways' used in the needs assessment are: accommodation; alcohol; attitudes and behaviour, children and families; drugs, employment, training and education, finance, budgets and debt; mental and physical health; and sexual exploitation.
- ▶ **Agreeing goals and conditions:** Based on the needs assessment, the Navigator agrees a 'contract to engage' with the subject, which lasts for 4 months. This contract is tailored to each person and can include up to five conditions as follows:
 - ▶ **Offending condition:** Not to reoffend over the period of the contract (mandatory)
 - ▶ **Victim condition:** To take part in a Restorative Approach if the victim wishes (mandatory)
 - ▶ **Interventions:** To attend sessions with relevant services to address needs
 - ▶ **Community condition:** To complete 18–36 hrs of voluntary/community work and/or wear a GPS tag.

Outcomes

Implementation of the programme with 519 offenders in the programme produced a *lower re-arrest and reoffending rate* in comparison to a typical Durham Out of Court Disposal (OoCD) sample, *at reduced harm and cost*.

Source – Weir et al. (2019)

4.4 Evidence of Effectiveness: Pre-Trial Diversion Programmes

Various systematic reviews have examined the effectiveness of different types of pre-trial diversion programmes for different groups, primarily within the North American context. Lange et al.'s (2011) review of programmes for those with mental illness identified 36 post-booking studies. They found that jail-based programmes had a high degree of effectiveness in reducing recidivism; moderate effectiveness in reducing the number of days incarcerated, substance use, increasing service utilization and the quality of life; and limited effectiveness in improving mental health status. Court-based diversion programmes were found to have moderate effectiveness for reducing recidivism, the number of days incarcerated, substance use and increasing the quality of life; and limited effectiveness in increasing service utilization or improving mental health status. Similarly, Harvey et al.'s (2006) review of diversion programmes for drug-involved offenders, which covered both post-booking and post-conviction intervention as well as after-care initiatives, the majority of studies articles reported a reduction in recidivism among treatment participants over the follow-up period.

Heilbrun's (2012) specifically reviewed studies to examine the extent to which there was evidence to support the effectiveness of interventions at different levels of the SIM model, identifying nine primary studies and one review evaluating post-arrest diversion programmes for those with serious mental health problems. As with Lange et al. (2011) and Harvey et al. (2006), studies found that those diverted tended to have higher rates of treatment participation, spent more time in the community, fewer arrests and less homelessness than non-diverted individuals. More recently, an impact evaluation of five prosecutor-led pre-trial diversion programmes pointed to positive outcomes with all five programmes reducing the likelihood of conviction—often by a sizable magnitude (Rempel et al., 2018). All five programmes also reduced the likelihood of a jail sentence, four out of five reduced the likelihood of re-arrest two years after programme enrolment. In addition, in all four programmes where a cost evaluation was conducted, diverted cases produced sizable cost and resource savings. Similarly, a review of the research literature on pre-court diversion found strong international evidence and moderate evidence from the UK that, when implemented properly, pre-court diversion can reduce reoffending.

While studies included in the above reviews focus predominantly on North American population, there is some evidence for the efficacy of interventions within the UK context (see Centre for Justice Innovation, 2019b).

4.5 Pre-Trial Diversion Programmes: Best Practice Considerations

In reviewing the pre-trial diversion research and practice literature, the Centre for Justice Innovation (2019b) identified promising practice principles to inform the development of such services in the UK:

- ▶ 'Avoid net-widening i.e. drawing individuals further into the criminal justice system than they otherwise would have been;
- ▶ Keep eligibility criteria broad thereby working with all those suitable and avoiding unnecessarily low referral numbers;
- ▶ Consider the impact of formal admissions of guilt on service eligibility and participation especially for people from groups which tend to have less trust in the criminal justice system;
- ▶ Ensure the referral process is quick and simple so that practitioners are not discouraged from referring and because evidence shows that swift responses build future compliance;
- ▶ Prioritise victim satisfaction and procedural fairness for the benefit of both specific victims and to ensure that the process commands public trust;
- ▶ Avoid 'overdosing' with overly intensive interventions which offenders may struggle to complete;
- ▶ Deliver responsive and need-focused interventions on the basis of assessed risk and to address the needs which are driving re-offending;
- ▶ Work in partnership to ensure that all the agencies involved share the aims of the scheme and a vision of how it should be delivered' (p.2).

Operational concerns and advice for programme implementation are examined in various practice guides and reviews (Fader-Towe & Osher, 2015; Livingston et al., 2008). These include:

Integrated Working and Collaboration: Successful pre-trial diversion initiatives will draw on expertise and resources from criminal justice, health and social care systems. As such it is essential that the development of a pre-trial diversion programme (including the framework, funding and staffing) should be done by an integrated planning team that includes key stakeholders such as judiciary, prosecution and defence counsel, mental health service administrators, community service providers, police, and social services. Team members should be leaders within their sector and be committed to the promotion of effective collaboration and linkages between systems. The programme planning process should entail setting realistic, evidence based goals and foundation principles for the initiative to avoid the common pitfall of overly optimistic goals for reductions in the jail population or recidivism rates noted by Livingston et al., (2015). At an operational level, an integrated coordinating group with service providers from the same key sectors should meet on a regular basis to discuss day-to-day aspects of the pre-trial diversion program.

Early Identification and Formal Case Finding Procedures: Identification of persons with possible mental health concerns and/or wider complex needs and vulnerabilities should occur at the earliest opportunity through police information or routine initial screening for mental health problems, co-occurring substance misuse and/or other indication of complex needs at time of intake. Further mental health/vulnerability screening should be conducted within 48 hours when mental health concerns are suspected, with follow-up evaluation as necessary. Defendants who are awaiting trial in custody and are identified as having a mental disorder/other co-occurring vulnerabilities should be considered for crisis intervention. It is important for the defence/duty counsel to be appointed early in the process, potentially before charges are laid, in order to identify the mental health status of their client and assess their potential for pre-trial diversion. Defence counsel should have sufficient training to identify mental health issues of their clients and should consider reviewing multiple information sources as soon as possible after appointment. It is suggested that, at a minimum, diversion programme staff check daily rosters of jail and remand inmates to find clients, interview them, recommend diversion if appropriate, and link them to mental health treatment and support opportunities. These must also be available to the Crown counsel early in the process to consider alternatives to prosecution.

Release and Diversion Options: As part of the planning process, stakeholders should review legislation and policy in order to delineate the various possibilities for pre-trial release and diversion and establish clear multi-agency protocols for the use of each of these options. In addition to being knowledgeable about mental health issues, professional staff members that are involved in pre-trial processes need to be aware of the available alternatives to criminal justice processing and incarceration and how to access them. By the end of the planning process, a list of release options at different stages of a criminal case should exist that includes how released individuals are connected to community-based treatment and supports.

Identification, Assessment and Informed Decision-Making: Identification of persons with possible mental disorders/co-occurring vulnerabilities and/or complex needs should occur at the earliest opportunity through police information or routine initial screening for mental illness, co-occurring substance misuse and other vulnerabilities at time of intake. There is a need to develop processes that strike the balance between gathering information and minimising the length of pre-trial detention. It is also essential to ensure that the relevant information is passed to prosecutors and courts to inform decision-making.

Community Supervision and Treatment at the Pre-trial Stage: Criminal justice, health and social care stakeholders need to work together to support defendants' adherence to conditions of release and progress toward recovery and to minimize future involvement with the criminal justice system. Co-ordination should include information sharing, assessment and case planning with regards to pre-trial release and throughout the diversion period. Pre-trial supervision should be provided by staff trained on the signs and symptoms of mental health concerns and effective communication strategies. These staff should remain in regular communication with community-based service/treatment providers.

Procedures, Protocols, and Conditions: There should be specific policies for the diversion of persons whose offence is linked to their mental health and/or complex vulnerability. These should include clearly defined referral pathways, treatment protocols and service guidelines which serve to expedite access to care and/or services for diverted individuals.

Performance Measurement and Evaluation: Data should be collected and analysed at regular intervals to identify opportunities for improvement, assess quality in the delivery of treatment and supervision, and support initiative sustainability. Suggested outcome and performance measures and critical operational data for pre-trial diversion programs developed by National Association of Pre-trial Services Agencies (NAPSA, n.d) are outlined in Table 2.

Table 2: Suggested outcome and performance measures and critical operational data for pre-trial diversion programmes

SUGGESTED OUTCOME MEASURES
<ul style="list-style-type: none"> ▶ SUCCESS RATE: The percentage of diversion participants who successfully complete the diversion programme. ▶ SAFETY RATE: The percentage of diversion participants who are not charged with a new offence while participating in diversion programmes or services. ▶ POST-PROGRAMME SUCCESS RATE: The percentage of participants who complete diversion successfully and are not charged with a new offence during a specific period after programme completion.
SUGGESTED PERFORMANCE MEASURES
<ul style="list-style-type: none"> ▶ SCREENING: The percentage of diversion-eligible persons assessed for diversion placement. ▶ PLACEMENT: The percentage of persons appropriate for diversion placement who are placed into diversion and specific diversion programmes or services. ▶ COMPLIANCE: The percentage of participants successfully completing specific diversion requirements (community service hours, restitution, fines, etc.) ▶ RESPONSE: The frequency of policy-approved responses to compliance and noncompliance with diversion conditions. ▶ PROVISION: The percentage of assessed and appropriate participants who receive substance abuse, mental health, and/or other needed services. ▶ SATISFACTION: Qualitative measures of stakeholder opinions of the pre-trial diversion programme's quality of supervision and services, interactions and value within the criminal justice system
SUGGESTED CRITICAL OPERATIONAL DATA
<ul style="list-style-type: none"> ▶ REFERRALS: Number of referrals to the diversion program and referral sources. ▶ TIME TO PLACEMENT: Time from the defendant's arrest or diversion eligibility screen and actual diversion programme engagement. ▶ TIME IN DIVERSION: Time from programme entry to successful completion, voluntary withdrawal, or termination. ▶ TIME IN PROGRAMMING: Time from entry to successful completion, voluntary withdrawal, or termination for each diversion programme component. ▶ EXITS: Recorded graduations or other successful completions, voluntary withdrawals, and programme terminations

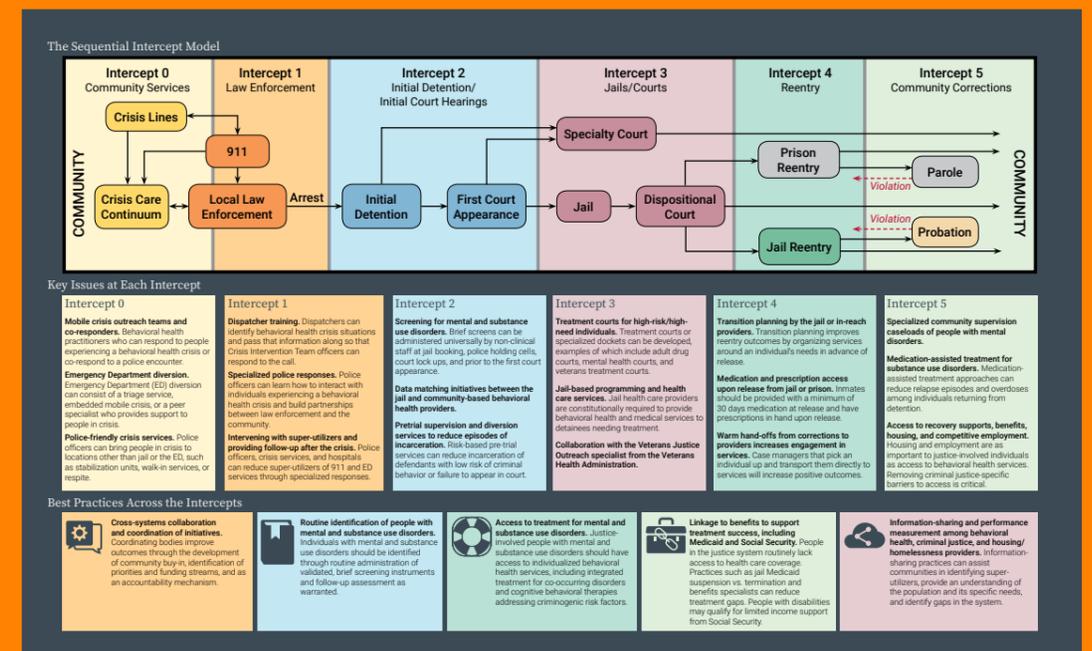
4.6 Intercept 2: Key Messages

There is a growing body of literature outlining the key features of effective pre-trial diversion with evidence that programmes can reduce the rate of re-offending for both young people and adults. Key messages in brief include:

- i. Collaboration:** The importance of effective collaboration and negotiated shared goals between criminal justice, health and social care systems, including the judiciary, prosecution and defence counsel.
- ii. Identification for diversion:** Early identification of persons as suitable for diversion through clear protocols.
- iii. Screening for complex needs:** Early identification of persons with complex needs through the use of brief screens followed by more detailed assessment by trained professionals.
- iv. Information-sharing:** It is essential that information regarding client need is shared between relevant agencies to ensure appropriate services and treatment can be made available in a timely manner and that these needs can be taken into account by decision-makers.
- v. Maximise opportunities:** Risk-based pre-trial services can reduce incarceration of defendants with low risk criminal behaviour. Opportunities for pre-trial release should be maximised and assistance provided to help people with complex needs to comply with the conditions of pre-trial diversion.
- vi. Specialist supervision:** Pre-trial supervision for people with complex needs should be provided by specialised staff who maintain communication with community-based service and treatment providers.
- vii. Service linkage:** People with complex needs on pre-trial diversion should be connected with a comprehensive range of services to meet identified needs, including mental health and substance use treatment providers, as well as prompt access to benefits, primary healthcare and housing. The availability of stable housing is noted as an important factor in successful pre-trial diversion.

Common gaps at intercept 2 are thought to include a lack of diversion opportunities and specialised pre-trial supervision for people with specific mental health or substance use conditions.

CHAPTER 5 INTERCEPT THREE: COURTS/PRISON



5.1 Overview of Intercept Three

INTERCEPT 3: COURTS/PRISON

Intercept three occurs after the initial hearing, and involves jails/prisons, courts, forensic evaluations, and commitments.

Common strategies:

At the court level, initiatives often take the form of alternative judicial procedures, such as *problem-solving courts/treatment courts*. These include adult drug courts, mental health courts, and veterans treatment courts in the US. Mental health courts (MHCs) were created specifically to help defendants who have a mental illness that significantly contributes to their criminal offence. MHC interventions are diversion programmes which are characterized by three key components: screening, assessment, and negotiation between court and criminal justice staff to decide on diversionary alternatives.

Once an individual has been incarcerated, the focus of Intercept 3 turns to the provision of prison based healthcare and treatment. Common strategies involve screening and assessment of prisoner needs and linkages with in-house or community-based treatment options.

Key stakeholders: the judiciary, prosecutors, prison service, probation, mental health and social care providers (both community and prison based)

5.2 Key Issues and Challenges at Intercept 3

Considerations and challenges at intercept 3 in the NI context fall largely into three broad areas: issues with regards to sentencing, the level of need and the prison environment.

5.2.1 Sentencing concerns

Process, options and facilities: Sentencing has been identified as problematic for a number of reasons in meeting the needs of individuals in NI with mental health problems who have been prosecuted and/or convicted (NIAO, 2019). Once a case goes to court, the prosecutor is required to take account of any relevant change in circumstances which may necessitate reviewing whether to discontinue the proceedings against the defendant, or divert the case from the courts. However, responsibility for case management at court lies with the judges and decisions by trial judges are made entirely independently of other justice organisations. It is argued that there is currently an inadequate range of sentencing options, which is further hampered by the absence of step-up/step-down facilities offering a level between community supervision and prison detention, where offenders could be more effectively managed.

Short sentences and reoffending: It is noted that the vast majority (79%) of offenders who received custodial sentences in NI in 2017-18 spent less than 12 months in prison (NIAO, 2019 p.32). There is a general consensus among justice organisations that these short detention periods provide insufficient time for rehabilitative or psychological work to be undertaken (NIAO, 2019). In addition, the rate of re-offending within one year is high, particularly for those who receive short custodial sentences rather than a community sentence. Analysis by the DoJ of the 2015/16 cohort found that while overall 29.7% of young people included in the baseline year reoffended within a year, this increased to 40 out of 41 young people released from custody. Similarly, while the overall rate of reoffending within one year for the adult population was 17.6%, this increased to 39.1% of those who received a custodial sentence. This compares with 48% of adults in the UK reoffending within 12 months, which increases to 63% of those serving a sentence of less than 1 year (Prison Reform Trust, 2019).

5.2.2 Level of need, assessment and communication

Co-occurring vulnerabilities: There is considerable evidence of complex and unmet needs in the prison population in NI. A review of documentation by the NI Audit Office (2019, p.20) found that more than a third of prisoners (36%) reported being in contact with community mental health services at the time of their committal to prison between May 2014 and September 2018. Not only was a high prevalence of pre-existing mental health concerns in new prisoners evident in the review, but also a range of other co-existing vulnerabilities at the time of committal, such as drug use (58%) and history of self-harm (44%).

Self-harm and suicide: Rates of suicide and self-harm are of particular concern in the prison population, with self-inflicted deaths 6.2 times more likely in prison than the general population (MoJ, 2018a). Since 2011-12, there have been 18 confirmed or suspected suicides amongst the prison population and 5,217 recorded incidents of self-harm in the NI prison estate (NIAO, 2019 p.33). Self-harm is noted as a near daily occurrence, with more than one incident recorded on most days in 2017 and 2018 – on just over one third of days, there were 3 or more incidents recorded across the prison estate (NIAO analysis of data provided by NIPS, NIAO, 2019 p.33). NIPS processes for recording self-harm incidents within the prison do not currently include an assessment or recording of the seriousness of the incident (NIAO, 2019 p.33). Issues of documentation and communication of risk presentation have been identified as problematic with the prison system. Although 70% of people who died by self-inflicted means whilst in prison had already been identified with mental health needs, the Prisons and Probation Ombudsman (PPO) found that mental health problems had only been flagged on entry to the prison for just over half of these people (PPO, 2016).

5.2.3 Prison environment

It is acknowledged that ‘providing a healthy prison environment for vulnerable offenders is difficult’ (NIAO, 2019 p.32). For people with underlying mental health issues, there is a risk that the stresses of prison life can cause distress and deterioration. In addition, the basic structure of prison life, both in terms of the physical environment and the daily social regime imposed, can pose a threat to an individual’s mental wellbeing and many of the strategies recommended to a person in the general community to help manage their condition are hard to apply within a prison environment. Inspections of NI’s largest prison have consistently identified (NIAO, 2019 p.34):

- ▶ Inadequacies in the committal process and failure to provide medication to new prisoners in the first days after they enter custody
- ▶ High levels of bullying and violence
- ▶ The availability of drugs
- ▶ The number and quality of purposeful activities
- ▶ A lack of sophistication in the implementation of the SPAR process to support and protect vulnerable prisoners
- ▶ The provision of general and mental health services and medication to prisoners

Ministry of Justice incident recording in England and Wales also indicate that restraint and assault rates amongst children and adults in custody remain high (2019a&b), with records of sexual assaults in prison quadrupling since 2012 (2019b).

5.3 Intercept 3 Initiatives: Problem-Solving Courts

Problem-solving or specialty courts are key initiatives which have been developed in both the USA and UK to address the needs of people with complex needs at the court stage of the criminal justice process. They include mental health courts and drugs courts, and have been extended to include initiatives such as peer courts and community courts. The model is also being applied to family justice through for example family drug and alcohol courts. Problem-solving courts aim to 'bring together community treatment and services with the court, and more specifically the judge, as a principal mechanism for delivering behaviour change. Putting judges at the centre of rehabilitation, problem-solving courts deliver specialised community sentences, tailored to change offenders' behaviour and hold them accountable through regular monitoring by the judge' (Centre for Justice Innovation, 2016).

5.3.1 Development of Mental Health Courts in the USA and UK

Mental health courts are an alternative to navigating the criminal justice system for people with mental health concerns and other related vulnerabilities. 'Therapeutic Jurisprudence', a concept which emerged in the late 1980s, is the cornerstone of these 'problem-solving courts'. Therapeutic Jurisprudence acknowledges the fact that any contact with the justice system will have an impact on an individual and seeks to enhance the therapeutic effect of the court without diminishing due process or other rights of the accused (Ryan and Whelan, 2012). Within this context, judges and lawyers act as therapeutic agents as well as agents of justice, balancing the needs of the individual with the needs of victims and public safety requirements. In traditional court processes, diversion can occur in multiple courts settings. In MHCs diversion occurs within a specialised setting in which judges, prosecutors, defence lawyers, and other court staff are likely to have specialised training in working with persons with serious mental illness and will often work collaboratively, in conjunction with mental health court liaison staff, to link the accused to appropriate treatment and supports (Sirotych, 2009). These courts mandate community-based mental health treatment and monitor participants' treatment adherence, using sanctions where necessary to encourage treatment compliance. Although enrolment is voluntary, the promise of dismissed charges or the avoidance of incarceration is used as an incentive to participate in treatment.

Since the 1990s, Mental Health Courts have been created in numerous jurisdictions across the United States (see Sacramento Mental Health Court case study). Generally, there are two types of MHCs:

- ▶ the pre-adjudication model, in which prosecution is deferred until the defendant completes the mutually agreed-upon programme, and
- ▶ the post-adjudication model, in which the defendant is required to submit a guilty plea to participate in the programme.

Key elements of MHCs include: screening of defendants for mental illness, assessment of identified defendants by a mental health professional, and the negotiation of sentencing between MHC staff and judicial staff (Steadman et al. 1994). Despite these common features, they can vary considerably in their operation, particularly in relation to:

- ▶ the type of charges they accept (misdemeanour versus felony versus a combination);
- ▶ the type of community supervision that they employ (community treatment providers monitoring treatment adherence and reporting back to the court versus probation officers or court personnel monitoring compliance);
- ▶ the type of dispositions that they entertain (dismissal of charges, guilty plea but deferred sentence, or conviction with probation in lieu of a jail sentence);
- ▶ the duration of court supervision of treatment and the frequency of status review hearings of treatment progress;
- ▶ the use of sanctions for non-compliance with treatment conditions. Sanctions may include returning the person to court for hearings, admonishments, imposition of stricter treatment conditions, and re-incarceration (Sirotych, 2009).

While there are more than 300 MHCs in the USA, provision in England and Wales is much less developed, although Ryan and Whelan (2012) highlight efforts to pilot a problem-solving approach to offenders with mental disorders in Stratford and Brighton. In Stratford a dedicated mental health court operated one day a week, while in Brighton cases were heard among the normal court lists.

A process evaluation of this pilot (Winstone and Pakes, 2010) was generally positive and identified the core requirements of any further roll-out as:

- ▶ a Mental Health Court Practitioner available daily at court;
- ▶ comprehensive, pro-active screening and assessment for mental health concerns;
- ▶ multi-agency agreements for information exchange;
- ▶ creative use of Community Orders;
- ▶ court review processes;
- ▶ involving the Mental Health Court Practitioner post sentence.

However, it is worth noting that the Bradley Review (2009) questioned the value of such courts if the role of liaison and diversion services were to be developed as recommended and made available across all courts rather than a select few specialist courts.

5.3.2 Sacramento Mental Health Court (USA)

SACRAMENTO MENTAL HEALTH COURT

The Sacramento MHC began operating in 2007 and operates a post-adjudication model, in which offenders are convicted, but the court may not impose sentences.

Focus:

- ▶ reducing the recidivism of offenders with mental illness by addressing their mental health issues, including taking medication and/or attending therapy
- ▶ mandating offenders to address other issues such as substance abuse.

Collaboration - between the District Attorney's office, the Probation Department, the court, the Public Defender's Office, and the Sacramento County Division of Behavioral Health Services

Requirements:

- ▶ Offenders with mental illness must sign a contract to participate in the MHC programme, and the probation department supervises offenders' treatment progress.
- ▶ The court will not withdraw a participant's plea until he or she successfully completes the programme requirements.
- ▶ If participants do successfully comply with treatment recommendations (made by behavioural health and agreed to by the court before the participant enters MHC), then they avoid incarceration

Outcomes

At the time of evaluation 100 individuals have participated in the Sacramento MHC. Quantitative data analysis found that:

- ▶ defendants had a lower rate of recidivism after the MHC programme than before it.
- ▶ graduates were less likely to be re-arrested and re-hospitalized than non-graduates.

Facilitators and Barriers to Implementation Success

Qualitative findings highlighted key facilitators of success and barriers to effectiveness.

Systemic facilitators of success: effective collaborative relationships among justice partners; effective leadership of the presiding judge; offering incentives (e.g. gift cards; a switch to a biweekly rather than weekly court visit schedule) to motivate participants to comply with MHC recommendations; strategic use of sanctions (e.g. spending a week in jail; assignment to work detail) to address non-adherence to recommendations and failure to appear in court; ability to provide transportation, in the form of paratransit³³ services and public transportation vouchers, facilitated many defendants' successful participation

Individual-level facilitators of success: defendants increasing their engagement in pro-social activities (e.g. community service, peer mentoring within the mental health system); positive family relationships which provided emotional support and helped defendants to adhere to MHC recommendations.

Systemic barriers: unavailability of secure, appropriate housing for MHC participants as a barrier to success. Interviewees noted that: participants with histories of illicit substance use often resided in areas with high levels of drug trafficking (due to restricted housing options); limited capacity for oversight by probation officers due to staffing and funding limitations (behavioural health professionals could potentially provide such oversight, if more intensive behavioural health services were more widely available to defendants); procedural heterogeneity regarding which defendants the District Attorney accepted into the MHC, determination of graduation requirements and how these were communicated to participants.

Individual-level barriers: Ongoing substance use; very low adaptive skills; family members who "enabled" patterns of maladaptive behaviours

Source – Yuan & Capriotti (2019)

³³ special transportation services for people with disabilities, often provided as a supplement to fixed-route bus and rail systems by public transit agencies

5.3.3 Evidence of Effectiveness: Mental Health Courts

The empirical evidence is thought to be strongest in support of speciality courts at Intercept 3 (Heilbrun et al., 2012 & 2015). Problem-solving courts, particularly the most established courts such as drug courts and MHCs, have been described as at least promising practices (Heilbrun et al., 2015). A recent systematic review of the effectiveness of Mental Health Courts in reducing recidivism and police contact (Loong et al., 2019) identified twenty studies which used a comparison/control group to assess outcome. Studies that examined recidivism used a variety of measures including the number of rearrests, bookings, or the incurrence of new charges and timeframes for which outcomes were recorded varied from the past 30 days to the past 2 years. There was some evidence that diversion to a MHC can lead to a significant decrease in reoffending, particularly for MHCs which had a case manager or provided court supervision as a part of the intervention. Interestingly, in the two studies identified by Loong et al. (2019) as showing no significant differences in recidivism, the comparison group was provided a case manager or access to vocational and housing services. Long et al. (2019) suggest this may be indicative of these features being important components of MHCs which successfully reduce client re-arrest rates. When investigating police contact, studies identified by Long et al (2019) reported outcomes either as time in the community or time to re-arrest. However, the review found results to be inconclusive with three studies reporting a significant decrease in police contact and three reporting no difference.

5.3.4 Data collection regarding speciality courts

Some of the recommended variables and measures to collect with regard to the workings of speciality courts include:

- ▶ Number of referrals to each court
- ▶ % of referrals accepted
- ▶ Current capacity of each court
- ▶ Rate of successful programme completion ('graduation;') of each court
- ▶ Rates of recidivism after programme completion

5.3.5 Mental Health Court implementation: Best Practice Components

The Council of State Governments Justice Center (Thompson et al., 2008) identified ten essential elements of Mental Health Court design and implementation:

- i. Planning and administration:** a broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community, which guides the planning and administration of the court.
- ii. Target population:** Eligibility criteria which address public safety and consider a community's treatment capacity, in addition to the availability of alternatives to pre-trial detention for defendants with mental illnesses. Eligibility criteria should also take into account the relationship between mental illness and a defendant's offences, while allowing the individual circumstances of each case to be considered.
- iii. Timely participant identification and linkage to services:** Participants are identified, referred, and accepted into mental health courts, and then linked to community-based service providers as quickly as possible.
- iv. Terms of participation:** Clear terms of participation which promote public safety, facilitate the defendant's engagement in treatment, are individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the programme.
- v. Informed choice:** Defendants should fully understand the programme requirements before agreeing to participate in a mental health court and be provided with legal counsel to inform this decision and subsequent decisions about programme involvement. There should be procedures to address, in a timely fashion, concerns about a defendant's competency whenever they arise.
- vi. Treatment supports and services:** MHC should connect participants to comprehensive and individualized treatment supports and services in the community and advocate for the increased use and availability of evidence-based treatment and services.
- vii. Confidentiality:** Health and legal information should be shared in a way that protects potential participants' confidentiality. Information gathered as part of the participants' court-ordered treatment programme or services should be safeguarded in the event that participants are returned to traditional court processing.
- viii. Court team:** The establishment of a team of criminal justice and mental health staff and service and treatment providers who receive special, ongoing training and help MHC participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process.

- ix. Monitoring adherence to court requirements:** Criminal justice and mental health staff should collaboratively monitor participants' adherence to court conditions, offer individualized graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery.
- x. Sustainability:** Data should be collected and analysed to demonstrate the impact of the mental health court and MHC performance should be assessed periodically (and procedures modified accordingly). Court processes should be institutionalized, and support for the court in the community cultivated and expanded.

5.4 Intercept 3 Initiatives: Prison Based Treatment

5.4.1 Practice Developments in the USA

Closure of community in-patient psychiatric units and other community resources coupled with increasing incarceration rates have led some to argue that incarceration has become the default option for long-term care of serious mental illnesses in the US (Allison et al., 2017), with State prisons and county jails holding 10 times more people with serious mental illness than state mental hospitals (Torrey et al., 2014). The prison environment makes the management of people with mental disorders particularly challenging, especially given the institutional focus is primarily centred upon security and control rather than care. These challenges are exacerbated by high levels of bullying and victimisation, high levels of self-harm and suicide, illegal drug use and the confinement of prisoners to their cells for long periods of time (Ginn, 2013). The lack of adequate mental health treatment for the prison population has been a source of concern and on-going criticism in the USA for many years. A study by the U.S. Department of Justice (James and Glaze, 2006) found that, while more than half of all prison and jail inmates had a mental health problem (compared with 11 percent of the general population), only one in three prison inmates and one in six jail inmates had received any form of mental health treatment.

Lack of treatment continuity for those taking medication for mental health conditions at the time of admission, the costs of transferring prisoners to acute psychiatric facilities and lack of available beds, the (mis)use of solitary confinement as a way to manage difficult or dangerous prisoners and the privatisation of mental health and medical services have all been highlighted as significant barriers to effective service provision (Anasseril, 2007; Metzner & Fellner, 2013). Although the Federal Bureau of Prisons issued a new policy outlining improved standards of care and oversight for inmates with mental health issues, there remains a general consensus that treatment falls far short of what is required to effectively meet the needs of this group (Black et al., 2019).

The two most prevalent models for mental illness management found in corrections facilities in North America are the Risk/Need/Responsivity Model (RNR) and the Illness Management and Recovery Model (IMR) (Black et al., 2019):

- ▶ **RNR model** assumes that criminal behaviour can be predicted and tailors individual therapy to reduce the likelihood of reoffending by offering specific social learning tools based on an individual's personality, learning style, and motivation. It involves the assessment of major risk factors for predicting criminal behaviour (anti-social personality, pro-criminal attitudes, social supports for crime, substance abuse, family/marital problems, school/work problems, and lack of pro-social recreational activities), as well as factors such as self-esteem, feelings of personal distress, major mental disorders, and physical health to develop an individual treatment programme.
- ▶ **IMR model** focuses on helping inmates become aware of their illness and develop strategies to improve coping and social skills to prevent relapse, in addition to any psychotropic drugs the individual may be prescribed. It generally includes a nine-month programme which can consist of individual or group therapy, occurring twice a week, as well as requiring that individuals attend 10 educational modules.

While a number of studies have demonstrated positive results from the implementation of both models of care, there is no standard of care for implementing components of the RNR or IMR approach across corrections facilities or state psychiatric hospitals.

In addition to pharmacological treatment, group psychotherapy is cited as the most common treatment intervention used in American prison settings, in part because it is the most cost effective. While individual psychotherapy, CBT and counselling services can benefit the overall mental health and coping ability of individuals with mental illness in prison, it tends not be as available in the US because of limited resources (Hills et al., 2004). A lack of qualified mental health professionals, limited staff knowledge and time to screen and assess inmates in relation to mental health, high caseloads and lack of therapeutic resources means that, more than not, medication is the only treatment provided to prisoners (Kolodziejczak & Sinclair, 2018). Despite these on-going difficulties, a number of prisons have introduced initiatives to improve prison mental health through establishing prison-based case management services to help identify offenders with mental illness, specialist in-patient psychiatric units/hospitals providing acute and sub-acute care and treatment and/or step-down or transitional programmes to prepare prisoners for release (Hills et al., 2004).

5.4.2 Correctional Health Care/Mental Health Services Program (USA)

CORRECTIONAL HEALTH CARE/MENTAL HEALTH SERVICES PROGRAMME, TEXAS

Aims: to provide public and institutional safety, promote positive change in offender behaviour, and reintegrate offenders into society through the provision of health care.

Programme Features:

- ▶ The 550-bed John Montford Unit in Lubbock, Texas, was established to provide a full range of inpatient psychiatric services to offenders with mental illness in the state correctional system. Offenders throughout the state are referred to Montford to receive individualized treatment in a safe environment. The Montford psychiatric hospital meets the needs of offenders in the state criminal justice system by offering a range of services at varying intensities. The Montford Unit provides the following psychiatric services:
 - ▶ 550 psychiatric beds.
 - ▶ 400 "Trusty Camp" beds.
 - ▶ A 48-bed general medical and surgical unit.
 - ▶ Geriatric services.
 - ▶ Non-traditional therapies, such as art therapy, music therapy, occupational therapy, and recreational therapy.
 - ▶ A trusty camp, gardens for the Lubbock food bank, housing, stables, and roads located on 120 acres
- ▶ Offenders referred to Montford are first transferred to the crisis management unit, where they receive a psychiatric evaluation, psychological evaluation, and, if necessary, physical evaluation.
- ▶ When offenders are admitted to Montford, they are transferred from crisis management to acute care, where they stay 10 to 14 days for additional evaluation and development of an individual treatment plan based on the medical model.
- ▶ As individuals stabilise, they are given increased privileges, individual treatment plans are adjusted, referrals are made to various groups offered by the staff, and offenders are evaluated to determine their educational needs.
- ▶ If hospitalisation is required after acute care, offenders are transferred to a sub-acute care programme. This programme follows a biopsychosocial model that emphasises group therapy. Individuals are closely monitored to determine their response to medications, and treatment plans are refined. The average length of stay in a sub-acute care unit is 90 to 180 days.

Source – Hills et al. (2004)

5.4.3 Practice Developments in the UK

Similar concerns about the care provided to mentally ill prisoners have been raised in the UK context. As in the USA, systematic review of UK mental health services and prisoners (Brooker, Beverley, Repper, Ferriter, & Brewer, 2002) highlighted a significant over-representation of the major mental disorders in the prison population compared to the general community identifying four major disorders: personality disorder, neurotic disorders, drug dependency and alcohol dependency.

'The Future Organisation of Prison Health Care' (HM Prison Service/NHS Executive, 1999) acknowledged that systems for dealing with the levels of mental health problems amongst prisoners were under-developed, particularly in relation to screening at reception and care-planning. It emphasised the need to deliver the same standards of healthcare in prison settings as in the community, recommending that Care Programme Approach (CPA) used to provide a framework for the delivery of mental health care to patients with severe mental illness be implemented within prison settings (Pyszora & Telfer, 2003).

'Changing the Outlook' (Prison Health Task Force and Policy Unit, 2001) called for a move away from automatically treating prisoners with mental health problems in prison healthcare centres, advocating for greater use of primary care, mental health in-reach services, day care and wing-based treatments in line with the range of community-based mental health services that would be available outside the prison setting. This was followed by publication of the DoH & NHS (2005) best practice guide on prison mental health services in 2005 and, in 2006, responsibility for taking over prison healthcare was transferred to the NHS with the goal of placing the delivery of mental health services to prisoners on the same footing as community-based services.

5.4.4 Mental Health In-Reach Services

To achieve these goals, a substantial investment was made towards developing mental health in-reach services (MHIRS) which was introduced nationwide to provide services similar to community mental health teams across the prison estate in England and Wales (Brooker & Webster, 2017). Although initially provided mainly in local prisons, over time they have expanded to category B and open/ training prisons (Ricketts et al., 2007; OHRN, 2009) as well as expanding their focus from those prisoners with serious and enduring mental illness, to include all those in prison with any mental disorder (Brooker et al, 2005). Mental Health In-Reach Teams (MHIRTs) are made up of mental health professionals who conduct multidisciplinary mental health assessments of need and risk, providing the prison healthcare team with advice and support to develop a care plan, and providing prisoners with appropriate medical and psychosocial interventions (see Mental Health In-Reach Services, Derbyshire case study).

Various evaluations and surveys reported positive effects of these teams (Ricketts et al., 2007; OHRN, 2009, Brooker et al., 2017) in terms of increased collaborative working, increased identification, assessment and treatment of prisoners, improved continuity and quality of care and the provision of training and education to prison staff. Nonetheless various challenges have also accompanied the implementation process, notably:

- ▶ Cultural clash between mental health professionals and prison professionals
- ▶ The anti-therapeutic nature of the prison environment
- ▶ Limited opportunities to engage with prisoners
- ▶ Complexity of service user's mental health disorders
- ▶ Lack of appropriate training, particularly in specific therapeutic techniques
- ▶ Inadequate triage by primary healthcare, the largest sources of referrals to in-reach teams
- ▶ Limited resources

Despite increases in the levels of staffing and resources available to MHIRTs, the prison environment remains an extremely challenging to provide effective mental health services within and the majority of prisoners with serious mental illnesses remain unidentified and untreated (Brooker et al., 2017; PPO, 2016).

5.4.5 Personality Disorder Programme

In addition to the establishment of MHIRS, there has also been recognition in recent years of the need to improve the identification treatment of personality disorder within the criminal justice context with the Personality Disorder (DSPD) Programme launched and piloted services in three prisons in 2001. Although Lord Bradley's Report (2009) acknowledged these steps as positive, it also highlighted the lack of coherent approach to the management of personality disorder in prisons. Review of the DSPD Programme led to recognition of the need for a strategic plan for the treatment and management of offenders with severe personality disorders. The Department of Health and the National Offender Management Service (NOMS) jointly developed an Offender Personality Disorder Pathway Implementation Plan which went for public consultation in 2011 and was subsequently implemented. The 2014 review of the Bradley Report found that, while there remained little or no provision for the bulk of prisoners with personality disorders, treatment pathways for prisoners with severe disorders who pose a high risk of harm were available to a larger number of such prisoners with Offender Personality Disorder treatment and progression services known as Psychologically Informed Planned Environment (PIPEs) available in a number of prisons. PIPEs are not a form of treatment, but are designed to offer a safe and facilitating environment to help prisoners develop socially and to retain any benefits they have already gained from treatment.

5.4.6 Mental Health In-Reach Services (UK)

MENTAL HEALTH IN-REACH SERVICES, DERBYSHIRE

Background: Prison Health Care is delivered through a formal partnership between the NHS and the Prison Service to achieve an effective and integrated service. The Prison Service continues to provide primary care whilst responsibility for secondary and specialist care rests with the NHS. The Prison In-reach service provides an integrated triage, primary and secondary service for females and males from 18 years at HMP Foston and HMP Sudbury, with mental health care equivalent to that available to those in the NHS.

Aims:

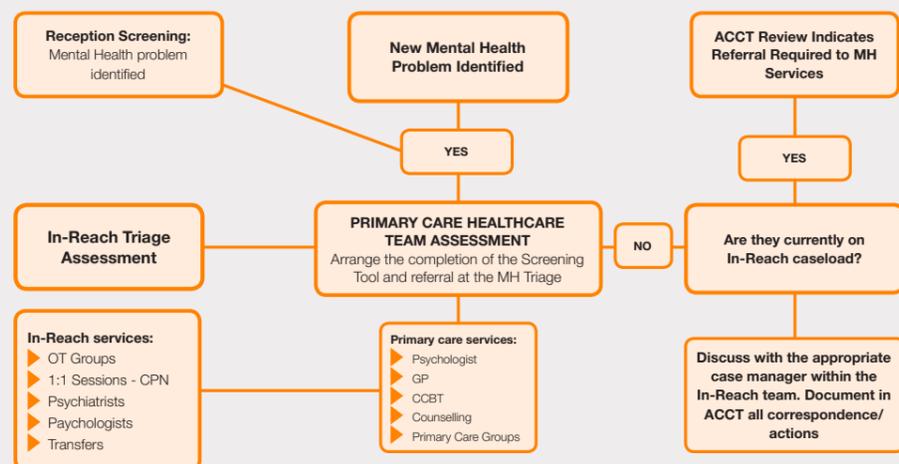
- ▶ To ensure that the prisoner’s health and social care needs are met whilst in custody
- ▶ To achieve effective resettlement and rehabilitation on release from prison – in particular addressing the prisoner’s mental health needs and other complex needs as well as ensuring personal and public safety

The Team: The team is an integral part of Prison Healthcare, working within the Prison alongside Healthcare staff and consists of a Team Leader, Community Psychiatric Nurses, an Occupational Therapist, Psychiatrists, a Psychologist and a Team Administrator. The Prison In-Reach Team operates between the hours of 9.00am and 5.00pm, Monday to Friday. No crisis provision is made out of hours, but there is an ‘out of hours’ crisis protocol (spot purchase of an out-of-hours consultant).

Models of Service Delivery:

- ▶ The Prison In-reach Team for Foston and Sudbury was established May 2002. The role of the team has evolved and delivers the following models of service delivery: CMHT; Triage Assessments; and Day Care Centre-Model of Human Occupation
- ▶ Additional Services include: a psychiatric clinic weekly at HMP Foston on the Sentenced and 3 out of 4 weeks on the Remand side. HMP Sudbury receives one monthly session; peer supervision and advice for Prison staff; Mental Health Awareness training and support for the delivery of training in Assessment, Care, Custody and Teamwork (ACCT).
- ▶ Referrals to the Psychiatric and Psychology Clinics are made by In-reach team members and patients’ needs are discussed with the relevant professionals.

Prison Mental Health Care Pathway:



Source: Derbyshire Mental Health Services NHS Trust (2010)

5.4.7 Evidence of Effectiveness: Prison Based Treatment

Despite worldwide recognition that prisoners have substantial mental health needs, research examining the efficacy of psychological therapies within the prison setting has been less commonly examined than those provided within community settings. A recent systematic review and meta-analysis (Yoon et al., 2017) identified 37 studies involving 2,761 prisoners, which used randomized clinical trial methodologies to measure mental health outcomes for incarcerated populations. It found that RCTs of CBT and mindfulness-based therapies showed moderate evidence to improve depressive and anxiety symptoms in prisoners where no pre-existing treatments are in place, with mindfulness-based therapies possibly demonstrating higher effect sizes. Trauma-based therapies demonstrated limited evidence of effect on trauma symptomology. It was difficult to come to conclusions about action-oriented approaches such as art and music therapy due to a lack of research and the difficulty in interpreting estimates based on different treatments. Most of the included trials involved short-term treatment with an average length of 10 weeks. Although the review found that the length of treatment did not alter treatment effects, it also found that the maintenance of psychological gains was not found at 3 and 6 months, suggesting the need to study the relationship between length of treatment and longer term outcomes more fully. The review also identified difficulties with follow-up and institutional constraints on scheduling and implementation of trials within prison settings, concluding that while CBT and mindfulness-based therapies are modestly effective in prisoners for depression and anxiety outcomes, more evidence is required before additional therapies can be recommended.

5.4.8 Data Collection regarding prison-based treatment

Given that prisons are often de-facto large mental health facilities (GAINS, 2019), there is a wide range of data that could be collected to create a comprehensive understanding of the extent to which the prison is providing mental health support and clarify the need for community-based treatment and follow-up. When treatments are provided by other agencies or contracted providers, this can pose challenges in accessing the data and will require high-level agreement to ensure the right data is collected and shared for analysis. Recommended variables and measures include (GAINS, 2019):

- ▶ Number and % of persons with a history or currently experiencing a mental health or substance use condition (either self-reported or confirmed via health records)
- ▶ Average length of incarceration among people with mental illness versus the general population
- ▶ Number of people connected to support services and programming (employment training education, faith-based groups etc.)
- ▶ Number of suicide watches and number of days the facility is on suicide watch annually
- ▶ Number and % of individuals receiving facility-based mental health or substance use treatment services
 - ▶ Number of persons seeing a psychiatrist
 - ▶ Number of persons receiving psychotropic medications
 - ▶ Number of persons receiving withdrawal protocol
- ▶ Capacity of mental health and substance use treatment staff to provide services

5.4.9 Prison-Based Treatment: Best Practice Considerations

Following a review of deaths in prison custody between 2012 and 2014, the Prisons and Probation Ombudsman (PPO, 2016) made a series of recommendations to improve the identification of mental health issues amongst inmates and improve the levels of care provided:

Identification of mental health issues

- i. Screening at Reception:* Reception staff should review all the documentation that a prisoner arrives with, and ensure that all relevant information is then passed onto the health professional responsible for the reception health screen. All information should be recorded on the prisoner's electronic medical record and this system should be checked during screening/assessment for relevant information.
- ii. Prison transfers, sharing information, and continuity of care:* Sharing information between prisons and health care providers is necessary to ensure continuity of care and support for when a prisoner is transferred from one prison to another, or returns to prison after a period in the community. Measures should be in place to ensure that community GPs provide comprehensive details of a prisoner's health records and that a comprehensive handover take place between prison mental health teams when a prisoner with complex needs is being transferred.
- iii. Making referrals:* Staff have a responsibility to make a mental health referral any time that they have concerns about a prisoner's mental health. The referral might be made by the health professional who conducts the initial health screen in reception, or by a prison GP. Primary care services in prisons are often delivered by GPs, who hold routine clinics to identify and treat a range of health conditions.
- iv. Assessment:* When a referral has been made, this should prompt an assessment from the appropriate healthcare professional. Depending on the nature of the prisoner's issue, and the reason for the referral, the assessment might be carried out by a GP, someone from the primary care team, or a member of a specialist mental health in-reach team. Mental health assessments should take into account all relevant information, use standard mental health assessment tools, and be compliant with NICE guidelines.

- v. **Mental health awareness:** While there are specialist mental health teams in prisons to assess prisoners and coordinate care when mental health problems are identified, residential staff have to manage prisoners with mental health issues on the wings as part of their daily routine. As such, all prison staff should have training in recognising and managing symptoms of mental health problems.

Provision of care

- i. **Treatment:** At a minimum, all prisoners should have access to the same range of psychological and talking therapies that would be available to them in the community. These services should be adapted for use in a prison environment where appropriate.
- ii. **Medication:** Prison healthcare leads should ensure that a robust system is in place for flagging non-compliance with medication, and that there is clear guidance for healthcare staff about the management of medication and dealing with non-compliance. Compliance with all medication should be monitored and encouraged as part of an up-to-date care plan for prisoners with mental health problems.
- iii. **Sharing information with prison staff:** When mental health problems are identified by healthcare staff, it is vital that relevant information is communicated to prison staff, so that they are as informed as they can be about a prisoner's needs and can play a part in providing support. All healthcare professionals have a responsibility to share with prison staff any information that might affect a prisoner's safety, within the boundaries of medical confidentiality.
- iv. **Coordinated care:** Prisoners with multiple health problems are often treated simultaneously by different healthcare teams. All healthcare teams involved in the care of a prisoner should communicate with each other and share information, to ensure consistency in diagnosis and a collaborative approach to treatment.
- v. **Assessment, Care in Custody and Teamwork (ACCT):** Prisoners with poor mental health can be particularly vulnerable. Identifying their needs and providing adequate support can help prevent mental health crises, which can lead to self-harm or suicide. PSI 64/2011, Safer Custody, gives detailed guidance to staff to help manage prisoners who have been identified as at

risk of harm to themselves. The instructions make clear that if a prisoner is identified as at risk, then Assessment, Care in Custody and Teamwork (ACCT) procedures need to be put in place. The mental health team should attend or contribute to all ACCT reviews for prisoners under their care, and should be fully involved in any important decisions about location, observations, and risk.

- vi. **Transfer to secure hospital:** Prisons need to be extra vigilant about the care of prisoners who are being considered for, or are awaiting transfer to a secure hospital. Segregation should be avoided for such prisoners, unless there are clearly recorded exceptional circumstances.
- vii. **Dual diagnosis:** Mental health and substance use teams should work together to provide a coordinated approach to prisoner care. This should involve the use of agreed dual diagnosis tools to assess prisoner needs and regular meetings to discuss and plan joint care. Details of all interventions from substance misuse services should be recorded in a prisoner's health record. Prisoners undergoing treatment for substance misuse should not be prevented from accessing secondary mental health services.
- viii. **Personality disorder:** The risks presented by all offenders with severe personality disorder who face long periods in prison should be identified and managed through informed sentence planning and suitably structured regimes. When a prisoner is moved to a standard prison wing, from a secure mental health hospital or a specialist prison unit for those with severe personality disorder, their reintegration should be supported and their progress monitored. They should initially be allocated a healthcare practitioner with experience of personality disorder and be given appropriate care in line with an agreed care plan.

5.5 Intercept 3: Key Messages

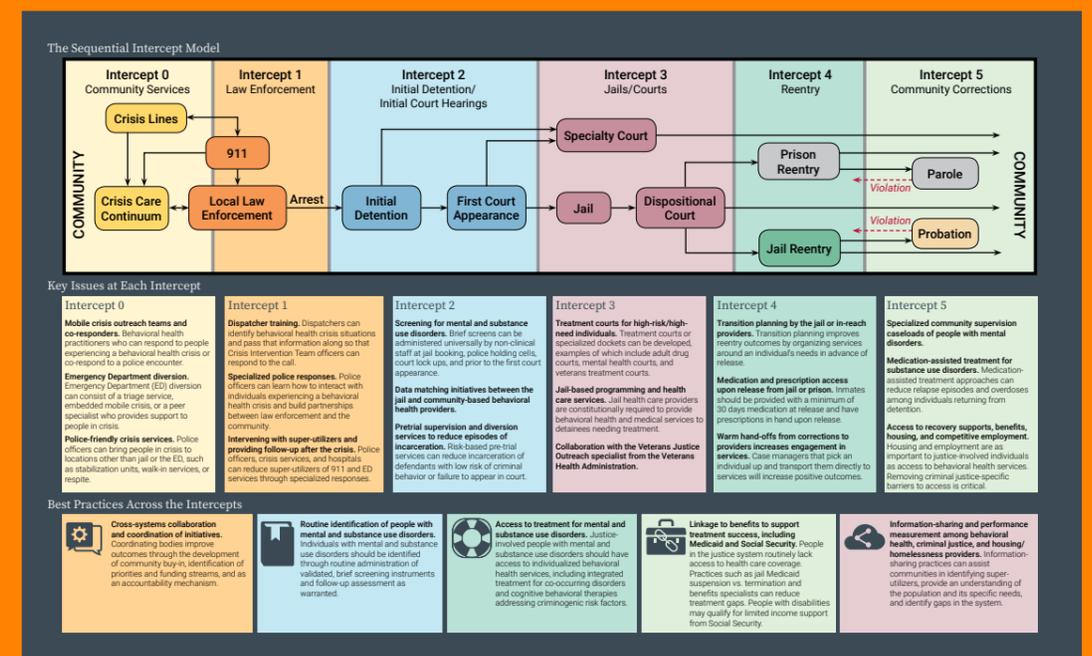
The literature reviewed suggests that **problem-solving courts** show promise in reducing re-offending. Key features suggested by the GAINS Centre and Policy Research Associates include:

- ▶ Court coordination is required to maximise the potential for diversion in a mental health court or other non-specialty court.
- ▶ Judicial leadership is identified as central to success
- ▶ Case managers are identified as important co-ordinating positions
- ▶ Paid peer staff with lived experience can make a significant difference
- ▶ Services and supervision should take account of co-occurring conditions
- ▶ Flexibility and individualised treatment plans are necessary
- ▶ People should be linked to a comprehensive service package including prompt access to benefits, healthcare and housing
- ▶ Communication and information-sharing should be promoted between courts and service providers by establishing clear policies and procedures.

A wide range of recommendations are outlined above with regard to the provision of **prison-based services** for persons with complex needs, including mental health and substance use conditions. It is noted that incarcerated persons should be provided with services that are consistent with community and public health standards, including access to psychiatric medications. Central features of good practice include the need for screening and assessment protocols; ensuring continuity of care; mental health awareness of all prison staff; mental health in-reach services to improve access to treatment and therapeutic supports; and critical information-sharing between prison staff and healthcare staff. However, it is noted that the prison environment remains an extremely challenging context to provide effective mental health services within and many needs continue to go unidentified and unmet.

CHAPTER 6

INTERCEPT FOUR: RE-ENTRY



6.1 Overview of Intercept 4

INTERCEPT 4: RE-ENTRY

This fourth intercept in the Sequential Intercept Model is focused on reintegration and rehabilitation, recognising that nearly everyone in prison will be released at some point. 'Re-entry addresses the continuity of care between correctional facilities and community mental health providers as people return to their communities. It concludes when someone is released from jail or prison and starts community supervision' (Willison et al., 2018, p. 3). The aim at this intercept is to successfully facilitate a justice-involved person's transition from an institutional setting using community-based treatment programmes (DeMatteo et al., 2013).

Common strategies used at this intercept include:

- ▶ **Transition planning** in advance of an individual's release. This involves prison staff '*reaching out*' to community services, and '*reach-in*' by community providers to undertake assessments, agree service needs and support engagement. Vital to this process is a sense of shared responsibility.
- ▶ **Warm hand-overs (warm hand-offs)** promote service engagement by appropriate data sharing between prison services and community providers, and the support of an *allocated case manager* to coordinate, transport and introduce the recently released person to any new services.
- ▶ **Ensuring basic needs are met** upon release from prison, including suitable housing and access to medication and prescriptions to avoid destabilisation of any health conditions.

Key stakeholders: prison service, probation, mental health and social care providers (both community and prison based)

6.2 Key Issues and Challenges at Intercept 4

It is recommended that planning for re-entry begins upon entry into prison, with validated screening and assessment tools used to identify the needs and risks associated with justice-involved persons planning to re-enter the community. This early identification of need is essential in order to shape services delivered while in custody, and to inform transition to the community following release. Particular consideration is needed to ensure that from the moment of release, justice-involved persons with complex needs have access to suitable housing, and can access and utilise medication, psychosocial treatments and wider healthcare services. This requires a high level of data-sharing at different points in the criminal justice process between numerous partners, and cross-agency cooperation. Successful re-entry is complicated by the following challenges:

6.2.1 Transition planning is difficult for people serving short sentences or on remand

Sufficient planning for re-entry is identified as difficult to achieve particularly for those serving short sentences or the remand population who may be get released unexpectedly (NIAO, 2019). Remand prisoners in England and Wales make up 11% of the prison population and receive no financial support on release (Prison Reform Trust, 2019). In NI, it is recognised that 'many offenders leave the justice system vulnerable or at risk and pathways to support services can be problematic' (NIAO, 2019 p.36).

6.2.2 The prison population is often vulnerable before entry to prison, and do not return to safe and stable contexts

Incarcerated persons often return to the high-crime, poverty-stricken communities from which they came, battling educational and job training deficits, drug addictions or mental illnesses that contributed to their offending in the first instance (Travis, 2005). Many of those with complex health and social needs have not been in contact with key services in the community prior to their entry to prison. A prisoner needs survey completed in the UK found that 9% of prisoners were not registered with a General Practitioner (the gateway to many other health and social care services), 19% reported they were either homeless or living in a hostel at the time they entered prison and 26% stated that they had no accommodation to go to upon release (NIAO, 2019 p.38). Statistics reveal that homelessness is a significant problem for people at re-entry. Ministry of Justice statistics confirm that 1 in 7 people who left prison in the year to March 2018 were homeless. This increased to 1 in 5 people serving a sentence of less than six months (MoJ, 2018e). This has important implications for re-entry planning as it is recognised that some people may re-offend as a means to get back into prison as a (relative) place of safety (Cornish et al., 2016).

6.2.3 The prison population is getting older

People aged 60 years and over are the fastest growing age group in the prison population, with nearly three times as many in prison than 15 years ago. People aged 50 years and over make up 14% of the prison population (Ministry of Justice, 2015). This MoJ (2015) report shows the nearly two-thirds (64%) of older prisoners reported a mental health problem(s) and eight in 10 reported a serious illness or disability. Thus many older incarcerated persons are likely to struggle to cope with life in the community as they face health and care issues that often come in later life, in addition to the difficulties commonly associated with release from prison.

6.2.4 Prison experience adds new vulnerabilities

There are a range of collateral consequences that stem from a criminal conviction. The Prison Reform Trust in the UK (2019) found that in England and Wales:

- ▶ Only 17% of people are in PAYE employment a year after leaving prison.
- ▶ One in seven people who left prison in the year to March 2018 were homeless.
- ▶ Many people in prison are released with debts which have built up during their sentence—adding to the problems they face on release.
- ▶ More than four in five former prisoners surveyed said their conviction made it harder to get insurance preventing access to many forms of employment or self-employment

The exclusion of justice-involved persons leaving prison from public housing and employment opportunities has been referred to as ‘invisible punishment’, which can be as severe as the prison sentence itself (Mauer & Chesney-Lind, 2002).

6.2.5 Loss of supportive relationships while in prison

Maintaining relationships with supportive family and friends whilst in prison is recognised as problematic, yet essential to the process of re-entry. Positive relationships and family contact are important factors in influencing how justice-involved persons cope with imprisonment and their reintegration and rehabilitation upon release. Positive family relationships have been found to be associated with reduced risk of re-offending (Markson et al., 2015). May et al. (2008) found that for a prisoner who receives visits from a family member, the chances of re-offending are 39% lower than for those who do not.

Recently Lord Farmer reviewed the importance of family and other relational ties as part of the UK Government’s plans to effect the biggest overhaul of prisons in a generation. While mindful that some family relationships can be harmful and the need to be alert to relationships that are damaging and abusive, he concluded:

‘Given that the majority of prisoners’ families are profoundly motivated to help men serving sentences build a better life for themselves, free from offending patterns of behaviour, they constitute a potential army of support for the prison system that has not as yet been strategically and consistently deployed across the estate’ (Farmer, 2017, p. 17).

This has also been recognised as an area meriting attention in the NI context. In a recent consultation document, the Northern Ireland Prison Service strategy for strengthening family relations stated, ‘We will actively encourage and support meaningful engagement by acknowledging the strengths and assets that families and wider social networks have to contribute to an individual’s desistance journey’ (NIPS, 2019).

6.2.6 Re-entry can literally be a matter of life and death

Re-entry of justice-involved persons to local communities is recognised as a time of crisis with a high risk of suicide in the days immediately post-release (Prison Reform Trust, 2019). In a study of 30,237 prisoners released in Washington State, Binswanger et al. (2007) found that 443 people died in the follow up period of 1.9 years, a death rate 3.5 times higher than that of the general public. For ex-prisoners with severe mental illness, the death rate rose to 12.7 times higher than the general population in the 14 days following release. The primary causes of death included drug overdose, heart disease, homicide and suicide (Binswanger et al., 2007). This situation is mirrored in the NI context. While 23 people died in custody in NI between 2014 and 2019, the same number died in the two weeks after leaving prison, the majority of these deaths were related to drug and alcohol use (Prisoner Ombudsman’s Office, 2019). There is a noted increase in the number of people leaving prison in NI whilst subject to SPAR protocol i.e. at risk of suicide or self harm, with currently no outreach system for health and social services to help manage the safe return of these vulnerable individuals to the community (NIAO, 2019 p.37).

6.2.7 Prison-based services for people with low level chronic needs are more accessible than community-based services

Incarcerated persons with low level chronic needs (including mental health issues, substance use, special needs) may have been in receipt of higher levels of treatment or intervention than would be provided in the community for someone with similar problems. The NI Audit Office report (2019) which examined issues in relation to the interface between the mental health and criminal justice systems reported the regular experience of prison-based practitioners referring prisoners for further support and treatment after their release who were then assessed and almost immediately discharged by local community health services due to higher access thresholds and non-attendance (p.38).

6.2.8 Achieving sufficient systems integration is challenging

It has been identified as difficult to achieve sufficient systems integration among multiple providers to sustain effective transition for incarcerated persons (Osher et al., 2002). A high level of intentionality and multi-agency organisation is required by, for example, the development of local prison transition coordinating groups.

For these reasons there has been considerable academic and practice focus on facilitating the process of reintegration to promote more successful rehabilitation and positive engagement with local communities and reduce recidivism rates.

6.3 Key Features of Intercept 4 Initiatives

Re-entry initiatives aim to facilitate the transition of people from incarceration to the community and reduce recidivism, often planning to accomplish these goals by using multifaceted approaches that increase access to basic community resources (e.g. housing, healthcare) and/or directly provide treatment or services for other identified areas of need (e.g. substance use; mental health).

6.3.1 The importance of general risk factors

Overwhelmingly, the literature reviewed supports the general principle of focusing programmes on general risk factors with modifications for mental health and substance use services, rather than primarily addressing mental health services (Heilbrun et al, 2015). Justice-involved persons have wide-ranging personal and social problems, including homelessness, unemployment and broken relationships with both partners and children (Butler et al., 2015), and they typically live chaotic lives. Therefore, for the great majority of justice-involved persons with mental illness and substance use problems, it is important for services at this intercept to address the same risk-relevant domains (family, education, employment, housing, leisure time) that apply when re-integrating justice-involved persons in general.

6.3.2 Re-entry practice principles

Widely established re-entry practice principles include:

i. Extending services received during incarceration post-release (Serin et al., 2010) via:

- ▶ **'Reach-out':** referral to community-based services based on detailed planning for release and intensive case management to meet the incarcerated person's assessed needs (health, housing, financial and relational).
- ▶ **'Reach-in' (pre-release):** community providers conduct assessments and arrange service plans to support service planning and engagement on release.
- ▶ **'Warm handover':** Effective communication, liaison and information sharing between services to assist service transition and engagement.
- ▶ **Basic needs:** Ensuring immediate basic needs are provided for, including clothing, housing, financial and transport needs.
- ▶ **Case manager:** A case manager is appointed to coordinate prison and community services.

- ii. **Medication:** Prisoners with specific health problems have a minimum of 30 days medication at release (Policy Research Associates, 2017).
- iii. **Service matching:** Matching services to individuals' risk level and needs (Smith et al., 2009).
- iv. **Assertive community outreach:** Addressing multiple needs via assertive community outreach (Heilbrun, 2012).
- v. **Individualised services:** Delivering services in individual rather than group formats (James et al., 2013).
- vi. **Access to treatment:** Providing access to evidence-based treatments (Smith et al., 2009; Visher et al., 2017)
- vii. **Resourcing important relationships:** Sustaining supportive personal relationships throughout custody with additional support in the lead up to release (Farmer, 2017).

6.3.3 The importance of Substance Use programmes at re-entry

The availability of community-based substance use programmes has been flagged as an important feature of successful transition from prison, with many justice-involved individuals re-entering the community trying to maintain abstinence from alcohol and/or drugs. It is estimated in the USA that between 60-70% of incarcerated individuals have substance use disorders (Bronson et al., 2017), and over 60% of inmates identify substance use treatment as a primary need upon re-entry (Begun et al., 2016). Analysis of first night committals in NI (2014-18) identified that 58% of prisoners identified themselves as drug users (NIAO, 2019 p.20).

In the first few months' post-release, justice-involved individuals with substance use problems have been identified as having heightened risk of relapse (Kopak et al., 2016), fatal and non-fatal overdose (Merrall et al., 2010), and recidivism (i.e., technical violations, re-arrest, re-incarceration) (Scott et al., 2014). Consequently, re-entry is a critical time to provide effective substance use treatment.

6.4 Intercept 4 Initiatives

Two re-entry practice initiatives are briefly described below. The first is the APIC model widely applied in the USA and the second is the Critical Time Intervention (CTI) model being trialled in parts of the UK.

6.4.1 The APIC Model (USA)

APIC MODEL - USA

The APIC model for transitional planning (Osher et al., 2002), developed in the USA to launch SAMHSA's GAINS Center's Re-entry Initiative, is a framework of best practice guidelines for the release of people with mental health and addiction needs. It stresses the importance of systems integration among providers (Osher et al., 2002) and has been widely accepted as a foundational framework for re-entry services (Munetz & Griffin, 2006; Willison et al., 2018). At the individual level it comprises the following components based on the APIC acronym:

- ▶ **Assess** clinical and social needs and public safety risks
- ▶ **Plan** for treatment and services that address needs
- ▶ **Identify** required community and correctional programmes responsible for post-release services
- ▶ **Coordinate** transition plans to ensure implementation and avoid gaps in care with community-based services.

At the system level, the APIC model highlights the importance of collaboration among multi-sectoral community partners to ensure that the community is committed to the transition process, which may take the form of a *local prison transition coordinating group* to apply the APIC model at the individual level.

Source – Osher et al., 2002

6.4.2 Critical Time Intervention (UK)

CRITICAL TIME INTERVENTION (CTI) Model - UK

Critical Time Intervention (CTI) is a structured time-limited model, with the overarching aim of *long-term engagement with community services*. It underscores the importance of problem-solving training, motivational coaching, and advocacy during a relatively short period immediately following release.

Shaw et al. (2017) evaluated a trial of CTI in eight prisons involving a total of 150 male prisoners. The intervention *started up to 6 months before each prisoner's release date and continued for 6 weeks after*. The intervention included:

- ▶ **Needs assessment:** A detailed needs assessment by the case manager to identify the services required both while in prison and on discharge to the community
- ▶ **Basic health access:** Registration of the participant with a local GP
- ▶ **Accommodation:** Housing needs assessment
- ▶ **Income:** Identification of a key source of income
- ▶ **Engagement with informal supports:** Family and peer group networks contacted as appropriate
- ▶ **Warm handover:** Appointments arranged for the participant with community service providers and that they are accompanied by the case manager to aid service engagement
- ▶ **Matching service to need:** Service provision is reviewed and adjusted in real time to ensure the 'best fit' of provider to participant need
- ▶ **Goal negotiation:** The case manager, participant and service providers agreed longer-term goals and strategies and the person's care was signed over fully to community services.
- ▶ **Gradual withdrawal** of the case manager

Outcomes: research results showed promise with *53% of the intervention group in contact with their team* at 6 weeks, compared with 27% of the control group. At 6 months' follow-up, intervention participants showed a *continued increase in engagement with teams* compared with the control group, but there were no significant differences at 12 months' follow-up.

The significant positive impact up to 1 year is important when considering the high risks of suicide and drug overdose concentrated in the early days and weeks post-release.

Source – Shaw et al., 2017

6.5 Re-entry for Young Offenders: Key Principles and Initiatives

Justice-involved adolescents face many of the same challenges as their adult counterparts, but their relative lack of development and life experience, often compounded by emotional and low-level mental health issues stemming from early trauma and adversity (Cordis Bright, 2017), may result in them finding these more difficult to negotiate successfully. These challenges commonly include returning to an unstable home environment in a community that lacks effective schools and/or employment opportunities (Nellis et al., 2009).

6.5.1 Key principles for young person re-entry

Mindful of this, the Juvenile Justice Youth Re-entry Task Force in the USA promulgated a comprehensive set of standards for adolescent re-entry planning (Nellis & Hooks Wayman, 2009) with the following principles:

- ▶ Re-entry planning and related service delivery should occur for at least one year post-release
- ▶ Individualized services should be provided that address any developmental deficits
- ▶ Housing support should be provided, when needed
- ▶ Family connections should be emphasised
- ▶ Access to mental health and substance use treatment, when needed
- ▶ Structured support for education and/or employment should be provided
- ▶ Young people should be exposed to better ways to spend their leisure time

6.5.2 Young People's Re-entry Initiative (USA): Wayne County Second Chance Reentry Program

THE WAYNE COUNTY SECOND CHANCE RE-ENTRY PROGRAMME - USA

The Wayne County Second Chance Re-entry (WC-SCR) Program was implemented in a locked residential treatment facility for young justice-involved persons located in a large, poor urban city in the mid-western United States. It included the following features:

- ▶ A sample of 273 young males ranging in age from 13 to 18 years
- ▶ Offences included crimes against persons, sexual offences and property crimes
- ▶ *A residential re-entry specialist was assigned to each participant, who facilitated monthly re-entry planning meetings with the participant, their parents/caregivers, residential treatment team, and assigned community-based case manager*
- ▶ Once the young person was released, the community-based re-entry case manager met with the young person weekly for the first 2 months, then every other week for the remaining 4 months
- ▶ The dosage of re-entry services ranged from 100 to 300 hours of post-release re-entry case management services for 6 months

The evaluation of the WC-SCR programme employed a quasi-experimental design consisting of two non-randomized groups. Recidivism data were collected for up to 2 years' post-release. Type I recidivism (a new charge or violation that did not result in confinement) rates were 9.5% for the control group and 4.3% for the WC-SCR group, whereas Type II recidivism (a new charge or violation that resulted in confinement) rates were 18.9% for the control group and 8.5% for the WC-SCR group. *The WC-SCR re-entry programme participants had a greater than 50% reduction in recidivism.*

Source - Calleja et al. 2016, 2019

6.5.3 Young People's Re-entry Initiative (UK): Resettlement Consortia

RESETTLEMENT CONSORTIA - UK

In 2014 the Youth Justice Board (YJB) established four resettlement consortia (East Midlands; South and West Yorkshire; North East London; and South London) consisting of organisations working together to improve the life chances and resettlement outcomes of young people, aged 10-17 years leaving custody. The intervention known as an '*enhanced offer*' included a series of services and provision available to the cohort, which went beyond what was already delivered by the agencies working within the youth justice system. Examples of services included:

- ▶ Mentoring services
- ▶ Improving family relations
- ▶ Trauma interventions
- ▶ Life coaching
- ▶ Aggression Replacement Training (ART)
- ▶ Restorative justice projects.

A process evaluation of these consortia was undertaken by conducting interviews and focus groups with the project manager, strategic lead, Youth Offending Team (YOT) managers, strategic steering group members, and operational group members. They found that *key enablers* for the consortia were:

- ▶ Having a dedicated project manager
- ▶ Conducting resettlement planning early on in an offender's custodial sentence
- ▶ Training of community and custody delivery staff
- ▶ A holistic partnership approach among the key partner agencies.

Unfortunately, due to difficulties with data collection processes, the evaluation did not seek to draw conclusions about the impact or relative effectiveness of the resettlement consortia.

Source - Hitchens et al., 2018

6.6 Evidence of Effectiveness at Intercept 4

While evidence-based practices constitute widely accepted effective strategies to support successful transition from prison and reduce future offending, the results of current research supporting the effectiveness of re-entry planning have been somewhat equivocal. This is thought partly due to the challenges of collecting consistent data within busy prison environments and across the prison–community interface, resulting in difficulties with the quality of many studies (Visher et al., 2017).

6.6.1 Evidence review of re-entry initiatives

One meta-analysis found that re-entry planning had a small, yet significant, impact on recidivism (James et al., 2013), particularly if it is well-implemented and consists of individual instead of group treatment, and if it is aimed at older and high-risk youth. The results of another larger meta-analysis (Weaver & Campbell, 2015) did not find re-entry planning overall to have a significant impact on recidivism, although significant effects for samples of adolescents who averaged over 16.5 years of age and whose predominant index offense was violent were found.

Another recent systematic review of initiatives at the transition from prison to the community for incarcerated persons with mental illness (Hopkin et al., 2018) noted that of the 13 research studies included, the majority (10) were conducted in the USA with only two studies having taken place in the UK (Jarrett et al., 2012; Shaw et al., 2017). Overall, they found that:

'the interventions identified were targeted at different stages of release from prison and their content differed, ranging from Medicaid enrolment schemes to assertive community treatment. It was found that contact with mental health and other services can be improved by interventions in this period but the impact on reoffending and reincarceration is complex and interventions may lead to increased return to prison' (Hopkin et al., 2018, p. 2).

What is clear from these meta-analyses is that while the body of research on the effectiveness of re-entry planning is growing, more research is required to clearly identify what constitutes effective re-entry planning.

6.6.2 Evidence Review of Substance Use Programmes

A recent systematic review of initiatives addressing substance use in some capacity, which began during incarceration and continued post-release or began within 3 months of release, identified 38 articles (7 programme evaluation reports and 31 peer-reviewed publications) representing 34 unique initiatives in total (Moore et al., 2018). Of the 34 initiatives identified, 21 provided substance use treatment whereas 13 facilitated connections to treatment. Of the 21 interventions providing treatment, the primary modalities were cognitive behavioural therapy ($n = 6$), motivational interviewing ($n = 2$), medication assisted treatment ($n = 2$), therapeutic community ($n = 2$), psychoeducation/12-step ($n = 5$), and 4 did not specify the modality. Of the 31 studies that assessed recidivism outcomes, 18 found reduced recidivism for the treatment group on at least one indicator (e.g. re-arrest, re-incarceration). Of the 13 studies that assessed substance use outcomes, 7 found reduced substance use for the treatment group on at least one indicator. Results were not consistent for any particular treatment approach or modality, highlighting the need for integration of a range of evidence-based treatments for substance use into re-entry initiatives and further research on the impact of such interventions.

6.6.3 Data Collection at Intercept 4

The key variables and outcomes commonly measured in studies at this re-entry intercept include:

- ▶ Number and % of persons receiving assessment(s) to shape their re-entry plan
- ▶ Number and % of persons with mental or substance use disorders released annually
- ▶ Number and % of persons released with psychotropic medications
- ▶ Average number of days between release and contact with community-based treatment or support provider
- ▶ Number and % registered with a General Practitioner (GP)
- ▶ Number of Emergency Department visits post-release
- ▶ Number of days hospitalised post-release
- ▶ Number of persons discharged to homelessness, a shelter, or unknown address
- ▶ Rate of linkage to re-entry services

- ▶ Days in the community prior to new contact with the criminal justice system
- ▶ Level of re-involvement in the criminal justice system (arrests, charges, convictions)
- ▶ Employment status
- ▶ Quality of life measures
- ▶ Quality of social network (friends and family)

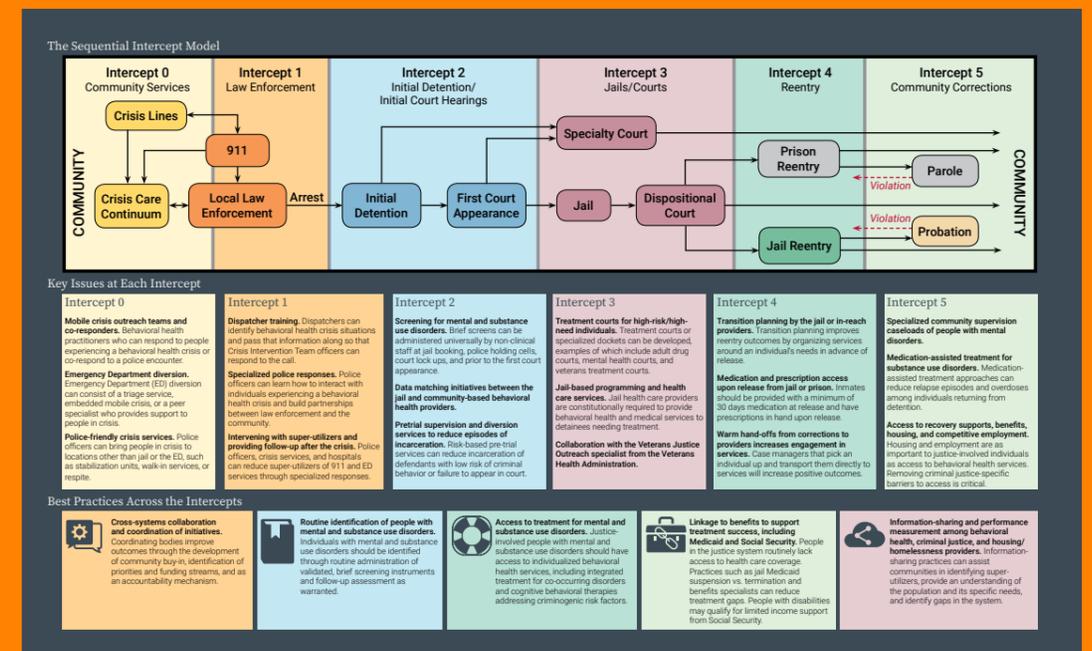
6.7 Intercept 4: Key Messages for Re-entry

Re-entry from prison is clearly a high risk time for justice-involved persons. The data on health and mental health outcomes reviewed above and the recidivism rate emphasise the importance of the following principles of good practice to promote re-integration to local communities and reduce the rate of reoffending:

- Planning is essential:** Assessment of needs should take place at a very early stage in a prisoners' incarceration. Planning for continuity of care between prison and community services is essential for good levels of post-release engagement. This is recognised as problematic for people on remand who may get released unexpectedly.
- Attend to basic needs:** Programmes should focus on general risk factors (health, housing, financial and relational) with modifications for mental health and substance use dimensions.
- Treatment access:** Medication-assisted treatment approaches and substance use services can reduce relapse episodes and overdoses among individuals returning from detention.
- Support informal relationships:** Promoting positive social relationships (with family, friends, community, and social outlets) is key to successful re-entry, reducing recidivism and promoting health and wellbeing. This requires attention throughout the custodial process, not only at release.
- Case manager:** A specific manager is required to promote information sharing and coordination of required services across the prison-community interface to help create a holistic support network. This includes liaison between the justice-involved person, his/her family network and the required social welfare and health agencies.
- Warm handover:** The quality of care is central to providing effective services. A 'warm handover' and sustained interest by a professional with influence across the prison/community interface is central to effective transition.

CHAPTER 7

INTERCEPT FIVE: COMMUNITY CORRECTIONS/SUPPORTS



7.1 Overview of Intercept 5

INTERCEPT 5: COMMUNITY CORRECTIONS/COMMUNITY SUPPORTS

This is the fifth and final intercept in the SIM and focuses on justice-involved persons supervised in the community and involved with community corrections, i.e. probation and parole. Probation is a standard form of criminal justice processing, whereas parole occurs only after completion of a custodial sentence. However, as Heilbrun (2015, p. 16) notes, 'they are similar in their use of community-based monitoring of assigned conditions by a supervising officer, who strives to both rehabilitate the individual and protect society'. Hence, they are grouped together within this intercept. Probation and parole interventions are both designed to prevent deeper involvement into the criminal justice system by reducing the risk of reoffending.

Common strategies include:

- ▶ **Routine screening for complex needs** of justice-involved persons on probation or parole to ensure supervision strategies take adequate account of mental health or other issues
- ▶ **Specialised community supervision caseloads for people with complex needs:** speciality teams receive specialist training and supervision, as well as protected caseloads.
- ▶ **Access to range of supports for basic needs** including housing, benefits and employment: these issues are as important as mental health and substance use services and constitute key factors in re-offending. Barriers to access to housing and employment for justice-involved persons are essential to address.
- ▶ **Service availability for mental health and co-occurring substance use problems:** assertive community outreach may be needed to support service engagement where personal motivation may be low.
- ▶ **Service cooperation and appropriate information-sharing** between probation and community health and social care service providers.
- ▶ **Greater use of problem-solving strategies** by officers to avoid technical violations: reinforce positive behaviour and have range of responses to address supervision violations or non-compliance with conditions of release such as treatment non-attendance.
- ▶ **Engagement with families and supportive others in the community** as key protective factors which mitigate against offending.

Key stakeholders: probation, community-based mental health and social care providers

7.2 Key Issues and Challenges at Intercept 5

While much attention is focused on the earlier intercepts, the *bulk of criminal justice supervision in fact occurs in the area of community supervision* under the responsibility of probation (Wolf et al., 2014). The following issues present challenges for effective diversionary practices for people with complex needs on parole or probation.

7.2.1 The prevalence of mental health and co-occurring problems in justice-involved persons in the community

It is widely recognised that mental health disorders are over-represented among justice-involved persons at nearly three times the rate found in the general population (National Institute of Mental Health, 2010). This population are also likely to have co-occurring substance use problems, further complicating their supervision (Sirdifield, 2012). This is paralleled in the NI context. NIAO analysis of PBNi records (NIAO, 2019 p.23) found that of 8,600 people undergoing assessment over a 4 year period (2014-2018), 42% were assessed to have some level of 'mental health' problems and these problems were considered to contribute to the person's offending for 32% of those assessed. This increased to 72% determined to have a 'general emotional wellbeing' problems which were judged to contribute to the person's offending in 63% of cases. These statistics give some indication of the scale of the complex needs that are likely to be present in this population, and the additional supports which may be necessary.

7.2.2 Re-offending is common

Although re-offending rates within one year are highest for those who receive a custodial sentence in NI (39.1% adults; 40 of 41 youths), they are also significant for those with received community disposals with supervision (31.5% adults, 60.1% youths) (Department of Justice statistics – 2015/16 cohort).

7.2.3 Technical violations due to non-compliance with treatment

As compliance with mental health treatment is a frequent condition of probation or parole, failure to attend appointments often results in revocation of probation and return to incarceration (Munetz and Griffin, 2006). Thus, while under probation supervision, justice-involved persons with serious mental illnesses, compared to those without, are more likely to fail, i.e. have their community supervision term revoked, because of a violation of the special conditions of probation (i.e. technical violation) (Eno Loudon & Skeem, 2011).

Additionally, people who perceive medication to be less helpful or have low treatment motivation were much more likely to be re-incarcerated for a new charge or technical violation (Heilbrun, 2012). Such failure on probation pulls people with serious mental illness and/or complex needs deeper into the criminal justice system, further disrupting their already fragile community ties.

7.2.4 Linking information across systems

A person placed under community corrections is likely to have already provided a wealth of information through numerous assessments (GAINS Centre, 2019). It is vital therefore that this information is shared (as appropriate) across relevant systems, to ensure the development and implementation of effective supervision plans which take adequate account of the person's mental health, social care, any risk presentations or other needs and circumstances.

7.2.5 Positive family and community relationships

The importance of positive family and community connections is well established for improved mental health and reduction in the rate of re-offending (Farmer, 2017). In recent decades there has been unprecedented levels of family breakdown and arguably a reduction in the perceived value of family relationships. Thus, it can be particularly challenging for systems to prioritise the maintenance and enhancement of family connections at all stages in the criminal justice system (Farmer, 2017, p. 19). The impact of this can appear most starkly at the level of community corrections.

7.3 Key Features of Intercept 5 Initiatives

As with Intercept 4, it is recommended that specialised forms of parole and probation focus primarily on *general risk factors* with modifications for mental health services rather than primarily on mental health services (Heilbrun et al., 2015). The *relationship between a case manager or specialty parole/probation officer and the individual under supervision* appears to be arguably the most important feature related to success in these interventions (Heilbrun et al., 2012).

The GAINS Centre identify the following components of community corrections interventions at Intercept 5:

- i. Screening:** all individuals under community supervision for mental illness and co-occurring substance use disorders should be screened and linked to support services
- ii. Maintain a Community of Care:**
 - ▶ establish policies and procedures that promote communication and information sharing
 - ▶ connect individuals to employment opportunities
 - ▶ facilitate engagement in supportive health services
 - ▶ link to housing
 - ▶ facilitate collaboration between community corrections and service providers
- iii. Implement a Supervision Strategy:** Concentrate the supervision on the period immediately after release; adjust strategies as needs change; implement specialised caseloads and cross-systems training
- iv. Graduated Responses & Modification of Conditions of Supervision:** Ensure a range of options for community corrections officers to reinforce positive behaviour and effectively address violations or non-compliance with conditions of release.

Similarly, Policy Research Associates (2010) summarise the ‘action steps’ for service-level change at this intercept as:

- ▶ Creating specialised community supervision caseloads of people with mental disorders
- ▶ Providing medication-assisted treatment for substance use disorders to reduce relapse episodes and overdoses
- ▶ Access to recovery supports, benefits, housing, and competitive employment.

Heilbrun et al. (2015) highlight five key features of specialised probation services in contrast with standard probation:

- i. Caseloads comprised only of probationers with mental health disorders
- ii. Officers with reduced caseload size
- iii. Provision of ongoing training of officers in mental health-relevant issues
- iv. Integration of internal and external resources, i.e. specialist Probation Officers actively maintain a close working relationship with treatment providers and advocates to help secure social resources (e.g., SSI, housing, transportation)
- v. Officers rely more heavily on problem-solving (as opposed to threats and sanctioning) as a supervision strategy.

7.4 Intercept 5 Initiatives

Two examples of community correction initiatives are described below, both of which demonstrate good outcomes, albeit with some limitations. One is the implementation of the Specialised Mental Health Caseload (SMHC) model in a US state and the other the implementation of a mental health awareness-raising training programme for Probation officers in the UK.

7.4.1 Specialised Mental Health Caseload (USA)

Specialised MENTAL HEALTH CASELOAD – USA

The Specialised Mental Health Caseload (SMHC) model was implemented state-wide in New Jersey, USA in 2010. The SMHCs met the characteristics of specialised mental health probation and included the following features:

- ▶ **Specialist caseload:** Mental health probation officers (MHPO) caseloads were limited to clients with mental illnesses deemed in ‘distress’
- ▶ **Caseload size:** MHPO caseloads were limited to a maximum of 30 clients per officer
- ▶ **Training:** MHPOs received 90 hours of initial training and 77 hours of follow-up training on: psychopathology, co-occurring disorders, case management, problem-solving skills, motivational interviewing and stress management
- ▶ **Written guidance:** MHPOs adhered to a handbook that specifies practices of case management, problem solving, and collaboration across systems
- ▶ **Specialist supervision:** MHPOs were supervised by supervisors with specialty training in mental illness, and a project coordinator (at the State Central Office) supervised the implementation

The Specialised Mental Health Caseload (SMHC) model was evaluated using a quasi-experimental design to compare criminal justice, mental health, and community engagement outcomes among three caseloads: (i) a newly established SMHC supervising *no more than 30 clients* per officer (N = 1367); (ii) an established SMHC supervising roughly *50 clients* per officer (N = 495); and (iii) a traditional caseload of clients receiving mental health treatment and supervised by officers with average caseloads of over *130 clients* (N = 5453).

Outcomes: Overall, it was found that the SMHC was implemented with high adherence to fidelity (with PO average caseloads of 50), and comparisons with a ‘traditional caseload’ and other research caseload samples generally support the effectiveness of the SMHC model, particularly on criminal justice outcomes.

While there was the expected *drop in days in prison* and *improved mental health* outcomes in the 6 months’ post-assignment to the SMHC, there was a *slight increase in probation violations* in the intervention group. It is hypothesised that this increase may be a direct result of clients having more frequent contact with MHPOs, which provided more opportunities for drug testing.

Source – Wolff et al. 2004

7.4.2 Mental Health Awareness Training for Probation Staff (UK)

MENTAL HEALTH AWARENESS TRAINING FOR PROBATION STAFF - UK

A Mental Health Awareness Training for Probation Staff was piloted across the East Midlands, UK for probation staff. Participants studied the following topics:

- ▶ Mental Health – Myths, Stigma and Stereotypes
- ▶ Factors Impacting Upon Mental Health
- ▶ The Mental Health Act 1983
- ▶ Bi-Polar Affective Disorder
- ▶ Self harm and Suicide
- ▶ Personality Disorder
- ▶ Post-Traumatic Stress Disorder
- ▶ Learning Disability
- ▶ Depression
- ▶ Eating Disorders
- ▶ Mental Health and Probation Practice

Outcomes: The evaluation showed that *knowledge about mental health disorders* improved significantly as did *knowledge about local mental health services* and the *self-reported confidence of probation staff* to recognise mental health disorders. The training was well evaluated by staff who saw it as highly relevant to their work in the management of offenders.

Practice change limitations: The only statistical measure of practice change included in the evaluation was the number of offenders referred by probation staff to specialist mental health services before and after training. This interestingly did not significantly change. This may indicate that changes in knowledge, alongside a positive attitude, do not actually change behaviour as a number of other conditions are also required before sustained changes in practice are likely to occur after training. These conditions are thought to include:

- ▶ Having protected time to work with clients
- ▶ Organisational ownership of the work
- ▶ A high level of motivation
- ▶ All team members trained
- ▶ Access to ongoing high quality supervision

Source - Brooker and Sirdifield, 2009

7.5 Evidence of Effectiveness at Intercept 5

Heilbrun et al. (2012) in their comprehensive review of community-based alternatives for justice-involved individuals with severe mental illness state that the evidence suggests two key features in successful interventions at this intercept:

- i. Specialty agencies* which focus on monitoring medication and treatment attendance, hold considerable promise for improving clinical and criminal outcomes for probationers and parolees with mental illness.
- ii. Psychiatric medication and broader treatment motivation* plays an important role in the risk of re-incarceration for a new charge or technical violation.

7.5.1 Speciality Agencies: Evidence of Effectiveness

There is a small but growing body of evidence for the effectiveness of speciality agencies. Skeem et al. (2006) found that specialty agencies were more likely to focus on monitoring medication and treatment attendance, more likely to use problem-solving strategies, and less likely to use threats of incarceration. Problem-solving strategies are based on the concept of therapeutic justice, whereby the offender is encouraged to engage in treatment interventions in order to reduce their risk of reoffending (O'Hare, 2018).

In addition, Eno Loudon et al. (2008) surveyed supervisors of 54 specialty and 20 traditional probation agencies. They found that relative to traditional officers, specialty officers are more involved in supervising probationers with mental illness, meeting with probationers with mental illness more frequently. They were also noted to function as part of the treatment team and more likely to use problem-solving strategies. While both traditional and specialty parole/probation officers used graduated sanctions, traditional officers were found to generally respond to non-compliance with more punitive strategies than specialty officers.

Skeem et al. (2009) note that specialty agencies may be particularly important with probationers with co-occurring mental illness and substance abuse, as these individuals are described as having poor relationships with professionals and are considered more likely to feel coerced into treatment and are less likely to attend. They emphasise two factors which appear important to effectiveness:

- ▶ **Caseload size:** It becomes increasingly difficult to emphasise rehabilitation and avoid using coercion (e.g. return to jail) as the size of the caseload increases. *Specialisation without limiting caseload size appears ineffective.*

- ▶ **Personal motivation:** The probationer or parolee's attitude toward treatment and willingness to participate in treatment, appears strongly related to whether the individual will remain in the community without incurring criminal justice sanctions. *This suggests that service engagement is an important factor for success.*

The message is clear, if services wish to be effective in promoting integration and reducing recidivism for justice-involved persons supervised in the community, then they need to resource specialised teams with low officer caseloads. In such circumstances, well-trained officers can give sufficient time to build effective relationships with their clients, support their basic needs (e.g. housing), facilitate their connections with a range of services including health/mental health, substance use, employment services and help promote positive social relationships in the community.

7.5.2 Data Collection at Intercept 5

Key variables and outcomes commonly noted and/or measured at this intercept include:

- ▶ Number and % of persons being served by community corrections with identified mental health or substance use disorders
- ▶ Number of community corrections officers (both with and without specialised caseloads)
- ▶ Number of hours of mental health and substance use training of community corrections officers (both with and without specialised caseloads)
- ▶ Average monthly caseload of community corrections officers (both with and without specialised caseloads)
- ▶ Time allocated to the probationer or parolee
- ▶ Probation or parole stipulations
- ▶ Strategies used to address non-compliance
- ▶ Quality of Probation Officer and Probationer/Parolee relationship
- ▶ Level of ongoing training of Probation Officers in mental health-relevant issues
- ▶ Reasons for supervision failure
- ▶ Incarceration or no incarceration in relation to any technical violations or new charges

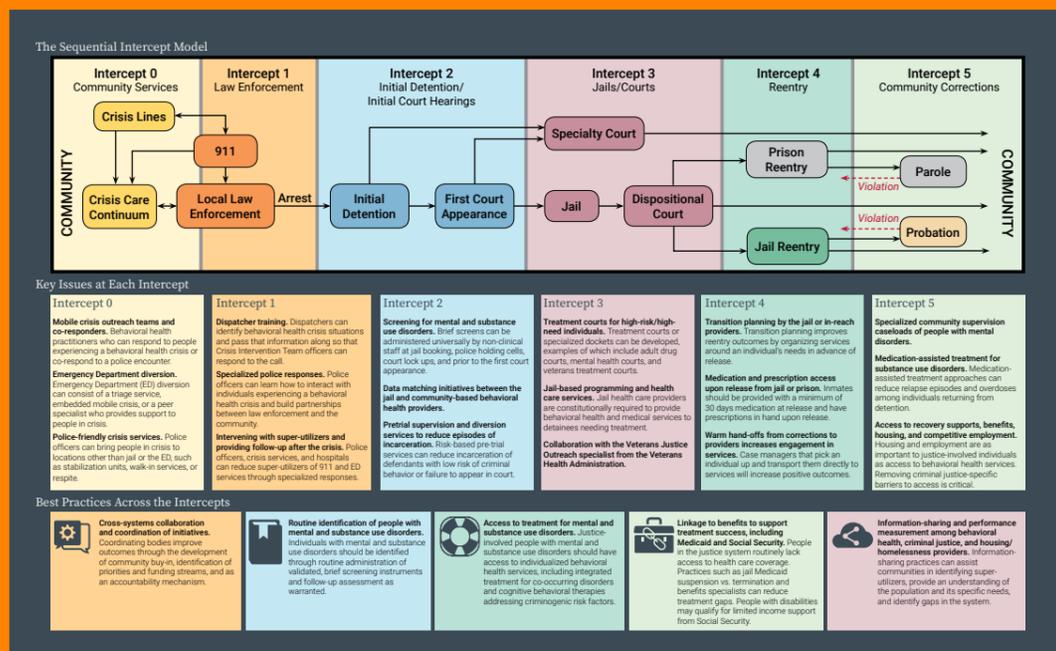
7.6 Intercept 5: Key Messages

Justice-involved persons with complex needs are at risk for increased probation or parole violations and can benefit from added supports at this intercept. Overall, the use of validated assessment tools, staff training on mental and substance use problems, and responsive services, such as specialised caseloads are effective in reducing violations, decreasing criminal re-offence, and improving mental health outcomes, through enhanced connections to services and coordination of mental health treatment and criminal justice supervision goals (GAINS, 2019). The key messages to inform community correction initiatives include:

- Specialist probation and parole teams are important to improve clinical outcomes for probationers and parolees with mental illness and reduce reoffending.
- Specialist probation and parole officers are more likely to utilise problem solving strategies (and less punitive strategies) and focus more on monitoring medication and supporting treatment/service attendance.
- A good relationship between the specialty parole or probation officer and the supervisee is vital to good outcomes.
- Specialisation without limiting caseload size appears ineffective.
- Positive support of family and friends promotes prosocial behaviours.
- Engagement with mental health and substance use treatment and support services can reduce relapse.
- Assertive outreach strategies are necessary for community health and social care providers to support service engagement for this population.
- Access to basic recovery and rehabilitation supports, such as welfare benefits, housing, and employment, are as important to justice-involved individuals as access to behavioural health services.
- The importance of ongoing high quality supervision for specialist teams and service providers.

CHAPTER 8

APPLYING THE SIM TO THE NORTHERN IRELAND CONTEXT: KEY MESSAGES ACROSS THE INTERCEPTS



8.1 Report Overview

This report has been commissioned by the Safeguarding Board NI as part of the cross-departmental Early Intervention Transformation Programme's initiative to support the development of Trauma Informed Practice across systems of health, social care, education, justice and the community and voluntary sectors in NI. The report uses the 'Sequential Intercept Model' (SIM) as a framework to provide a selective review of practice innovations at different stages of the criminal justice process as a means to identify good practice to better meet the needs of young people and adults with complex needs in NI who interface with the criminal justice system. The SIM emerged as a cross-systems framework in the USA to address the interface between the criminal justice and mental health systems given the high prevalence of justice-involved people with mental health or substance use problems (Munetz & Griffin, 2006). It is premised on the recognition that the criminal justice system is often ineffective at meeting the multi-faceted needs of people impacted by multiple adversities, and that justice involvement itself can exacerbate the existing difficulties of this already vulnerable population, inadvertently increasing the likelihood of reoffending (Munetz & Griffin, 2006). The SIM has been used in the USA as a strategic planning tool to assess available resources, determine service gaps, identify opportunities and develop priorities for action to improve system and service-led responses focussed toward adults with mental health and substance use disorders who are involved with the criminal justice system (Policy Research Associates, 2018). It should be noted that although much of the SIM literature reviewed specifically to people impacted by 'mental health and substance use disorders', this report opted to use the over-arching term of people with 'complex needs' as a means to better capture the range of adverse health and social experiences identified as common in justice-involved young people and adults. These include adverse childhood experiences, trauma, domestic violence, experience of care and homelessness (see Chapter 1, section 1.2).

Each chapter in this report explores one of the six SIM intercepts (community services; law enforcement; initiative detention/initial court hearings; jails/courts; re-entry; community corrections/community supports), highlighting key messages and challenges from the literature as well as providing international examples of practice initiatives that show promise. A brief review of the evidence of effectiveness of practice initiatives is provided, alongside indication of common data to be collected at each intercept. The report aims to assist stakeholder groups in NI consider current service provision and address identified gaps. This chapter concludes the report by examining key messages across the intercepts located in the SIM literature reviewed and adapted to the NI context. This includes the five best practice principles developed by SIM advocates (Figure 2) as well as two additional overarching themes identified in this selective review.

8.2 Best Practices across all Intercepts

8.2.1 Cross-systems collaboration and co-ordination of initiatives

Cross-systems collaboration is identified as a key best practice principle across all six intercepts. It is noted as essential for effective outcomes that co-ordinating bodies develop ‘community buy-in’ through shared identification of priorities, funding streams and accountability mechanisms (PRA, 2018). It is in this regard that the SIM ‘mapping process’ has been developed as an important strategic planning tool to bring stakeholders and communities of interest together across different services and sectors at each of the six intercepts to engage in facilitated mapping exercises to assess available resources, determine service gaps and develop shared priorities for action (Willison et al., 2018). Emerging evidence confirms that this mapping process has been well-received by participants and led to enhanced cross-sector collaboration and co-ordination (Bonfine & Nadler, 2019). Collaborative and co-ordinated efforts are identified as essential to avoid justice-involved persons with complex needs falling through the inevitable gaps that emerge when multiple service providers do not take shared responsibility for the person’s welfare and commit to working together to this end.

8.2.2 Information-sharing and performance measurement among behavioural health, criminal justice, and housing/homelessness service providers

In order to achieve consistent and effective cross-system collaboration and co-ordination to better meet the multi-faceted basic health and social care needs of justice-involved persons (such as safe accommodation and access to primary healthcare) as well as more tailored treatment and support for specific mental health conditions or substance use issues, appropriate information-sharing *within* and *between* agencies and services is deemed essential for success (PRA, 2018). This requires the development of information-sharing protocols and memoranda of understanding between interfacing service providers and training for personnel to understand their responsibilities in this regard in order to achieve the recommended ‘warm handovers’ as a person transitions between providers. It also demands a commitment to performance management as a means of identifying, gathering, analysing and applying relevant data to inform service developments (GAINS, 2019). It is noted that efforts to share data can fail when stakeholders lack clarity on the most essential information to collect, integrate and examine (GAINS, 2019). It is recommended that aggregate data should be gathered and shared between relevant agencies to understand the volume of people requiring access to specific services to help identify gaps or insufficiencies in service provision. Each chapter in this report has therefore highlighted some of

the common variables and measures that could be collected at each intercept. Additionally, it is noted that identifiers may also be used to track individuals as they move through the intercepts. Such processes will assist identification of ‘super-utilisers’, providing a better understanding of their specific needs, identifying service gaps and promoting tailored, joined-up service provision (PRA, 2018).

8.2.3 Routine identification of people with complex needs

Across each intercept, there is a need for routine identification of people with complex needs, including mental health and substance use issues as well as other issues identified as common in justice-involved persons (such as adverse childhood experiences, trauma, domestic violence, experience of care, homelessness etc.). It is recommended that individuals with mental health and substance use conditions would be identified through the routine administration of validated screening instruments (PRA, 2018). Routine identification is noted to require different forms of assessment at different stages in the criminal justice process and may be conducted by different professions or services. Such early identification is understood as essential to enable follow-up assessment and the provision of services and targeted treatment to meet identified needs. It is noted that early identification of complex needs will also be assisted by appropriate information-sharing between services and agencies.

8.2.4 Access to treatment

It is recommended that justice-involved people with mental health and substance use conditions, wherever they are on the justice system continuum, have access to tailored evidence-based mental health and substance use treatments and interventions (PRA, 2018).

8.2.5 Linkage to basic support services

While US SIM advocates recommend that people with particular health conditions within the justice system are provided with access to healthcare insurance options to reduce the likelihood of any treatment gaps for people without insurance (PRA, 2018), fortunately this is not needed in the UK given the rights of citizens to universal healthcare services via the National Health Service. This over-arching best practice principle however reminds service providers of the need to ensure justice-involved persons across all intercepts have appropriate access to basic health, social care and financial supports including social security, safe housing and social supports in the community. Without such basic supports, it is unlikely that targeted mental health or substance use treatments alone will be effective in helping individuals avoid interaction with the justice system. Much of the literature makes reference to housing as a key priority for successful diversion.

8.2.6 Strengthening relationships with family and supportive others: The ‘golden thread’

The Ministry of Justice commissioned review on the importance of strengthening male prisoners’ family ties to prevent reoffending and reduce intergenerational crime conducted by Lord Farmer (2017) concluded that ‘... harnessing the resource of good family relationships must be a golden thread running through the processes of all prisons’. This report drew attention to a landmark study which found that 63% of male prisoners’ sons went on to offend themselves (Farrington et al., 1996). This review has since been followed by a recently published report into the importance of strengthening female offenders’ family and other supportive relationships to prevent reoffending and reduce intergenerational crime (Farmer, 2019). Like its predecessor, this report draws attention to research which found that adult children of imprisoned mothers were more likely to be convicted than adult children of imprisoned fathers (Dallaire, 2007). It also recognises that ‘a large proportion of female offenders have endured domestic and other abuse, often linked to their offending’ (Farmer, 2019 p.7). This report reiterates conclusions from the previous report, and outlines the importance of family and other supportive ties as the ‘golden thread’ through all processes in the criminal justice system – from early intervention to community solutions and better custody for those women who must serve a custodial sentence – and calls for action across several government departments. Lord Farmer concludes that systems of care (whether justice, health or social care) ‘cannot waste any opportunity to capture information about a woman’s family and relational background, including her children and other relationships which may be supportive’ (2019 p.9).

This emphasis on building working relationships with family and supportive others is noted as a central message in some of the SIM literature relating to specific intercepts (e.g. Intercepts 4 and 5), but it is not mentioned specifically as an overarching best practice principle in the SIM literature reviewed. This may be as a result of the SIM model’s initial focus in the US on mental health and substance use ‘disorders’, leading to recommendations for evidence supported treatment, rather than the wider concept of ‘complex needs’ adopted by this report and much of the criminal justice/health interface policy and practice developments in the UK and Europe. These UK developments draw on the evidence related to the impact of adverse childhood experiences (ACEs) on future health and wellbeing and are informed by the drive to integrate key aspects of trauma informed care into the education, health, social care and justice systems in England, Scotland, Wales and NI.

This report about applying the SIM to the NI context concludes that enquiring about relationships and intervening to strengthen supportive relationships should feature as an essential component of practice initiatives across all six intercepts. This is in keeping with the current NIPS consultation on the strategy ‘Strengthening Family Relations 2019-2024’.

8.2.7 Peers with lived experience

The inclusion of peers with lived experience emerged as a consistent theme in the design and delivery of effective practice innovations. Indeed, this aspect of service design and delivery was specifically noted by Lord Bradley in his follow-up report of 2014 into the reforms needed to support people with mental health problems and learning disabilities in the justice system, where he recommended:

‘the adoption of a more psychosocial model of care to recognise the multiple and complex nature of need and a move towards recovery orientated approaches with a greater role for current and former service users (‘experts by experience’) in designing and delivering care’ (Durcan et al., 2014).

This may be of relevance to the NI context, where the inclusion of peers with lived experience in service delivery across all sectors is still in development.

8.3 The Sequential Intercept Model and Northern Ireland

This report has highlighted a range of key messages for service providers and policy makers for consideration in their efforts to improve the outcomes for justice-involved young people and adults with complex needs who are impacted by early life trauma, mental ill health and/or substance use problems. These messages are consistent with many policy developments and initiatives already underway in NI such as; the piloting of mental health triage and mental health courts (NIAO, 2019 p.40-41), and the recently published 'Improving Health within Criminal Justice Strategy and Action Plan' (June 2019). This action plan aims to ensure that children, young people and adults in contact with the CJS are 'healthier, safer and less likely to be involved in offending behaviour'. It recognises that many young people and adults who come into contact with the CJS have a history of under-utilising health and social care services and consequently have unmet needs. Contact with the CJS is therefore recognised as 'an important opportunity to engage or re-engage such children, young people and adults with the services they need' with the intention that providing 'the right care and treatment may have a positive impact in terms of reducing re-offending' (DoH & DoJ, 2019, p.ii). The action plan crucially recommends that:

- ▶ health and social care services for children, young people and adults in contact with the CJS are aligned to need
- ▶ the continuity of health and social care for this populations will be improved by developing care pathways and information-sharing where it is in the best interests of the individual
- ▶ health, criminal justice workforces and third sector partners should be equipped to work confidently across organisational boundaries, to share information and to take co-ordinated action
- ▶ the importance that the needs of vulnerable children, young people and adults in contact with the CJS are known and understood and that opportunities are taken to divert them, where appropriate, into mainstream health and social care or other services
- ▶ social care is included within each priority area
- ▶ a range of accommodation options is in place to meet the health and social care needs of this population.

These goals are coherent with those of the SIM approach outlined in this report. In conclusion, it is noted that despite the challenging financial climate, where front-line services are under pressure, 'there is much that can be done without significant additional resources in terms of improved information-sharing and working together effectively and efficiently as one seamless service' (DoH & DoJ, 2019 p.iv).

While the prevalence of complex needs in the justice-involved population are indeed significant, with issues not always easily separated or addressed, this report highlights that with concerted cross-system collaborative efforts, there are opportunities to make a positive contribution to improving the life chances of children, young people and adults with complex needs by ensuring early access to the most appropriate health and social care supports and treatments to meet identified needs and divert from sustained involvement in the justice system.

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