CSIM Quality Investigations Safeguarding the Vulnerable Reducing Demand Managing Workflows

Subject	**'A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders'**
Date	21/12/21
PURPOSE	Briefing Note
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COMMISSIONED BY	N/A

INTRODUCTION

This briefing note is written in response to *'A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders'*, published on 17th November 2021.

This inspection was led by HM Inspector of Probation, supported by a team of inspectors from Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI), Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Care Quality Commission (CQC), Healthcare Inspectorate Wales (HIW) and Her Majesty's Inspectorate of Prisons (HMIP) with additional support provided from Her Majesty's Courts and Tribunals Service (HMCTS).

This inspection, aimed to consider the following critical issues:

- Are people with a mental illness identified when they first come into the CJS?
- Is this information passed on through the rest of the system from the police and defence lawyers to the Crown Prosecution Service (CPS) and the courts or from the courts to the probation and prison services so that the right decisions can be made about next steps?
- Are people with a mental illness entering the CJS being properly assessed and then referred for help or treatment where this is identified as necessary?
- What is the quality of support they are getting? Is it timely and adequately resourced or are people having to wait many months to get it?
- Are the most seriously mentally ill people being looked after in appropriate settings and places of safety, or is custody still having to be used?

GENERAL FINDINGS

The report concludes that not enough progress has been made in the 12 years since the 2009 'Bradley review' which found that '*failure to adequately address the mental health needs of offenders is a fundamental cause of the chronic dysfunction of our criminal justice system'*. More specifically key observations are summarised as follows :-

- There continues to be no common definition of mental health used in the CJS and this leads to individuals' needs being missed as they progress through the system.
- Information from the police to the Crown Prosecution Service about an individual's mental health needs is often not clearly communicated or transferred at all, even when it is identified. This makes timely and appropriate charging decisions more difficult and can have an impact on court proceedings.
- Following court, the mental health flagging system used by the probation service is not helping practitioners to fully identify the risk and level of need presented.
- Strategic leaders across the CJS must make better use of the data that is available but not always systematically collected or used to inform service delivery on the ground.
- Incorrect interpretation of data protection regulations means that important information is not exchanged between agencies, leading to poorer assessments and poorer mental health outcomes.
- A Memorandum of Understanding on information-sharing needs to be agreed urgently with all partners involved in managing this journey through the CJS.
- Courts' face concerning delays in the timely production of psychiatric reports.
- There is a shortage of good-quality mental health provision and unacceptable delays in accessing services.
- Further, and most distressingly, acutely unwell prisoners who require urgent transfer to a secure mental health inpatient hospital for treatment experience long waits in prison.
- Seriously mentally unwell prisoners are being held in conditions that worsen their mental health.
- There are learning and development needs which, if addressed well, will support better mental health outcomes.

POLICE SPECIFIC FINDINGS

The inspection report highlights the following strengths and areas for improvement from a policing perspective: -

Strengths

- Police leadership of mental health at a national level is comprehensive and well-coordinated through the National Police Chiefs' Council (NPCC). Most forces had accessible mental health leads either at force level, local level or both.
- Forces have arrangements for patrol/response officers to access either 'at scene' advice via street triage vehicles or remote advice via control room triage.
- In all forces, the commissioned services included a L&D service based within police custody.

- In most forces, the availability of 'place of safety beds' had improved or was improving, so police facilities are now only being used as a place of safety (for adults) in exceptional circumstances. These were very rare occurrences that were fully and properly justified.
- Police officers had a good understanding that minor crime, particularly crime caused by the mental health crisis itself, could be swiftly discontinued in favour of a health care approach.
- There is an extensive suite of diversion opportunities and critical pathways in every force, although their use varies, and officers do not always take advantage of the specialist help available.
- Police custody staff take screening and managing detainee risk very seriously and this featured heavily in custody staff training and in custody management systems.
- HMICFRS's rolling custody inspection programme, undertaken with HM Inspectorate of Prisons, has found risk assessment to be of a generally good standard. As a result of the risk assessment and healthcare process, custody staff took necessary steps to safeguard the detainee and others.
- Most forces have extensive healthcare coverage in all sites.

Areas for improvement

- Police officers are not clear about the mental health information that needs to be passed to the CPS when they are seeking charging advice.
- There is no prompt for officers to include this information on the papers and they did not routinely ask L&D services for this information.
- There is a variable picture in relation to mental health training.
- Data relating to mental health within policing is limited. Mental health flagging is available on systems across policing, but these systems did not universally allow for subcategories, specific conditions or qualifying information, which limited their usefulness.
- In most forces, recording of pertinent information in custody records was inconsistent.
- Identification and assessment of mental ill-health were poorer for suspects who were not detained in custody but invited to attend at a later date for interview ('voluntary attendance' cases). This group was significantly less likely to be referred to a healthcare professional or an L&D scheme for assessment.

SUMMARY OF RECOMMENDATIONS

The report makes a total of twenty-two recommendations, eight of which are directly relevant to the police or local criminal justice boards.

The report states that recommendations should be completed within 12 months, unless otherwise stated.

Local criminal justice services (police, CPS, courts, probation, prisons) and health commissioners/providers should:

10. Develop and deliver a programme of mental health awareness-raising for staff working within criminal justice services. This should include skills to better explain to individuals why they are being asked questions about their mental health so that there can be more meaningful engagement

11. Jointly review arrangements to identify, assess and support people with a mental illness as they progress through the CJS to achieve better mental health outcomes and agree plans for improvement.

Local criminal justice boards should:

12. Agree, produce and analyse cross system data sets to inform commissioning decisions and promote joint working

13. Ensure that Liaison and Diversion mental health assessments undertaken in police custody are provided to the Crown Prosecution Service and defence lawyers to help inform charging decisions, representations for diversion and sentencing decisions.

Response to recommendations 10,11,12 13- these recommendations have been passed to the Norfolk and Suffolk Criminal Justice Board to action (C/Supt Wvendth).

The police service should:

14. Ensure that all dedicated investigative staff receive training on vulnerability which includes inputs on responding to the needs of vulnerable suspects (as well as victims). This should be incorporated within detective training courses

Suffolk Constabulary's current position in respect of this recommendation: -

Vulnerability, safeguarding and harm reduction are all aspects that feature heavily within the student learning curriculum and detective pathway programmes. Student officers receive extensive inputs including from subject matter experts to discuss mental health, safeguarding assessments, decision making and public protection principles. This is supported by their learning programme which develops initial understanding and requires the student to research, explore and evidence referrals to local agencies, their decision making in doing so and what the role of the police was in these circumstances. The force is moving to PEQF programmes from 18th April 2022 where training on vulnerability and safeguarding has been expanded further over the duration of the significantly longer Degree programme.

The Foundation Detective programme (FDP) dedicates around 4 days to vulnerability specifically in relation to stalking, harassment, coercive and controlling behaviour, sexual crime focusing on the victim and investigation factors that require consideration. This module also has input from subject matter experts.

A bespoke online (LMS) training package has been built and has been rolled out to all front-line staff via an on-line interactive training session – this is supplemented by a vulnerability leaflet which contains detailed information and guidance for officers on vulnerability

Additionally, a training video covering acute child experiences (ACES) has been circulated to detective investigators in early 2021.

Importantly, the constabulary employs an experienced mental health co-ordinator, who in addition to continuing to provide support for student officer training , will also be commencing the delivery of mental health inputs for operational officers, starting with neighbourhood response officers as part of mandatory training days scheduled to begin in early 2022.

This training will cover the Mental Health Act, Mental Capacity Act, suicide prevention/awareness and an overview of what services are available for the police to utilise for suspects/victims/involved parties to access the appropriate support.

15. Dip sample (outcome code) OC10 and OC12 cases to assess the standard and consistency of decision making and use this to determine any training or briefing requirements and the need for any ongoing oversight.

Suffolk Constabulary has a well-established process for completion of monthly crime audits utilising Inspecting ranks. These audits aim to examine in excess of 200 crimes per month following a structured format for inspection. This process considers standards of investigation, supervisory oversight and aims to address learning and service recovery requirements. In addition to this process, thematic audits are conducted often utilising specialist staff to focus on key performance issues.

In light of this recommendation, we will ensure that monthly crime audits consider the requirements for OC10 and OC12 cases as outlined in this report. We will also aim to complete a thematic audit at the earliest opportunity and within timescales allowed.

16. Review the availability, prevalence, and sophistication of mental health flagging, to enhance this where possible, and to consider what meaningful and usable data can be produced from this.

This recommendation is noted and actions to address this will be provided with timescales allowed (12 months)

17. Assure themselves that risks, and vulnerabilities are properly identified during risk assessment processes, particularly for voluntary attendees. They must ensure that risks are appropriately managed, including referrals to Healthcare Partners, Liaison and Diversion and the use of appropriate adults.

This recommendation is noted and actions to address this will be provided with timescales allowed (12 months)

18. Police leadership should review MG (manual of guidance) forms to include prompts or dedicated sections for suspect vulnerability to be included.

This is a national as opposed to local requirement and it is anticipated that MG forms will be phased out with introduction of digital case file management plans.

Andy Smith

T/Detective Chief Superintendent, 22nd December 2021