

## RESEARCH AND EVALUATION

# Mental illness in the UK criminal justice system: A police liaison scheme for Mentally Disordered Offenders in Belfast

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### Abstract

*Background:* This paper describes and appraises an inter-agency police liaison scheme for MDOs in Northern Ireland.

*Aims:* To examine administrative outcomes and psychiatric assessment data (including some follow-up information) and to assess the views of service-users and key stakeholders.

*Method:* A battery of measures was devised to assess mental health status, drug and alcohol abuse and risk-related behaviour. Outcomes were assessed (as far as possible) within a prospective follow-up design including a survey of service professionals and interviews with MDOs. The performance of the scheme was measured using objective indicators.

*Results:* Ninety-one per cent of all assessed detainees ( $n = 382$ ) were judged to have a mental health problem. Sixty-eight per cent were GHQ cases whilst 62% attained "above-threshold" BPRS scores; 48% and 53% respectively had a history of harming self or others. Improvements in mental health were recorded for MDOs who were linked to services and who could be followed up. The service was valued highly by service-users and key stakeholders.

*Conclusions:* The scheme effectively identified, assessed and linked most MDOs to existing services. However, significant changes in mainstream mental health services are required before the full potential of the service can be realized.

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**Keywords:** *Mental disorder, offenders, service provision, dangerousness.*

### Introduction

Since the early 1990s, the UK government has actively promoted the diversion of mentally disordered offenders (MDOs) from the Criminal Justice System (CJS) to the care of health and social services (Home Office Circular 66/90). Parallel shifts in criminal justice and mental health policy—as evidenced in key documents such as the Reed Report (1992) and Home Office Circular 12/95—have led to significant service developments for MDOs over the last decade. These include approximately 150 court-based diversion schemes

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throughout England and Wales and 40 police liaison schemes (James, 1999) for which the main point of entry is the police station. Only a few of these services appear to have been evaluated in terms of their overall appropriateness and effectiveness and little is known, in particular, about police liaison schemes. This paper describes the development, implementation and impact of a multi-agency police liaison scheme designed to identify offenders with psychiatric illness and/or learning disabilities within the integrated health and social care system in Northern Ireland (NI).

The scheme, which was implemented in June 1998 in response to local and national recommendations, shares some features in common with the DAPA (**D**iversion **A**t the **P**oint of **A**rrest) model in the West Midlands described by Chung, Cumella, Wensley, and Easthope (1998) and the Community Psychiatric Nurse (CPN) police liaison scheme established in London (Etherington, 1996). The service comprises a rapid screening and mental health assessment at the earliest point of contact with the CJS, plus a mechanism for appropriate referral or diversion to health and social services. It is based in the largest of four police stations in Belfast which operate under PACE (Police and Criminal Evidence (PACE) NI Order (1989)) legislation and which provide specialized settings for the questioning, identification and treatment of mentally disordered suspects. The service is provided by two Community Mental Health Nurses (CMHNs) (07.00 h–19.30 h, Monday to Friday and 07.00 h–15.00 h weekends) who receive support from forensic psychiatry. The CMHNs liaise with Forensic Medical Officers (FMOs), police officers, court officials, probation officers and a range of health and social services professionals and voluntary agencies.

The service is unique in that the nurses also co-ordinate follow-up care and provide ongoing advice and support to offenders, the police and health care professionals. Furthermore, they screen the custody record forms (CRFs) of *all* detainees against the following criteria or evidence of: (1) a history of mental illness and/or learning disability; (2) an “odd” crime; (3) a violent crime; and (4) unusual behaviour leading to referral by the police. Screening detects people who may have a mental illness, but who have not been so identified by the custody sergeant and/or the FMO. Everyone who meets *one or more* of the above criteria is asked to participate in an assessment after which a brief psychiatric report is prepared and made available to the court, arresting officer and the defendant’s solicitor.

The researchers informed the practical implementation of the scheme during its first 6–9 months by: (a) introducing performance indicators based on Mental Health Foundation (1997) guidelines; (b) reviewing, adapting and testing screening/assessment measures; (c) identifying and recording stakeholder views and multi-agency working; (d) providing formative feedback and advice to relevant agencies; (e) maintaining an anonymized offender database; and (f) reviewing the progress and day-to-day operation of the scheme. The objectives of the study were to assess the effectiveness of the scheme and its impact on MDOs and existing services by: (1) examining administrative outcomes during the first 18 months; (2) providing a service-user profile of symptomatology, functioning and risk-related behaviour; and (3) investigating outcomes in terms of changes in symptomatology, service utilization and the views of service-users and key stakeholders including forensic psychiatry.

## Method

### *Assessment measures*

A battery of mental health measures, including several well-known instruments, was devised on the basis of a review of research and discussions with other service providers in England

and with local stakeholders. A series of filters or “gate” questions on most forms obviate the need to administer subsequent instruments (or parts thereof) (see Figure 1).

- (a) A Profile Form (PF) is completed for everyone who meets one or more of the inclusion criteria and who agrees to be assessed. This includes information on: sociodemographic background; primary diagnosis; institutional history; current and previous offence(s); police and court “disposal”; and follow-up service(s).
- (b) The Screening Questionnaire (SQ) is administered to all respondents and includes: a two-question case-finding instrument for depression on which a “yes” reply to either question represents a positive test result (Whooley, Avins, Miranda, & Browner, 1997); and the Psychosis Screening Questionnaire (PSQ) (Bebbington & Nayani, 1995) comprising five “introductory questions” on which a positive or uncertain response may be associated with psychosis and to which further “key questions” are then required. Bebbington and Nayani report a sensitivity of 97% and specificity of 95% for the PSQ.
- (c) Offenders are screened for learning disability using the four-item Learning Disability Questionnaire (LDQ) (Lyall, Holland, Collins, & Styles, 1995). A positive response to *one or more* of the first three questions and/or attendance at a special school indicates a possible learning disability.
- (d) Completion of an Assessment of Risk Form (ARF) is compulsory for offenders who have committed a violent offence, an “odd” crime and/or where there is evidence of, or grounds for suspecting, self-harm. Information on previous incidents of violence is obtained from criminal records. The ARF comprises: (1) a checklist of selected items based mainly on standard risk assessment guides; (2) 8 questions about the respondent’s attitude to harming self and others (based on risk assessment guidelines); and (3) the Dangerous Behaviour Checklist adapted from the Problems Questionnaire (Clifford, 1987) in which five “core” dangerous or risk-related behaviours are rated on a scale from 0 (“no problems”) to 4 (“serious problems”).
- (e) Completion of the 18-item Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962) is required only if a positive response is obtained on one or more of the PSQ introductory questions. Total scores indicate the extent to which an offender has a possible diagnosis of schizophrenia or severe affective disorder. Items are scored from 0 (not present) to 6 (extremely severe) and total scores may be categorized to indicate “not a case” (0–9), “a possible case” (10–20) or “a definite case” (21 or more). The nurses received training in BPRS administration and joint rating sessions undertaken during the pilot indicated good agreement between them.

Each respondent completes three self-report questionnaires. (f) The GHQ-12 (Goldberg, 1978) provides a measure of minor psychiatric morbidity on which a score above 4 indicates “caseness”. (g) The *AUDIT* (Saunders, Aasland, Babor, De La Fuente, & Grant, 1993) comprises 10 questions which screen for harmful alcohol consumption. Responses to 8 questions are scored from 0 (never) to 4 (4 times a week or more) in order of increasing severity; two questions are scored 0, 2 or 4 to produce a maximum score of 40. An overall score of 10 or more indicates a “positive case”. (h) The DAST (Short Form) (Skinner, 1982) includes 20 questions which assess drug misuse (“yes” scored 1; “no” scored 0); scores above 4 indicate a drug abuse problem. (i) The Marlowe-Crowne Social Desirability Scale Short-Form (M-C SDS) (Crowne & Marlowe, 1960) assesses socially desirable responding which may be particularly problematic in a criminal justice setting where offenders may distort the truth (eg. under-report illegal drug use). The M-C SDS comprises

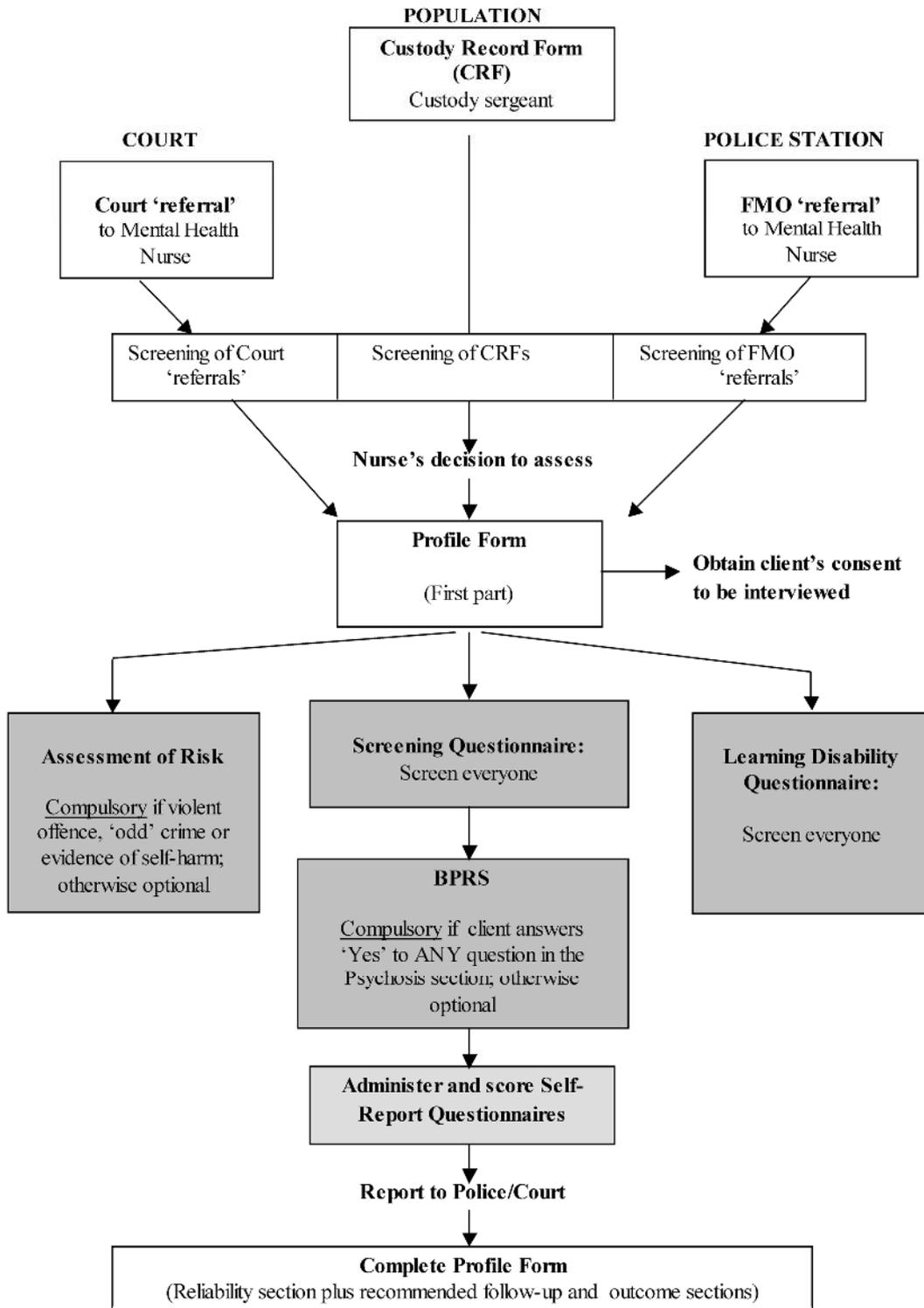


Figure 1. Screening and assessment schema.

13 items, 8 of which have a socially desirable keying direction of false and 5 of which are true. Each socially desirable response (e.g., a "No" response to the "False" item) is scored 1 to yield a maximum score of 13.

*Follow-up survey: service professional and service-user views*

A postal survey of all 127 professionals whom the CMHNs had contacted during the previous 6 months was undertaken to investigate service uptake amongst offenders assessed by the scheme and subsequently directed to community-based services. A Service Professional Form (SPF) was devised to ascertain the nature and duration of the professionals' contact with MDOs and to elicit their views about their mental health. Respondents forwarded a letter from the researchers to offenders requesting their participation in interviews. Face-to-face interviews were also conducted with offenders who gave their informed consent to participate in the research. A Client Follow-up Questionnaire (CFQ) was devised to assess: current mental health status; service receipt; views about the scheme; and further contact with the police. The BPRS and self-report questionnaires were also administered.

## Results

*Administrative outcomes: first 18 months*

During the first 18 months, the nurses screened 4917 CRFs, 16% (787) of which met one or more of the assessment criteria. It was possible to undertake assessments for almost half of this group (48%, 382/787), 15% (59/382) of whom were assessed on two or more occasions yielding 470 assessments in total. The remainder of potential MDOs were not assessed either because the nurses were not on duty or the defendant refused assessment. The majority of assessments (83%, 390/470) were completed within 24 hours of arrest; 3% (13/470) were undertaken within 2 days; while 8% (37/470) were completed more than 2 days after arrest. Almost half of the assessments (48%, 226/470) arose from the routine screening of CRFs by the nurse rather than from an FMO (or magistrate) recommendation.

*Profile of offenders*

Defendants were typically single, unemployed males in their early 30s, (mn = 33, range = 62, SD = 10.54), the largest proportion of whom was living alone (26%, 98/382) and 18% (72/382) of whom were homeless. Approximately three-quarters (74%, 282/382) had an institutional history including 44% (168/382) who had been psychiatric inpatients. Ninety-one per cent (348/382) were judged to have a mental illness and the most commonly recorded primary diagnoses included: clinical depression (41%, 155/382), alcohol/drug-related problems (16%, 63/382), schizophrenia or schizophrenic/paranoid psychosis (11%, 40/382), anxiety state (7%, 28/382) and personality disorder (7%, 28/382). Eight people (2%) had a formal diagnosis of learning disability. Proportionately more of the hospitalized group had a diagnosis of schizophrenia or schizophrenic/paranoid psychosis (16%, 27/168) and personality disorder (13%, 22/168) when compared to the non-hospitalized group (3% and 2% respectively) whilst fewer also had a diagnosis of depression (31%, 52/168 vs. 47%, 101/214).

A sizeable proportion of people was considered to have a dual diagnosis involving alcohol and this is confirmed by the results of the standardized scales presented later (more accurate information was unavailable). Two-thirds of defendants (255/382) were taking mental

health medication and the same proportion had seen one or more mental health professionals including a psychiatrist (61%, 233/382), CPN (16%, 60/382), or social worker (12%, 47/382). Fewer of those without any such contact had a severe illness, but approximately one third (34%, 23/67) had been in prison compared to less than a quarter (24%, 60/252) of the "contact" group.

Eighty-four per cent (218/322) of the group had a known criminal history, over two-thirds of whom had *one or more* previous convictions. More than one third (36%, 139/382) of the first recorded offences were of an "acquisitive" nature (e.g., theft), one quarter (96/382) involved destructive property or "miscellaneous" offences (e.g., alcohol/drug related), while 20% (75/382) entailed offences against the person including homicide. There were no systematic differences in the type of offence committed between the previously hospitalized and non-hospitalized groups or between those with or without contact with community mental health services. Approximately three-quarters of defendants (74%, 281/382) displayed *one or more* problem behaviour(s) prior to assessment, such as physical and/or verbal aggression (37%, 139/382) and self-harm (10%, 27/281), although these may have been situationally dependent.

#### *Re-presenters*

Approximately half of the 59 people who re-presented to the scheme were assessed by the nurses on three or more occasions. The profile of this smaller subset of people was similar in most respects to the larger group who received only one assessment. However, a larger proportion had been homeless (25%, 15/59) and more than two-thirds had been psychiatric inpatients whilst a similar proportion (64%, 40/59) had been in prison. Importantly, all but 6 had previous contact with psychiatric services. There were no statistically significant changes ( $p > 0.05$ ) in mental health status between the first and second assessments.

#### *Follow-up services and court outcomes*

The follow-up services to which MDOs were directed included primarily GPs, Community Addiction services and the Community Mental Health Team (CMHT) (Table I). Ten per cent (37/382) were recommended for psychiatric hospitalization or urgent psychiatric or hospital assessment. Only one in ten were currently in contact with existing mental health services.

Information on court "disposal" was unavailable for 70 people (18%), but most of the remainder were remanded on bail either to the community (46%, 144/312) or in custody (27%, 85/312) while 11 people (4%) were admitted to a psychiatric hospital or remanded in custody to the prison hospital. In all 11 cases, the nurses' recommendation for hospital care was accepted by the magistrate. Twenty people (5%) were diverted by the police as a result of the nurses' report, most of whom were either released without charge (7) or released to report/appear at the police station (5). Diversion from the CJS was considered in a further 14 cases (4%).

#### *Screening and assessment*

Initial SQ screening indicated that 75% (285/382) of defendants had experienced depression during the previous month. PSQ responses suggested the need for a BPRS assessment in all but 29 (8%) cases. Nineteen people responded positively to all three questions on the LDQ (although only 8 had a formal diagnosis of learning disability) and were rated as having impaired social behaviour.

Table I. Recommended follow-up service(s)

Type of service(s) <sup>1</sup>	Number	%
Educational advice and support <sup>2</sup>	302	79
Formal contact with GP	133	35
Direct to community addiction services	89	23
Other <sup>3</sup>	52	14
Suggest "self-refer" to GP	51	13
Direct to CMHT	47	12
Continue with existing services	38	10
No recommendation	20	5
Client refused help/was indifferent to suggestions	16	4
Compulsory informal admission to psychiatric hospital	16	4
Voluntary outpatient treatment	15	4
If remanded in prison, urgent psychiatric assessment	15	4
Recommend hospital assessment	6	2
Direct to psychology services	5	1
Missing	16	4

1. 316 people (82%) were directed to *more than one* service. Therefore, percentages do not sum to 100.

2. This is often provided by the CMHN at the time of the assessment and, if required, on subsequent occasions.

3. "Other" includes "self-refer" to Community Addiction Services, forensic psychiatry and prison hospital wing.

#### *Mental health status and alcohol/drug abuse*

Similarly high proportions of defendants scored above the cut-off indicating "caseness" on both the GHQ-12 and the BPRS (Table II). There were no statistically significant associations with age or sex ( $p > 0.05$ ) on either measure. Approximately sixty per cent of BPRS cases (56/98) were identified by the FMO as having a potential mental health problem and were referred to the CMHNs for assessment. The remainder of BPRS cases were identified solely by the nurses. The mean score for the group was well above the threshold of 9 indicating an above average level of severe psychiatric disorder (Table II). There were statistically significant associations between "caseness" and history of both harm to self ( $\chi^2 = 14.52$ ,  $df = 6$ ,  $p < 0.05$ ) and to others ( $\chi^2 = 13.73$ ,  $df = 6$ ,  $p < 0.05$ ). Two-thirds of BPRS cases (144/332) were also identified as cases on the GHQ ( $\chi^2 = 18.70$ ,  $df = 6$ ,  $p < 0.01$ ), but no statistically significant associations ( $p > 0.05$ ) were found with AUDIT or DAST scores. More than two-thirds (226/331) of MDOs also reported harmful levels of alcohol consumption, although comparatively fewer reported drug abuse problems (Table II). There were statistically significant (positive) associations between harm to self and others and AUDIT caseness ( $\chi^2 = 6.34$ ,  $df = 2$ ,  $p < 0.05$  and  $\chi^2 = 48.31$ ,  $df = 2$ ,  $p < 0.001$  respectively). Drug abusers were also more likely to report harmful alcohol consumption ( $\chi^2 = 18.78$ ,  $df = 1$ ,  $p < 0.001$ ) and to be GHQ cases ( $\chi^2 = 3.86$ ,  $df = 2$ ,  $p < 0.05$ ). Almost all had used (or were using) illegal drugs (95%, 129/136), while three-quarters (102/136) had also abused prescribed drugs. Most respondents indicated that drug abuse had, among other things, created problems in their close personal relationships (76%, 103/136) and/or led to illegal activities (57%, 78/136).

#### *Socially desirable responding*

There were statistically significant, but weak to very weak negative (Pearson) correlations between the total MC scores and the total scores on the self-report scales (AUDIT:  $p = 0.00$ ,  $r = -0.30$ ; DAST:  $p = 0.00$ ,  $r = -0.26$ ; and GHQ:  $p = 0.002$ ,  $r = -0.18$ ). These results

Table II. Summary scores on mental health measures and primary diagnoses

Instrument	Mean score	SD	Range	Number (%) scoring above cut-off
BPRS ( $n=353$ )	15	10.67	64	122 (32) "possible case" 97 (25) "definite case"
GHQ ( $n=332$ ) <sup>1</sup>	8	5.05	12	225 (68)
AUDIT ( $n=331$ )	19	13.58	40	226 (68)
DAST ( $n=331$ )	5	6.07	18	122 (37)

<sup>1</sup>71% (162/332) obtained the maximum score of 12.

suggest some degree of under-reporting with respect to alcohol/drug use and minor psychiatric morbidity.

#### *Assessment of risk/dangerousness*

Sizeable proportions of people showed evidence of psychopathic traits (e.g. emotional shallowness (38%)) and characteristics predictive of potentially dangerous behaviour (e.g. substance abuse). More than half had a history of harming others (53%, 203/382), 42% (160/382) had engaged in self-injurious behaviour whilst 23% (809/382) had a history of both. Fewer than half, in each case, admitted to feelings of guilt/remorse. There were statistically significant associations between harm to self and/or others and institutional history (self-harm:  $\chi^2=26.63$ ,  $df=10$ ,  $p<0.01$ ; harm to others:  $\chi^2=20.82$ ,  $df=10$ ,  $p<0.05$ ). For example, 48% (98/203) of people whose current offence(s) or previous criminal history involved harm to others had received psychiatric inpatient care.

Fifty-four per cent of the group (208/382)—including more than half of the re-presenters (33/59)—were judged to have violent tendencies, albeit of a mainly minor or mild nature (129/208). Global ratings of overall dangerousness showed that one in five posed a "significant" (15%, 59/382), "serious" (2%, 9/382) or "very serious" (2%, 7/382) risk to themselves or others whilst urgent professional intervention was considered necessary in 23% (89/382) of cases. Almost one third of the group (30%, 116/382) reported some degree of suicidal preoccupations.

#### *Follow-up study: survey of service professionals*

One third (34%, 43/127) of professionals returned questionnaires, including Consultant Psychiatrists (51%, 22/43), GPs (21%, 9/43) and CPNs (19%, 8/43). Forms were completed for 36 offenders, but only 14 (39%) had subsequently contacted the professional(s). Eight had attended the service for 1 week or less while 6 had contact lasting at least 1 month. Six of the 14 MDOs were still seeing a professional at the time of the study. All but one person was considered to have "fair" to "very poor" mental health (Table III). Information about further contact with the police was known for only three offenders, none of whom had any contact since their mental health assessment.

#### *Profile of "attenders" vs. "non-attenders"*

Proportionately more of the "attenders" ( $n=14$ ) of follow-up services than "non-attenders" ( $n=22$ ) (i.e. who failed to contact any health care professionals) had a primary diagnosis of

Table III. Reason for clients' contact with professional and their mental health rating ( $n = 14$ )

Item	Number
Reason for contacting professional:	
To receive treatment for mental ill health	4
Consultation for repeat prescription	3
Advice regarding addiction	2
Lack of accommodation	1
To receive social work support	1
To maintain contact with the CMHT	1
Not known	2
Rating of mental health:	
Good	1
Fair	6
Poor	5
Very poor	2

schizophrenia/schizophrenic psychosis (5/22 as opposed to 2/14 attenders) or personality disorder (4/22 compared to no attenders). Approximately half in each group had previously been psychiatric inpatients and similar numbers had been re-assessed by the scheme. However, non-attenders tended to have more previous convictions and to have committed more serious offences.

#### *Service-user and stakeholder views*

Thirty-eight MDOs agreed to participate in face-to-face interviews 6 months after their assessment, but it was possible to reach only half of this group despite vigorous efforts by the research team. Many MDOs appeared to provide false addresses and did not wish their relatives to know about their contact with the CJS. Interviewees were aged between 18 and 59 years (mean = 36 years) and comprised approximately equal numbers of mainly single (14/19) males and females. More than a third (7/19) had been remanded on bail to the community while mixed outcomes (e.g. absolute discharge (3)) were recorded for the remainder. Seven of the interviewees had been psychiatric inpatients; 11 were taking psychotropic medication; 8 had a history of harming others; and 8 had engaged in self-injurious behaviour. Only BPRS scores showed a statistically significant change (improvement) ( $Z = -2.41$ ,  $n = 17$ ,  $p < 0.05$ ) between both timepoints.

GPs (17/19) and community-based psychiatrists (10/19) were the most commonly used services during the previous 6 months. Two interviewees were already in contact with mental health services whilst 10 of the remainder were directed formally to a GP, 9 of whom attended on two or more occasions. Fifteen people had contacted the health and social service professional(s) to whom they had been directed by the CMHN. All but one person rated the new service as "very helpful" and interviewees mentioned, in particular, the nurses' caring approach and their help in facilitating access to other services. Eight people indicated a need for other kinds of help and support when in custody including, for example, contact with a social worker. One of the four interviewees who no longer had any contact with services had started abusing alcohol again (a 60 year-old man) whilst another (a 27 year-old man) had been refused treatment by his GP. All but one person described their overall health during the previous few months as "fair" (4) to "poor" (6) or "very poor" (8/19). They all reported specific symptoms such as hallucinations, panic attacks and depression.

Separate face-to-face interviews were conducted with key stakeholders including a senior forensic psychiatrist, two FMOs and several CJS representatives. All expressed very positive views about the service and most indicated that their expectations had been exceeded. Recurring themes included the development of successful multi-agency working between and within health and social services and the CJS as well as the highly valued efforts of the CMHNs.

### **Discussion**

The principal aim of this study was to provide a detailed description and appraisal of the operation and performance of a new police liaison scheme in NI by examining: administrative outcomes; psychiatric assessment data (including some follow-up information); and the views of service-users and key stakeholders. Our findings are based on the first 18 months of the scheme during which time it appeared to have reached a “steady state” in terms of its practical implementation and development of inter-agency links. For example, the scheme has achieved a 100 per cent screening rate, has been well received by the various agencies involved and is able to provide, within an inter-agency context, a comprehensive mental health assessment and referral service for offenders usually within 24 hours of arrest. Furthermore, the demand for the service remains high as evidenced by its recently extended (partial) coverage to include other PACE stations throughout Belfast.

The 91% prevalence rate for mental disorder amongst those assessed in this study compares favourably with the 85% and 90% rates reported most recently for police liaison schemes in England (James, 2000; Riordan, Wix, & Kenny-Herbert, 2000). Importantly, almost half of the MDOs were identified from the routine screening of CRFs as opposed to a recommendation from the FMO (or the police or other criminal justice personnel). It is also worth noting that the FMOs “missed” a significant proportion of potentially more severe cases as indicated by our BPRS data. This supports evidence suggesting that the detection rate in a criminal justice setting may be low due to the potentially concealing effects of alcohol/drug abuse and the frequent clinical presentation of depression in this population (Rice & Harris, 1997). It is also possible that the methods of identification employed by police officers are insufficiently thorough. This may be addressed, in part, by the Mental Health Awareness Training currently being implemented in a number of local police stations. Either way, our findings suggest that a significant proportion of MDOs may pass, perhaps continuously, through the CJS without receiving proper health and social care. However, schemes such as that described here can be effective in terms of identifying mental illness more accurately than CJS personnel.

The re-presenting rate (15%)—similar to the 12% reported in the first year of the North Humberside Diversion Project in England (Straite, 1995)—is low, but the well-established criminal histories of most of the group underlines the importance of early intervention. While re-presenting provides a useful indication of re-offending (and therefore, of outcome), we were unable to determine empirically the true rate of recidivism in this group. Arguably, effective service delivery at an early stage may help to reduce recidivism rates, particularly in this small sub-group of vulnerable revolving door “re-presenters”, more than two-thirds of whom appeared to have serious levels of psychiatric disability and/or alcohol or drug abuse problems. It is interesting to note that most of this “difficult-to-engage” group had contact, at some stage, with mental health services, but they do not appear to have been managed effectively by these services and/or they have been lost to follow-up due to serious problems relating to longer-term engagement or appropriate treatment. This may be compounded by the greater psychiatric mobility in this group when compared to the general population. The

fact that more than half also had violent tendencies highlights the need for secure therapeutic provision whilst those presenting a risk both to themselves *and* others may also benefit from specialist mental health care.

Most MDOs appear to have had previous experience of psychiatric services and/or one or more inpatient admission(s). This provides further evidence to suggest that existing services do not appear to be intervening successfully with this group, many of whom have complex needs that require a more flexible, co-ordinated and integrated service response. The findings also highlight a recurring, problematic theme of “engagement” most probably due, in large part, to the high levels of social deprivation and substance abuse seen in this group. Many MDOs were typically single, unemployed, living alone (or homeless) with previous experience of “institutional” living and with significant alcohol and/or drug problems. Offenders with a dual diagnosis of mental illness and alcohol/drug abuse—similar to many of those assessed in our study—are particularly difficult to engage and to treat due to their greater tendency toward violent behaviour (e.g. Swanson, Holzer, Ganju, & Jono, 1990) and the fact that they may fall between local (demarcated) psychiatric and addiction services.

The service response to MDOs and especially those with a dual diagnosis requires close attention. Ideally, it should involve assertive outreach and sustained support with the aim of engaging and (re)connecting MDOs to existing and specialist services. Arguably, this may require the implementation of outreach teams that operate more aggressively than normal. The development of social relationships and networks is also important in facilitating the re-integration of mentally ill offenders into society and the prevention of re-offending. Further research is needed to identify how mental health services may be successfully delivered to this group, particularly in view of the *perceived* threat to public safety from people with mental illness (e.g., the Ashworth inquiry (Fallon, Bluglass, & Edwards, 1999)). Similarly, the high incidence of self harm merits special attention in the context both of the increased suicide risk in this group and their management within the CJS.

#### *Limitations of the study: client outcomes*

The assessment of outcomes including service-user and stakeholder views are often neglected in MDO research due, in large part, to offender non-compliance and residential instability, both of which make follow-up studies notoriously difficult. This was borne out by our own experience despite vigorous efforts by the two CMHNs and the researchers. Whilst the follow-up study is limited in terms of sample size, it nonetheless provides one of the few insights that is currently available into outcomes and service-users’ views. The findings suggest, albeit tentatively, that those most likely to initiate and maintain contact with psychiatric services and, therefore, to fare better in the community have less serious disorders than non-attenders and tend to have lower rates of criminality. Consistent with the results of Holloway and Shaw (1993), service attenders appeared to be successfully “maintained” in the community with some improvement in their overall mental health. Thus, the short-term outcomes for those who were linked to services and for whom information was available are reasonably encouraging. However, much more information is needed before drawing any valid conclusions about the number of MDOs who attended services to which they were referred and the effectiveness of those services. The scheme appears to be valued highly by both service-users and stakeholders alike, although again, too few of the former agreed to participate in interviews or could be followed up. The response rate from the service professionals was also disappointingly low.

### Conclusion

The new service appears to be detecting and assessing most, if not all, offenders with significant levels of mental disorder, a large proportion of whom may require specialist health and social services intervention. Our findings illustrate unambiguously that mental illness amongst many detainees went undetected by Custody Sergeants and/or FMOs, but was identified accurately by the CMHNs who also achieved considerable success in linking MDOs to health and social services. Therefore, the scheme may be judged to be effective in terms of identifying, assessing and linking MDOs to existing services, although evidence to support the criterion of diversion is less conclusive.

Importantly, the CMHNs developed close and mutually supportive working relationships with other health and social service professionals and a wide range of CJS personnel. Key stakeholders indicated that the newly developed scheme has played an important, perhaps pioneering role in terms of developing and facilitating a much-needed liaison between psychiatric services and the CJS. However, it is difficult to gauge the long-term impact of the scheme on the two systems of service provision, particularly in the absence of a fully integrated forensic mental health service in NI. Nonetheless, this model of inter-agency working has developed within a region of the UK often considered more strongly associated with division and civil unrest than partnership, and it is possible that the integrated health and social services in NI contributed positively to this development. The service also appears to have promoted a better understanding of the relationship between mental illness and crime and its prevention. Realistically though, many initiatives set up in isolation from mainstream services often fail to achieve their long-term goals, and this is particularly true of nurse-led schemes which are most effective when fully integrated with local psychiatric services or staffed by (senior) psychiatrists (Birmingham, 2001). Thus, a community forensic mental health service and/or a re-configuration of existing services would provide much needed support for the new scheme. A significant proportion of MDOs—including a sizeable group of violent offenders and those committing acts of self-harm—are unlikely to receive appropriate health and social care unless there are significant changes to general mental health service provision. Our findings suggest the need for a radical re-think and an informed public debate about how more positive outcomes may be achieved in this population. Furthermore, as indicated by Cohen and Eastman (2000), much more research is needed to ascertain the mental health needs of this group and to establish what works best so that national clinical and service protocols can be developed.

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