Editorial

Title:

Over 30 years of liaison and diversion in England and Wales: how far have we come, and what is now needed?

Authors:

Howard Ryland, Tim Exworthy and Andrew Forrester

Affiliations:

1. Dr Howard Ryland, Senior Clinical Researcher, Department of Psychiatry, University of Oxford, Warneford Lane, Oxford OX3 7JX – ORCID ID: https://orcid.org/0000-0002-5287-555X
2. Dr Tim Exworthy, Visiting Senior Lecturer, Department of Forensic and Neurodevelopmental Sciences, Institute of Psychiatry, Psychology and Neuroscience King's College London, Denmark Hill, London SE5 8AF, and Consultant Forensic Psychiatrist, Cygnet Hospital Stevenage, Stevenage, Hertfordshire, SG1 4YS – ORCID ID: https://orcid.org/0000-0003-1971-0283
3. Professor Andrew Forrester, Professor of Forensic Psychiatry, Department of Psychological Medicine and Clinical Neurosciences, School of Medicine, Cardiff University, Haydn Ellis Building, Maindy Road, Cardiff CF244HQ – ORCID ID: https://orcid.org/0000-0003-2510-1249

Word count: 1295

Liaison and diversion (L&D) services are now well over 30-years old in England and Wales, having under-gone step-wise progression in the years since they first opened as single-site schemes. They are now are said to have 100% coverage across the jurisdiction. (1). These services are meant to manage people who present with a wide range of mental health conditions and related vulnerabilities – including mental illness, substance misuse, and neurodevelopmental conditions – as they come into contact with the criminal justice system (CJS). (2) A recent evaluation estimates that they presently cost around £659 per referral made, but likely contribute to overall savings of up to £41.5 million per annum within the criminal justice system. (3)

The idea that mental health services should operate within criminal justice / correctional systems to divert people away to alternative forms of care and treatment is over a century old. The first formal psychiatric scheme, the Psychopathic Laboratory at the Municipal Court of Chicago, USA, having commenced in 1914. (4) In the decades that followed this, similar services were developed in other jurisdictions in the USA, offering court-related functions including assessments of fitness to stand trial and opinions on legal insanity defences. Many decades later, from the 1980s and 1990s, the model was adapted and applied in other English-speaking countries, including England and Wales, Australia and New Zealand. Although these services have been under-pinned by broadly similar aims, their application in different jurisdictions has required local adaptations, to take into account specific legal frameworks, and jurisdictional variations in the roles of psychiatrists operating within them. (5) In England and Wales, mental health legislation provides a range of options for the assessment, treatment and diversion of people who present with mental health conditions in the criminal justice system (CJS). (6)

L&D services in England and Wales were initially dependent upon the availability and interests of local psychiatrists, and were only available in a handful of locations. (1, 5). However, by 1990, government had become interested in their potential to produce wider benefits for vulnerable defendants, and the landmark document Home Office Circular 66/90 set a new direction for people with mental health conditions in the CJS, as follows (7):

It is government policy that, wherever possible, mentally disordered persons should receive care and treatment from the health and social services.

and

It is desirable that alternatives to prosecution, such as cautioning by the police, and / or admission to hospital, if the person's condition requires hospital treatment, or support in the community, should be considered first before deciding that prosecution is necessary.

In specifically emphasising the need for effective cooperation between agencies, the aims of this circular would be echoed nearly 20 years later in the 2007 Corston and 2009 Bradley reports. (8, 9). In the intervening period, these services had continued to develop in a piecemeal fashion, seemingly without strategic

overview. However, between them the government-sponsored Corston and Bradley reports galvanised cross-party political backing. This in turn secured treasury support, leading to their widespread development and implementation. As these services began having their moment in the sun, there was also a distinct shift away from just hospital diversion towards a wider range of more flexible health and justice options, including accommodation, treatment by community teams, and management under community orders. Additionally, their scope was widened to include an earlier stage of the criminal justice pathway, in police custody (10, 11)

More mature services are now in place, overseen by agreed service specifications outlining their core aims. (2) These include facilitating access to mental health care in the CJS, diverting people away to health, social care, education or training pathways where appropriate, and maximising their ability to participate in the criminal justice process. There is also an ambition to produce wider societal benefits by reducing reoffending. On the ground, these services provide mental health assessments and interventions where often there was little or nothing before, successfully engaging with a marginalised population with a broad range of vulnerabilities. (12) Interventions are often delivered at a critical point of acute crisis for people who need support. For some this may represent their first contact with mental health clinicians, facilitating access to services that may otherwise have been delayed or missed altogether. (13) There is evidence that these schemes are well-liked, and that they can be effective in identifying people with mental health conditions in the CJS, then linking them with health and social care services. However, the overall quality of the research evidence in this field has been low, limiting wider conclusions. (6, 14). Nonetheless, early evidence of effectiveness, including a potential impact upon reoffending behaviour, is promising. (15)

Yet despite this, when measured against their original aims, L&D services fall short. Bradley's vision of an all-illness model has not been realised, with many teams remaining focused on severe mental illness. (3, 12) On the ground, a tick-box approach to assessment has emerged in many service, partly in response to the national service specification, producing limited services focused on simple triage and referral that lack the necessary oversight across the whole criminal justice pathway. These narrowly defined services have been almost entirely nurse-led and managed, and the relative absence of psychiatric involvement has likely resulted in a missed opportunity to optimise early identification of mental health conditions, or report on court-related issues such as effective participation, fitness to plead, and hospital diversion. (2, 6, 16) A recent national review considered the support provided to the criminal justice system by wider mental health services. It found broken systems for inter-agency information sharing, with many people with mental health conditions overlooked at every stage of the criminal justice system. Limited access to community services for all, and delayed transfer to hospital beds for the most acutely unwell, are now the norm. (17) The resulting call for a national inquiry in this area is timely, given the problems that have arisen within both mental health and CJS services as a result of first austerity, then Covid-19. (18, 19, 20)

Earlier opportunities to provide high quality research evidence in this field prior to the wide expansion of services were missed. However, not all is lost, and it is now time for us to frame some fundamental questions to guide the next steps.

- How can we move away from a focus on severe mental illness towards the all-illness model originally envisaged?

- What health and justice outcomes arise following L&D interventions, and how might they be further improved?

- Are adaptations required for particular groups, such as women, or people with learning disabilities, given emerging evidence of the effectiveness of specific interventions in these areas (10, 21)

- How can we move the focus of these services away from site specific triage and referral interventions, to the provision of wider oversight across healthcare pathways in the criminal justice system?

- As the excitement of the initial national rollout fades, how do we best ensure that L&D services are fully supported over time, so that they do not drift away and become mere satellites of the wider health service?

In our view, the improvements that have so far taken place in L&D services in England and Wales have largely been quantitative in nature, with an increase in geographical spread and the introduction of a national specification. However, the next phase in the evolution of these services must include qualitative improvements, such as moving towards an all-illness model, and away from single-event triage and referral models towards whole-pathways oversight. To get this right, this next phase must be informed by high quality research, to help answer these fundamental questions and define what works, in which circumstances. This knowledge will allow us to sculpt services that are better equipped to meet the many challenges that will undoubtedly arise in the CJS in the years to come.

References:

1. James DV, Hamilton LW. The Clerkenwell scheme: assessing efficacy and cost of a psychiatric liaison service to a magistrates' court. *British Medical Journal.* 1991 Aug 3;303(6797):282-5.

2. NHS England and NHS Improvement. *Liaison and Diversion Standard Service Specification.* 2019. Available from: https://www.england.nhs.uk/wp-content/uploads/2019/12/national-liaison-and-diversion-service-specification-2019.pdf [Accessed 13 March 2022]

3. Disley E, Gkousis E, Hulme S, Morley KI, Pollard J, Saunders C, Sussex J, Sutherland A. *Outcome evaluation of the national model for liaison and diversion.* RAND; 2021.

4. Kegel AH. The Municipal psychopathic laboratory. *Chicago's Health.* 1930; 24: 114 – 120.

5. James DV. Court diversion in perspective. *Australian & New Zealand Journal of Psychiatry*. 2006 Jun;40(6-7):529-38.

6. Srivastava S, Forrester A, Davies S, Nadkarni R. Developing criminal justice liaison and diversion services: research priorities and international learning. *Crim. Behav. & Mental Health.* 2013;23:315.

7. Home Office. *Home Office Circular No 66/90.* 1990. Available at: https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/Home%2520Office%2520Circular%252066%252090.pdf [Accessed 13 March 2022]

8. Home Office. *A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system: The Corston Report.* 2007. Available at: https://insidetime.org/wp-content/uploads/2021/12/Corston-Report_March-2007.pdf [Accessed 13 March 2022]

9. Bradley K. *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.* 2009. Available at: https://www.lscft.nhs.uk/media/Publications/CJLT/The%20Bradley%20Report_%20Executive%20Summary.pdf [Accessed 13 March 2022]

10. Forrester A, Hopkin G, Bryant L, Slade K, Samele C. *Alternatives to custodial remand for women in the criminal justice system: A multi-sector approach.* Criminal behaviour and mental health. 2020 Jun;30(2-3):68-78.

11. Birmingham L, Awonogun O, Ryland H. *Diversion from custody: An update.* BJPsych Advances. 2017 Nov;23(6):375-84.

12. Ryland H, Forrester A, Exworthy T, Gallagher S, Ramsay L, Khan AA. Liaison and diversion services in South East London: Referral patterns over a 25-year period. Medico-Legal Journal. 2021 Sep;89(3):166-72.
13. Forrester A, Samele C, Slade K, Craig T, Valmaggia L. Demographic and clinical characteristics of 1092 consecutive police custody mental health referrals. The Journal of Forensic Psychiatry & Psychology. 2017 May 4;28(3):295-312.
14. Scott DA, McGilloway S, Dempster M, Browne F, Donnelly M. Effectiveness of criminal justice liaison and diversion services for offenders with mental disorders: a review. Psychiatric Services. 2013 Sep;64(9):843-9.
15. Kane E, Evans E, Mitsch J, Jilani T. Are Liaison and Diversion interventions in policing delivering the planned impact: A longitudinal evaluation in two constabularies?. Criminal Behaviour and Mental Health. 2020 Oct;30(5):256-67.
16. Forrester A, Hopkin G. Mental health in the criminal justice system: a pathways approach to service and research design. Criminal Behaviour and Mental Health. 2019 Aug;29(4):207-17.
17. Her Majesty's Inspectorate of Probation. A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders. 2021. Available from: https://www.justiceinspectorates.gov.uk/cjji/wp-

content/uploads/sites/2/2021/11/Mental-health-joint-thematic-report.pdf [Accessed 20 March 2022]
18. Brooker C, Coid J. Mental health services are failing the criminal justice system. bmj. 2022 Jan 26;376.
19. Sen P, Forrester A, Georgiou M, Haque Q, Ismail N, Neville P et al. Mental health in the criminal justice system: austerity must now be reversed *BMJ* 2022; 376 :o727 doi:10.1136/bmj.o727
20. Ismail N. The politics of austerity, imprisonment and ignorance: a case study of English prisons. Medicine, Science and the Law. 2020 Apr;60(2):89-92.
21. Chaplin E, McCarthy J, Marshall-Tate K, Ali S, Xenitidis K, Childs J, Harvey D, McKinnon I, Robinson L, Hardy S, Srivastava S, Allely C, Tolchard B, Forrester A. Evaluation of a liaison and diversion Court Mental Health Service for defendants with neurodevelopmental disorders. Research in Developmental Disabilities. 2021 Dec 1;119:104103.