Revolving Doors Agency submission to West Midlands Mental Health Commission

April 2016

About Revolving Doors

Revolving Doors Agency is a charity working across England to change systems and improve services for people who face multiple and complex needs, including poor mental health, and come into repeated contact with the police and criminal justice system. We work with policymakers, commissioners, local decision-makers, and frontline professionals to share evidence, demonstrate effective solutions, and change policy, while involving people with direct experience of the problem in all our work including through our National Service User Forum.

Revolving Doors is part of the Offender Health Collaborative which has been commissioned by NHS England to support the roll out of mental health liaison and diversion services across the country.

Introduction

We are pleased that this commission is considering the wider range of needs faced by 'troubled individuals' as well as the interaction between poor mental health and criminal justice. Recent research suggests that there are at least 58,000 people in England facing a combination of substance misuse issues, homelessness, and offending needs at one time; and that 55% of those experiencing these three disadvantages have a mental health issue which has been diagnosed by a professional, while 92% of that group have a self-identified issue. [1]

Both Birmingham and Coventry were in the list of 20 Local Authorities with the highest prevalence of severe and multiple disadvantage, based on three national data sources for England, 2010/11.[2]

We also know that:

- 72% of male and 71% of female sentenced prisoners suffer from two or more mental disorders. This compares with 5% of men and 2% of women in the general population.[3]
- 62% of prisoners screen positive for personality disorder.[4]
- There are particularly high levels of co-morbidity amongst those with substance use issues.[5]

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[1] Fitzpatrick, S., Bramley, G., et al (2014) *Hard Edges: Mapping severe and multiple disadvantage – England* London: Lankelly Chase Foundation, p. 13.

[2] Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F. and Watkins, D., 2015. Hard Edges: Mapping severe and multiple disadvantage in England. London: Lankelly Chase Foundation.

[3] Revolving Doors Agency (2013) - Balancing Act: Addressing health inequalities among people in contact with the criminal justice system

4 *Stewart, D, The problems and needs of newly sentenced prisoners: results from a national survey, Ministry of Justice Research Series 16/08 (MOJ, 2008)*

5 Mental health and substance misuse, (2015) DrugScope, London

- 25% of women and 15% of men in prison reported symptoms indicative of psychosis, a far higher rate than in the broader population.

What are the barriers to accessing mental health service that are faced by offenders?

Thresholds

People facing multiple needs are often considered sub-threshold for secondary mental health services. These individuals often fall through gaps in services, despite their significant need. Addressed further below, the concept of thresholds can include both clinical thresholds (i.e. meeting a particular level of clinical need) and risk thresholds. There are diagnoses, such as personality disorders (some of which are associated with offending) where treatment outcomes are generally poorer (although still achievable[6]) and access to treatment can be particularly problematic.

While the establishment of the concept of parity esteem has been important, and both the Children & Young People's Mental Health & Wellbeing Taskforce and the Mental Health Taskforce have been effective in driving the agenda and raising the profile of mental health, the reality is that services have experienced significant real terms cuts[7] since 2010, and that the announcement of £1bn extra funding by 2020-21 will do little more than offset these. The announcement of the increased funding was accompanied with ambitious targets relevant to this review, including community-based crisis services in every area, earlier intervention, increased access to talking therapies and improved care for physical health needs.[8]

Dual diagnosis

There are continuing issues accessing treatment by offenders with a dual diagnosis of a mental ill health and substance misuse problems. Examining the patterns of mental health service access among probation clients in the East Midlands, Brooker et al (2011) [9] found barriers to service access including motivation. The review also highlighted two common obstacles to accessing treatment for coexisting substance misuse and mental ill health: unwillingness on the part of mental health services to treat psychiatric symptoms that may be associated with substance misuse, and failure to meet service thresholds.

There is limited evidence of the prevalence of coexisting substance misuse and mental ill health that is both recent and of high quality, but research published in 2001 suggests that comorbidity may be common rather than exceptional, with 44% (95% CI 38.1–49.9) of community mental health team (CMHT) patients reporting past-year problem drug use and/or harmful alcohol use; 75% (95% CI 68.2–80.2) of drug service and 85% of alcohol service clients (95% CI 74.2–93.1) had a past-year

[6] Bateman, A.W. and Fonagy, P., 2000. Effectiveness of psychotherapeutic treatment of personality disorder. The British Journal of Psychiatry, 177(2), pp.138-143.
[7] Mind press release, available at http://www.mind.org.uk/news-campaigns/news/mental-health-services-cut-by-8-per-cent/
[8] NHS England. 2016. Mental Health Five Year Forward View. London: Department of Health
[9] Brooker, C et al (2011) An Investigation into the Prevalence of Mental Health Disorder and Patterns of Health Service Access in a Probation Population. Lincoln: Criminal Justice and Health Research Group.

psychiatric disorder.[10] The most recent data published by Public Health England suggests that 20% of people in treatment for alcohol misuse are concurrently receiving treatment for mental ill health, the corresponding proportion for those in treatment for drug misuse being 21%. These figures are broadly comparable to areas within the West Midlands Combined Authority area. Time taken to access drug treatment in Birmingham (as the largest population centre in the West Midlands Combined Authority) is comparable to national figures, with 98% of new referrals starting treatment in under three weeks, and around 86% of alcohol referrals being seen as quickly, which is slightly worse than the national figure of 93%.

Compared with benchmark: Lower | Similar | Higher | Not compared

Indicator	Period	England	West Midlands region	Birmingham	Coventry	Dudley	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
Number in treatment at specialist drug misuse services	2014/15	206117	23417	6666	1263	1202	675	1209	948	690	2293	1794	777	1396	1419	1422	1663
Number in treatment at specialist alcohol misuse services	2014/15	89107	10399	2105	582	548	244	232	753	597	1405	783	444	278	903	640	885
Numbers in stop smoking services	2014/15	450582	56989	11110	5148	3394	525	4092	2701	1403	8829	3424	1812	2932	5094	1828	4697
Concurrent contact with mental health services and substance misuse services for drug misuse	2014/15	21.0	18.5	21.2	18.5	27.6	15.1	17.5	16.2	14.9	18.7	12.7	11.4	20.2	11.9	23.9	7.3
Concurrent contact with mental health services and substance misuse services for alcohol misuse	2014/15	20.0	23.4	36.2	19.7	31.6	11.9	25.3	15.2	15.1	18.5	18.2	9.9	24.1	16.2	35.9	10.8

Undiagnosed mental health need

Whilst the data is unknown, there is likely to be significant undiagnosed mental health need across the criminal justice population. A recent report from the Prisons and Probation Ombudsman Learning from PPO investigations: Prisoner mental health states:

> "As mental health problems frequently go unrecognised and undiagnosed, the prevalence of mental health issues found in PPO investigations is likely to be an under-representation." [11]

Issues relating to criminal justice system

We also know that the nature of the churn of criminal justice – particularly for short sentenced prisoners presents a barrier to treatment. Few short-sentence prisoners are able to access prison based mental health services – a 2010 study found that just one in 15 short-sentence prisoners reported receiving help for a mental health problem while in custody.[12]

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[10] Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., Barnes, T., Bench, C., Middleton, H., Wright, N. and Paterson, S., (2003). Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. The British Journal of Psychiatry, 183(4), pp.304-313.

[11] http://www.ppo.gov.uk/wp-content/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf

[12] National Audit Office (2010) Managing Offenders on Short Custodial Sentences. London: HMSO.

Finally, the relationship between Community Rehabilitation Companies and local health and mental health services should be clarified and supported. As we understand it, there appears to be no reporting requirements on CRCs in regard to mental health (CRS do have reporting requirements around accommodation, education and work). Ensuring there are good and effective links between these services and Transforming Rehabilitation again seems likely to improve outcomes as well as reduce duplication and, potentially, costs.

Low take-up of Mental Health Treatment Requirement as part of a Community Order

Offender management statistics indicate that between October 2014 and December 2015, out of 194,938 Community Orders imposed nationally, only 611 included a Mental Health Treatment Requirement (MHTR).[13] Between October-December 2014 and the corresponding period 12 months later, the number of Orders including MHTR had fallen by 32%, compared to an overall fall in the number of Orders of 16%.

The National Offender Management Service (NOMS) in guidance published in 2014 that this level, consistently below 1%, masks much higher levels of mental health need among probationers.[14] While this is somewhat speculative, discussions with stakeholders suggest that magistrates may be reluctant to impose requirements that may be difficult or impossible to fulfil, and that the general perception that mental health support is difficult to access may be influencing sentencing decisions.

To what extent is poor mental health resulting in demand within the criminal justice system?

Police time

While robust data, either local or national, is difficult to come by, it has been estimated that around 20% to 40% of police time is taken up by incidents involving mental ill health.[15] This clearly represents a significant financial impact in staff time and custody costs as well as an opportunity cost. It is important to note that not all of these incidents will relate to offences and offending. Many will involve police participation in a mental health crisis or emergency. The Crisis Care Concordat initiated under the previous government has made significant progress in improving the way that local areas respond to mental health crises, but the involvement of police officers may continue to be inevitable in some situations and circumstances.[16]

Wider costs

[13] Ministry of Justice. Offender management statistics quarterly: October to December 2015. Available at: https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2015

[14] National Offender Management Service. 2014. Mental Health Treatment Requirements – A Guide to Integrated Delivery. London.

[15] House of Commons Home Affairs Committee. 2015. Mental Health and Policing, p. 8, and MPS Corporate Development. 2013. Mental health and the police: understanding demand and incident management in the Metropolitan Police Service.

[16] See http://www.crisiscareconcordat.org.uk/

Under the coalition government, the Department of Health published an economic case for improving mental health care.[17] The Department found that mental ill health contributed 22.9% to the burden of disability at a cost of £105.2bn annually, or around 6% of GDP. The case includes evidence supportive of not only prompt interventions to mental health itself, but also addressing the social determinants and consequences of mental ill health. The report highlights the breadth as well as the scale of the costs, including 'costs to the NHS, the costs of reduced educational outcomes, reduced employment and productivity and increased crime, as well the wider impact on reduced quality of life'.

In recent years, attempts have been made to quantify the costs associated with mental ill health and multiple and complex needs. Unpublished analysis conducted by the Department for Communities and Local Government suggests that the avoidable costs associated with people with needs relating to mental health and offending is between £8,000 to £10,000 per person per year, rising to £10,000 to £12,000 for people with needs relating to mental health, offending and substance misuse.

A further key source for both costs and prevalence is *Hard Edges*.[18] While mental health was partially excluded due to data limitations, they found that on average 40% of those affected by one or more of homelessness, offending and substance misuse suffered from mental ill health. This report estimated that for combinations of substance misuse, homelessness and offending, costs ranged between approximately £10,000 to over £20,000 per person. As this analysis excluded mental ill health, these costs should be seen as representing the lower end of the range.

These costs are aggregate, although Hard Edges models costs broken down by category. One of the primary disincentives to commissioning effective services for people with mental health problems and multiple and complex needs is that the savings generated, while often substantial, infrequently accrue to the body commissioning the service. Devolution and the establishment of a combined authority should offer fresh opportunities to explore commissioning and funding arrangements with multiple stakeholders. An independent economic evaluation of three Making Every Adult Matter (MEAM) pilot areas suggests that while initially costs can increase (due to people who typically either are not engaged in services or who engage spasmodically and ineffectively with services engaging more closely), costs from year 2 can be brought down significantly.[19]

The associations between mental ill health are complex. Whether there is increased risk or not depends both on the type of offence being considered, and the diagnosis. [20] Far more people with mental ill health harm themselves than harm others. There is some evidence that comorbidity of substance misuse and some forms of mental ill health is associated with increased prevalence of

[17] Department of Health. 2012. No health without mental health: A cross Government mental health outcomes strategy for people of all ages Supporting document – The economic case for improving efficiency and quality in mental health

[18] Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F. and Watkins, D., 2015. Hard Edges: Mapping severe and multiple disadvantage in England. London: Lankelly Chase Foundation.

[19] Battrick et al. 2014. Evaluation of the MEAM pilots – Update on our findings. London: Pro Bono Economics

[20] Short V et al. 2012. Mental Illness, Personality Disorder and Violence: A Scoping Review. London: Offender Health Research Network

violence and/or self-harm.[21] [22] While mental ill health generally does not predispose an individual towards offending, a significant proportion of people in contact with the criminal justice system are affected by mental illness.

Psychiatric morbidity among the prison population is far higher than in the wider population, and the increasing number of people sentenced to prison means that there are more mentally unwell people in prison than ever before.[23] Short et al find evidence that this relates both to formally diagnosed and undiagnosed mental ill health: a large scale point prevalence survey conducted by the Office for National Statistics reported rates of 'probable psychosis' amongst men of between 4% in the sentenced and 10% in the remand population; for female prisoners was 14%, whereas within the general population, the rate of probable psychosis was 0.4%.[24]

Substance misuse has strong associations with offending. For drugs, this tends to be acquisitive crime. Drug misuse, particularly heroin misuse, may account for a substantial proportion – around a third – of all acquisitive crime, and the cost of crime committed by opiate and/or crack cocaine misusers who are not in treatment has been estimated to be around £26,000 per person per year.[25] The gradual fall in the number of heroin misusers[26] along with improved treatment penetration, retention and outcomes[27] are both credited with significant contributions to falls in offending over the last 20 years at individual and population levels.

Prevalence and need in the West Midlands Combined Authority area

Analysis of the most recent drug misuse prevalence data produced by Public Health England suggests that six of the seven authorities in the West Midlands Combined Authority area feature significantly higher prevalence of opiate and/or crack cocaine misuse, and injecting drug misuse, with Solihull being the exception.[28] Analysis of Hard Edges suggests that prevalence of 'SMD3' – that is, people affected by substance misuse, homelessness and offending, is significantly higher than the England average in Birmingham, Coventry, Walsall and Wolverhampton.[29] Analysis by the Health and Social Care Information Centre (HSCIC) suggests that the former West Midlands government region (which, as noted above, is not coterminous with the Combined Authority Area) has relatively low lifetime prevalence of formally diagnosed mental ill health (although it should be noted that people of Asian origin may generally be underrepresented in terms of diagnosis and prevalence

[21] Soyka, M., 2000. Substance misuse, psychiatric disorder and violent and disturbed behaviour. The British Journal of Psychiatry, 176(4), pp.345-350.
[22] Maremmani, A.G.I., Rugani, F., Bacciardi, S., Rovai, L., Pacini, M., Dell'Osso, L. and Maremmani, I., 2014. Does dual diagnosis affect violence and moderate/superficial self-harm in heroin addiction at treatment entry?. Journal of addiction medicine, 8(2), pp.116-122.
[23] Bradley K. 2009. The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System. London: Department of Health.
[24] Short, V., Lennox, C., Stevenson, C., Senior, J. and Shaw, J., 2012. Mental illness, personality disorder and violence: A scoping review. Manchester: Offender Health Research Network.
[25] Public Health England. 2014. Why Invest?
[26] Morgan M. 2014. The heroin epidemic of the 1980s and 1990s and its effect on crime trends - then and now: Technical Report. London: Home Office
[27] National Treatment Agency for Substance Misuse. 2008. Changes in offending following prescribing treatment for drug misuse.
[28] Available at http://www.nta.nhs.uk/facts-prevalence.aspx
[29] Hard Edges appendix

estimates).[30] As with other regions, the lifetime prevalence among women is substantially higher than for men.

Alcohol misuse is more closely associated with violent crime and offences relating to the night time economy. Public Health England has estimated the cost of alcohol-related crime to be around £11bn nationally, including almost half of all violent assaults. [31]

While substance misuse is a distinct issue and should be considered as such, the high prevalence of comorbidity referred to above suggests that offending related to substance misuse should be considered by the review. In both of the above examples, only costs directly relating to offending have been considered. There are, of course, very significant personal and social harms and costs associated with substance misuse that accrue elsewhere.

What initiatives are you aware of to promote and support work with offenders or troubled individuals across the UK? What do they cost and what is the evidence of their effectiveness?

Liaison and Diversion

Revolving Doors is part of the Offender Health Collaborative which has been commissioned by NHS England to support the roll out of mental health liaison and diversion (L&D) services across the country. As part of our work on the OHC we helped develop the operating model for liaison and diversion services. These services exist to identify offenders who have mental health, learning disability or substance misuse vulnerabilities when they first come into contact with the criminal justice system.

At this stage, we do not have data on effectiveness and cost effectiveness. However, substantial work has been undertaken in preparation of the Full Business Case on both the health and criminal justice outcomes, and their associated costs/benefits. This evidence, held by NHS England, and the DH-commissioned evaluation of L&D, may be of interest to the Commissioners. Likewise the DH evaluation of nine Street Triage schemes may be of interest. There is growing local evidence that shared decision-making between the police and mental health services (through street triage, home triage or control room response models) has positive impact on both police resource and individual health outcomes; for example, the reduction in the use of S.136 in Leicestershire.

The business case for L&D is based on the following anticipated benefits, including of relevance to this review: Improved access to treatment and support services; decreasing health inequalities; Improving health outcomes and improved experience of the health service (including through active participation in the treatment they receive). And for the health and social care systems:

- Improved efficiency as vulnerable people are identified earlier, thus reducing the likelihood that they will reach crisis-point

[30] Bridges S. 2014. HSE 2014: VOL 1 | CHAPTER 2: MENTAL HEALTH PROBLEMS. London: Health and Social Care Information Centre

[31] Public Health England. 2014. Why Invest?

- Improved information on vulnerable people and their conditions. These vulnerable people may be “frequent flyers” at A&E, in crisis mental health facilities, and may call on emergency accommodation services. Improved information will facilitate better planning of services across health, social care and the justice systems.

Integrated Offender Management

Integrated Offender Management (IOM) provides a strategic umbrella to bring together representatives from criminal justice agencies, the local authority, health services and the voluntary sector, to address locally determined offending priorities through targeted interventions. With no prescribed model for the delivery of IOM, local areas are given significant freedom regarding its implementation.

There is potential for this approach to reduce reoffending and improve outcomes. However, a recent inspection report found a mixed picture. Although there were individual cases where remarkable progress had been made, overall the proportion of sample that had been breached or reconvicted was 60%. Revolving Doors would like to see further robust evaluation of IOM schemes where they exist.

Peer led approaches & peer research

Although early in adoption and therefore lacking a strong evidence base, there is growing appreciation that peer-led approaches can produce better outcomes for individuals. Involving service users can improve the quality and impact of the services on offer; contributing to wider outcomes, including reducing re-offending; and enabling individual service users to build a new identity which supports their journey to desistance from crime.

Equally, peer researchers can offer unique insight. For example, people with their own experiences can: shape the research strategy so it is more meaningful to people it seeks to serve; frame the research questions to get more rich and relevant response; be relatable and authentic so interviewees feel comfortable sharing their views; draw on their own experience of how the ‘system’ works or doesn’t work for them and local context and be powerful advocates for the research findings.

We know that with support and skills, peer researchers can effectively feed these findings back to local services and commissioners. Revolving Doors’ model of peer research is based on the principles of Participatory Appraisal[32], which aims to empower people in local areas as agents of change within the research process and to ensure their effective participation in interpreting the evidence. We also draw on models from the field of health which identified different stages when the public can and should be engaged in commissioning decisions to have maximum impact.

[32] Participatory Appraisal has its roots in the community rural development movements of the 1970s and 80s, and has since been transferred to a range of other spheres including education and employment. The core principles of empowering participants and of ‘decentralization’ of data collection and analysis remain intact (Chambers, 1994).

We would urge the Commission to look at the wider impacts of service user involvement and how their insight can support the ongoing work of the West Midlands Combined Authority going forward.

Making Every Adult Matter (MEAM)

Referred to above, the MEAM pilots have attempted to work in an innovative and collaborative way to improve services and outcomes for people with multiple and complex needs. Many of the participants have offending histories, and both cause and face significant costs and harms. The evaluation of three pilot areas suggests that the approaches used have improved participant wellbeing and reduced costs. A number of areas (although none in the West Midlands Combined Authority area) have now adopted the MEAM approach.[33]

Revolving Doors evidence review of comprehensive services

Revolving Doors published in 2015 a review of the evidence of three interventions aimed at people with multiple and complex needs: Multisystemic Therapy, wraparound and the link worker model. This includes evidence both of the effectiveness and cost effectiveness of the interventions.[34]

What are the barriers to collaboration between public services, the private and third sector in mental health and criminal justice?

There is highly persuasive evidence that collaboration and coordination between services, or moves to broader service integration and reform are essential to improving outcomes for people with multiple and complex needs. Many will be in receipt of services from multiple agencies across several sectors in a variety of ways, from the mandated or effective to chaotic and irregular. As illustrated by the MEAM approach and the Revolving Doors evidence review, coordination and collaboration can take several forms, but appears to be effective and cost effective.

There are many potential barriers to collaboration. These can include lack of trust, lack of awareness of other services, legal barriers (such as some aspects of information sharing), organisational culture, silo working and commissioning, instability brought about by frequent retendering as well as time pressure and caseloads. This is by no means an exhaustive list.

With the increased role of outsourcing in public services, whether to the voluntary, social enterprise or private sectors, a relatively recent additional barrier may have been created – competition and commercial sensitivity. While there is extremely limited evidence, conversations with some service providers suggest that commercial interests can inhibit partnership working either temporarily, for example, when working with a potential competitor ahead of retendering or over the longer term.

Some of these barriers can be overcome through guidance, but a more direct approach may be necessary at times. This might include, for example, establishing formal service level agreements, or through commissioners facilitating case conferences or other forms of collaboration. Care should also be taken to design contracts, commission services and, devise payment models that encourage and incentivise partnership working, rather than stifling it. Consideration should also be given to

[33] See http://www.themeamapproach.org.uk/areas-delivering-now/

[34] Revolving Doors. 2015. Comprehensive Services for Complex Needs A summary of the evidence. London: Revolving Doors

how innovative practice can be incentivised through contract design and commissioning. There is some evidence that while commissioners can wield very substantial influence over providers, payment by results can sometimes limit innovation and introduce a 'safety first' culture.[35]

In the case of the current DWP Work Programme, for example, there are signs that the payment by results model chosen has been effective in focusing attention on the primary outcome of paid employment and has achieved performance comparable with previous programmes, but at a considerably lower cost.[36] Where it has demonstrably failed is with the harder to help group, including those with mental health problems and multiple and complex needs.[37] Addressing these deficiencies, improving collaboration between health and employment services, and others (and managing with a financial envelope around 80% smaller) will be essential for the West Midlands Combined Authority from 2017 onwards.

Conclusion

The above summarises some key evidence around multiple and complex needs. Other data exists that we do not have access to (for example, detailed data around substance misuse, treatment performance and criminal justice as well as local liaison and diversion activity); the individual authorities in the Combined Authority will have access. Revolving Doors would welcome the opportunity to review any such data with or on behalf of the review team, and would welcome any opportunity to discuss any of the matters raised in this submission in person.

For more information, or to discuss these issues with members of our National Service User Forum, please contact:

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[35] Webster R. 2016. Payment by Results: Lessons from the Literature. London
[36] National Audit Office. 2014. The Work Programme: Report by the Comptroller and Auditor General
[37] Riley T et al. 2014. Making the Work Programme work for ESA claimants. London: Centre for Economic and Social Inclusion.