Glasgow
Community
Justice
Authority

OFFENDER MENTAL HEALTH SERVICES

Report and Recommendations for Scottish Government Offender Mental Health Working Group

April 2008

1 Background

1.1 Glasgow Community Justice Authority has been asked by the Scottish Government, Offender Mental Health Working Group (MHWG), to bring the key local agencies together to scope out local models of working with offenders with mental health problems, especially at the lower end of the spectrum, and to report back to the Group with examples of good practice and/or proposals for improving current practice.

1.2 This report represents Glasgow CJAs submission towards the national work that will be considered by the National Advisory Body. This will consider the shape of future policy, while building on local practice and experience.

2 Consultation Activities

2.1 In January and February 2008, Glasgow CJA carried out a survey of Glasgow based services working with offenders or ex-offenders with mental health needs. This survey was designed to gather information on levels of demand for services, training needs and to help identify good practice, partnership and gaps in service. A report of responses to the survey is held in Appendix 1.

2.2 In addition GCJA and North Strathclyde CJA jointly hosted a half day seminar on 10th March 2008. This invited selected practitioners and managers to discuss the current offender 'journey' through services and how this could be improved. A report on the discussions on the day is held in Appendix 2.

2.3 The key findings in section 3 below bring together the main comments made within both these pieces of work. They generally echo the original comments made to the Scottish Government MHWG in terms of information sharing, staff training and multi-disciplinary working. Specific recommendations from Glasgow CJA follow in section 4.

3 Key Findings

3.1 People are positive about improvements in information sharing and joint working but are clear that more needs to be done. This would seem to include improvements in understanding what services are available, how they are accessed and the relative roles and responsibilities of different services. There may also be a need to look at the systems to support communication e.g. IT infrastructure.

3.2 Services have assessment processes in place and are aware of a wide range of services that can support clients. However there remain barriers to access both geographical and disciplinary. The plethora of assessments, thresholds for service and potentially apparently differing definitions employed within services may well hinder good communications. A clearer strategy in relation to mental health and offending may aid this.

3.3 Joint working and multi-disciplinary working are strongly supported. Models that bring different disciplines and services together on one site are highlighted as models of good practice.

3.4 The default priority given to an individuals offending, over any other needs, is questioned. This suggests a shift in focus to prioritise needs. This may mean treatment or 'ownership' of clients would be with health rather than criminal justice agencies. Those with Learning Disabilities including Autistic Spectrum Disorder as well as those with Mental Health difficulties were identified as perhaps requiring health not criminal justice inputs.

3.5 Staff were praised for their commitment and skill but there is an awareness of the ongoing need for training. Basic mental health awareness appears to be widely available but more specialist training, delivered jointly may be of benefit.

3.6 Accommodation issues for clients are identified as a key resource gap and one that hinders the co-ordination of other services around an offender. Related to this is the need for better continuity between custody and the community (on the way in as well as on the way out) to help people engage with services in their communities. Routes out of Prison (ROOP) were one of the few services identified by name. They are seen as effective in supporting transitions.

3.7 Supporting sentencers appears as another theme. The benefits of the specialist courts are highlighted as are specialist facilities for assessment and links to health services within courts. This may lead to a better assessment of need and more appropriate service response.

3.8 Specific resource gaps were identified for Personality Disorder and those with alcohol misuse issues.

4 Possible CJA Action Points

4.1 A shared strategy statement including agreed definitions and outlines of potential offender pathways

4.2 Review of mental health screening in non specialist services. Development or adoption of core screen.

4.3 Joint training sessions for different groups of staff

4.4 Accommodation work already ongoing to ensure consideration of mental health issues

4.5 Individual instances of good practice or barriers to working to be reported back through the CJA for dissemination and or resolution.

4.6 Discuss with Courts the needs of sentencers and make recommendations for support.

4.7 Ensure new alcohol service funding includes offenders as a priority target group.

Glasgow Community Justice Authority

APPENDIX 1

OFFENDER MENTAL HEALTH SERVICES IN GLASGOW

Questionnaire Returns

February 2008

1 Introduction

This brief report is the first stage of work in response to the Scottish Government's Offender Mental Health Working Group request for local information. In December 2007, Glasgow CJA decided to survey relevant service providers about the scale of the issues in the city and their views on good practice and gaps in service.

2 Response

30 different services were sent the questionnaire. Some responded on a city wide basis and others returned a response for a single CHCP area.

In total 18 Services returned questionnaires. This included large city wide organisations e.g. the NHS Forensic Service, 3 Prison establishments that accommodate Glasgow prisoners, 3 of the 5 Criminal Justice Social Work Services Teams, 2 further specialist social work projects and 9 voluntary sector providers working in the area of mental health or offending.

11 of the 18 said they dealt exclusively with offenders with a further 3 dealing mainly with offenders or ex-offenders. The remainder provided mental health, addictions, accommodation or employment services. All services recognised the issue of mental health among their client groups but the focus on this varied according to the type of organisation.

3 General Findings

Services generally found it difficult to quantify their client group beyond the total number of service users.

We questioned services about clients who were either **'Mentally disordered Offenders' (MDO)** or offenders with **'Lower Level Needs' (LLN)**. Not all

services recognised these distinctions and did not distinguish between groups. This may be an issue to do with the terminology used in the questionnaire.

A high proportion of both offenders and general service users were identified as having substance misuse problems in addition to mental health difficulties.

4 Numbers

Because of the incomplete coverage of the survey and issues with completing the questionnaire it is difficult to make any estimates about the size of the current client group. Some services said there were difficulties in identification due to non-diagnosis or non-disclosure by clients.

There is also the issue that individuals may be in contact with multiple services or figures may capture multiple referrals for the same individual.

While some services are aware of an individual's offending status they may not be aware of mental health problems, or the extent of these. Conversely mental health services may be in contact with individuals but be unaware of their offending histories.

Where numbers were reported or estimated, the main theme was the high level of substance misuse among clients. In some services, the level of substance misuse among those with mental health needs who were also offending was put at up to 90% of the total client group.

5 Assessment

Almost all services identify a specialist assessment tool but this may be focused on either criminal justice or health issues. There are a range of tools with few appearing to overlap between services. The tools can broadly be categorised as either 'general in house' or 'externally validated' assessments including psychometric tools for risk of re-offending and harm, tools to assess anxiety, depression, self harm and drug misuse. Two voluntary services identified the Social Work Services single shared assessment as the source of much information on clients.

6 Referral

All services indicate clear referral paths to a range of services based on individual need. These cover Specialist Mental Health services, Sexual and more General Health Services, Substance misuse services, a substantial number of Employment Services and of those aimed at maximising income and providing financial advice. Additional services included homelessness advice and support services and counselling services for trauma and bereavement. Most services appeared to be city wide or local teams of city services.

There appears to be a significant level of referral within the small group of services involved in the survey and also a high level of awareness of other

relevant services for client's wider needs. However there was some concern at a lack of (or lack of knowledge of) very local services.

7 Direct work

Not all services do direct work they would identify as being directly focused on Mental Health issues. Most services recognise life skills work and emotional support as mental health inputs and identify that they support clients with independent living, counselling and facilitating medical appointments. This is provided mainly on a one to one basis.

Other services at the more specialist end focus on the cognitive behavioural type interventions either on a one to one or group basis. Groupwork is mainly in the field of addictions or to address offending behaviour.

Criminal Justice Social Work Services (CJSWS) make a clear distinction between the offence focused work they do and any mental health inputs which may be provided in house. This is seen as dependent on the individual member of staff and their skills and experience but is mainly the subject of a referral to mental health services. This process of referral is identified as improving but still difficult locally because of a lack of interface between different social care teams.

There were a number of services providing direct advocacy on behalf of clients and a larger number providing general mental health awareness to their own and/or other organisations.

10 Staffing

Because of the wide ranging nature of the survey there were a limited number of staff identified as 'specialist' mental health staff. 11 services said they had at least one specialist mental health staff member. Specialist staff included Mental Health Nurses, Mental Health Officers and less commonly access to Psychologists or Psychiatrists.

Almost all services stated that staff require at least some general mental health awareness training. Most identified either in house or external sources where this was available. Day or half day mental health awareness or mental health first aid was included in the induction programmes of some services.

Respondents stated that more specific training required included more in-depth mental health awareness and how to work with individuals with mental health problems and training for working with personality disorder.

In terms of staff resources, a lack of staff to train to deliver more complex interventions such as CBT and psychotherapy was also identified.

11 Joint working

Services were asked *'How well do you think City services work together?'* This produced a mixed response. 6 services declined to comment. 4 provided fairly negative views, 4 positive views and 4 both positive and negative views.

The positives suggested that things continued to improve with good communication between agencies in relation to clients and that increasing specialism has led to a more 'referral friendly environment' with less competition between services.

Negatives are disputes between services about ownership of clients when clients are in crisis. This was highlighted in relation to the addictions/mental health interface and with learning disability resources. Other negatives simply cite poor communication between services. Some responses suggest the new CHCP structures may need more time to bed in be able to better promote joint working.

12 Good practice

Services were asked to identify any areas of good practice within their service and in the wider local or national context.

13 of the 18 identified areas of good practice in their own service. Broadly these can be grouped as

- Implementing multi disciplinary policies and practices
- Staff training, development and positive practice with service users

Specific references were made to the use of CBT and evidence of its effectiveness and a Diversion from prosecution scheme run with the Procurator Fiscal.

Only 8 of the 18 identified good practice beyond their own services. This tended to focus on individual local projects and the expertise of workers. Projects and services highlighted included

- ROOP
- Scotia Club House
- Community Addiction Teams Nursing Staff
- Edinburgh Community Link Centre
- Work on Autism Spectrum Disorder

9 Gaps in Service

Respondents were asked to identify gaps in service. These can be split between specific service gaps and gaps as a result of cultural or institutional barriers. Service gaps include

- Suitable accommodation for offenders
- Services for personality disorder
- Criminal Justice knowledge and training in Autistic Spectrum Disorder

- More diversion from prosecution

Gaps were however mainly focused on institutional barriers including;

- A limited interface between Criminal Justice and Mental Health services. This includes lack clarity about relative roles and responsibilities e.g. within MAPPA processes.
- Conflict between mental health and addiction services
- Geographical barriers either in service availability or eligibility
- Information on service availability
- Transition between prison and community -a lack of service follow through

APPENDIX 2

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nscja
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community justice authority

OFFENDER MENTAL HEALTH SERVICES SEMINAR

Report of Discussions from a Joint Seminar held by Glasgow Community Justice Authority (GCJA) And North Strathclyde Community Justice Authority (NSCJA) On 10 March 2008

31st March 2008

1 Introduction

On 10 March 2008 GCJA and NSCJA jointly hosted an event that brought together key individuals and agencies to discuss current provision and the priorities for moving forward. The event was hosted jointly, in recognition of the fact that both CJA areas share key mental health services from NHS Greater Glasgow & Clyde and the Voluntary Sector. 28 individuals attended from Health, Scottish Prison Service and HMI Inspectorate of Prisons, the Voluntary Sector, Social Work Services and the CJAs.

Participants were asked to consider a number of issues including:

- What works well?
- Gaps or frustrations?
- Sentencing and mental health
- Specific Needs
- Priorities for action?

The following report reflects the discussions of the groups by identifying shared themes between the groups and the relative importance given to these, Where only one group identified an issue this is clearly stated. It concludes with some priority areas identified by the groups and, where possible, actions within these.

2 What Works Well?

The general theme coming from the groups was that there is much good practice, particularly in the areas of joint working and information sharing on the ground, but more needs to be done.

Participants did not tend to name 'successful' services but rather focused on characteristics common to those identified as working well.

Assessment '…when time allows…' was identified as a strength. The ability and willingness of services to share information was seen to be improving the quality of reports for courts. One group said that communication between practitioners was improving but that IT systems were not yet able to communicate with each other effectively. Community Psychiatric Nurses (CPNs) based in courts were one group singled out as aiding communication between services.

A commitment to multi disciplinary working was identified as were the benefits of co-location where models of this exist. The groups identified prisons as a 'one stop shop' often with access to a range of services beyond those available in the community. The groups identified the paradox whereby individuals often seem to get a better service on entering custody. They suggested a model of service in the community that brings all services to the user rather than vice versa.

Generally services for high risk or individuals with a diagnosis were thought to be most effective, with more gaps for those at the less severe end of the spectrum. The Care Programme Approach (CPA) was highlighted by one group as a way by which agencies come together to co-ordinate services. This however is predominantly focused on in-patient Forensic Health Services and, is limited to those with the most severe and enduring problems. One group questioned the definition of mentally disordered offender and questions of definitions and thresholds were a common theme on the day.

Similarly, work with those on statutory orders was seen as more effective than those without this status. In the participants view this could be because without a statutory order clients are less motivated to engage. One group thought that perhaps the societal reduction in the stigma associated with mental health issues was aiding identification and engagement but also recognised the possibility of this leading to labelling e.g. 'depression', of those with a range of complex social and environmental difficulties.

Two of the three groups named the ROOP (Routes out of Prison) service as one that works well. This service links individuals leaving prison with local services through mentors who, it is thought, may be more able to identify with the experiences of the ex-prisoner.

3 Gaps in Service

The groups identified a range of gaps in service but also gaps in *knowledge of services,* their availability and access routes. Key areas where services were seen to be lacking were in relation to accommodation and substance misuse, particularly alcohol issues.

Other issues related to apparent inconsistency of approach according to geography or client group or based on resource limitations such as time for assessments, service waiting lists or shortages of particular professionals.

Groups identified the increasing use of prison as symptomatic of gaps in community services. Prison was seen as often being used as a place of safety or to hold those with behaviour that is particularly difficult to manage. In summary there was a call for individuals to be treated within the most appropriate services (e.g. health) rather than always first and foremost as offenders.

All groups identified accommodation and substance misuse issues as significant gaps in service provision. Accommodation was seen as a priority to enable other services to be put in place. A lack of a permanent and appropriate base was seen to hinder access to other services and making simple activities like registering for a GP problematic. Lack of housing, poor housing in poor areas and peer pressure within these areas were all identified as barriers to rehabilitation and good mental health.

However the groups recognised that a number of personal, social and environmental factors are at play and that often the chaotic nature of individual lives makes any stability difficult and means expectations need to be realistic. The often chaotic nature of the lives of offenders with mental health issues may mean exclusion from services, either voluntarily (as a result of not attending appointments) or on the basis of their behaviour. Poverty generally was identified as a factor for this group of individuals.

Substance misuse was identified as an almost universal issue in relation to this group of offenders. This was seen to complicate access to mental heath services as it was often difficult to establish the nature of the mental health issue at the outset. Often service provision is firstly about stabilisation of an individual's substance use before looking to mental health issues. There is an issue with the direction of causality and also which service has ownership for the individual. This can risk service users falling between services.

Alcohol was identified by the groups as a significant issue and one that has not had as much attention or service development as drug misuse. However the

existence of alcohol nurses within some CATs was noted as a useful development.

Access to service was identified as an issue with one example being the geographic barriers in accessing methadone as numbers in some places are 'capped'. Other frustrations for staff were the often limited time to assess clients, limited specialist staff (CPNs and MHOs) and lack of specialist services for those with personality disorder and young people transitioning from children's services. One group mentioned the 'unrealistic' expectations of courts and often service users of what service could be provided. Other frustrations were limited 'move on' services including difficulty in linking with mainstream services.

Two groups touched on the issue of evidence. One noted that services often do not collect the data required to evidence success. Even where evidence is available from e.g. pilot schemes these are not necessarily rolled out. The groups acknowledged the politically sensitive nature of offender services, where politicians from all sides must balance public concerns with other considerations. Politicians and others needed to be willing to make changes to current systems.

4 Issues in Sentencing

The main discussion in relation to sentencing focused on sometime geographical inconsistency between courts and variations between Sheriff decision making. Additionally, criticism of short term sentences appeared throughout the discussions. This is due to the lack of time for any type of intervention within prison and the lack of a statutory basis for intervention on release.

Some good practice in courts was identified. As already discussed above, the presence of CPNs within some courts is seen as a way to improve communication between services. The Forensic in-reach service at a specific court was also identified by one group as a good model.

One group highlighted the direct contact and review of cases by Sheriffs in specialist courts as a positive, contrasting this with a perceived lack of opportunity for conversations between Sheriffs and Offenders more generally.

One group identified the need for more resources for assessment, for the assessors to appear in court and for alternatives to prison for offenders throughout the assessment process.

5 Specific Needs

One group apiece identified women and young people as specific groups requiring additional services responses. For young people the gap between child and adult services was identified as problematic which may lead to a 'lack of ownership'. For women it was those in the middle range without severe

problems or a diagnosis of mental illness, but with significant personal, social and environmental issues, that require additional services. One group mentioned that cultural issues were sometimes confused with mental health issues. They also suggested that increasing language barriers were being faced by services and service users but there was no indication if this referred to new migrants or asylum seekers.

6 Priorities

Not all groups came up with a clear se of priorities and those that were identified were not common to all groups. They can be grouped generally as infrastructure, service specific and cultural recommendations.

Infrastructure

Better relationships and information sharing across services to include joint training, better compatibility of IT systems and more accessible information on what services are available and how to access them.

Service Specific

Increase in specialist staff including MHOs and CPN in all courts where they do not currently operate. Increase in services for personality disorder offenders in the community and SPS. More services related to alcohol issues. More attention paid to point of release from prison for those with no statutory throughcare provision. Explore the possibility of giving more autonomy for CJSWS in breach procedures.

One group discussed the opportunities that may be afforded by the renegotiation of the Scottish Prison Service contract. At present this is provided by non NHS providers but participants felt that should the NHS be contracted to provide prison healthcare the transition between community and institutional services could be strengthened.

Cultural

Need for earlier intervention and a focus on the health care needs rather than criminal justice aspects of individual cases. This would require earlier assessment processes and a political push to promote the use of health resources rather than prison. Generally need a focus on keeping people out of prison, particularly those receiving short term sentences, but this will have an impact on community services.

One group explicitly identified CJAs as having a role to make these things happen. This will require funding for new services, facilitating work between organisations and a management of the ‘politics’ of competition and co-operation between authorities and organisations. There was also a call for CJAs to find out ‘what works’ internationally.