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Successful Strategies for Working with Mentally Disordered Offenders within a Complex Multi-Agency Environment

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Background

In 2009 Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system was published (Bradley, 2009a). The government response, led by the Department of Health and Ministry of Justice, was to invest in Health and Criminal Justice Liaison and Diversion Schemes (CJLDs). Set against this, Stone (2003) stated that where multi-agency collaboration works well it is the most effective way of providing for the multiple and complex needs of offenders with mental health difficulties. However, he went on to add that such arrangements often collapse under the weight of festering personal differences rooted in the poor articulation of roles and responsibilities, restricted resources and professional and philosophical differences. How such issues were resolved will be addressed in this chapter.

With established mental health court assessment and diversion services in place since 1993 and a dedicated Mental Health Court in Brighton – the legacy of an earlier national 12 month pilot launched in 2009 (see Winstone and Pakes, 2010a; Pakes et al., 2010) – Sussex was well placed to deliver on this new initiative. The Sussex vision was initially borne out of the collaboration of leaders from Sussex Police and Surrey & Sussex Probation Trust. Each had experience of the earlier Sussex pilots and valued the outcomes achieved by criminal justice partners. The involvement of the local mental health provider Sussex Partnership Foundation Trust, local authority Community Safety partnerships in East Sussex, West Sussex and Brighton and Hove, and wider consultation with representatives from the voluntary and private sectors were all key to the early development of the scheme. A project manager was appointed

who brought additional experience having project managed the Mental Health Court pilot, Brighton and Stratford (East London), on behalf of Her Majesty's Courts and Tribunals Service (HMCTS).

Sussex was successful in securing funding to deliver dedicated police custody and court assessment and diversion services across the area. This followed the submission of a detailed business case, the result of the best efforts of the partnership. Governance was through a newly created Sussex Health and Criminal Justice Board (SHCJB), which was jointly chaired by the CEO of Surrey & Sussex Probation Trust and an Assistant Chief Constable from Sussex Police. Almost all of the funding was invested in dedicated criminal justice mental health nurses (CJLNs) (see also de Lacy, this volume). The nurses were, and continue to be, responsible for assessment and diversion activity across all police custody and court sites in Sussex. The key strategic objectives of the scheme are development of:

- Processes to assess individuals arriving in the police custody suites for multiple vulnerabilities including mental health, substance misuse (see Pycroft, this volume) and learning disability.
- Opportunities to divert the assessed individuals away from the criminal justice process and into relevant support services, if appropriate.
- Credible options to provide sentencers with alternatives to a sentence of imprisonment, where individuals either plead guilty or are convicted of an offence.

The alignment of liaison and diversion services to existing criminal justice partnership activities was seen as critical to its success. This approach was designed to eliminate duplication of effort and avoid silo working which we recognised as a risk for all concerned, to the detriment of service users. An alignment with existing Integrated Offender Management (IOM) arrangements offered the best fit.

IOM is an approach to working with groups of offenders promoted by the Home Office and the Ministry of Justice (MOJ). It aims to reduce both crime and reoffending by targeting offenders who are responsible for causing the most disruption to their communities through their criminal behaviour. IOM enables police, probation, youth offending services, local authorities and other agencies to pool resources and tackle the root causes of offending in an effective and efficient way. Criminal justice partners work together to address the behaviour of those found suitable for the scheme (there are strict selection criteria based on the number and type of offences committed), by applying appropriate sanctions for failure to comply with court orders or prison licenses as well as tailored interventions to address their needs. Interventions are linked to key offending pathways, which include employment and education,

accommodation, relationships, health and well-being, and attitudes and thinking skills (see McGuire, this volume; Göbbels, Thakker and Ward, this volume). The CJLD service objectives are similar to those of IOM, as are the available interventions. Governance of Sussex IOM schemes is through the Sussex Criminal Justice Board and local Reducing Reoffending Boards which are held in the counties of East and West Sussex and the Unitary Authority of Brighton and Hove. Membership of these Boards includes the key statutory criminal justice partners as well as representatives from Community Voluntary Organisations (CVOs). The Sussex Criminal Justice Liaison and Diversion (SCJLD) scheme was implemented in Brighton in April 2012 and went live in East and West Sussex on 2 July 2012.

The health and criminal justice partnership in Sussex were fortunate in being able to build on the foundations of previous approaches to the establishment of effective liaison and diversion arrangements. Although limited in scope, the existing service was well respected and had the confidence of sentencers and the broader criminal justice partnership. Our task was to put together a coherent framework that could inform national implementation whilst being sufficiently flexible to meet local need.

There were a number of considerations in the early stages of the project which are illustrated for ease of reference in the mind map below (Figure 13.1) and then in more detail under each section.

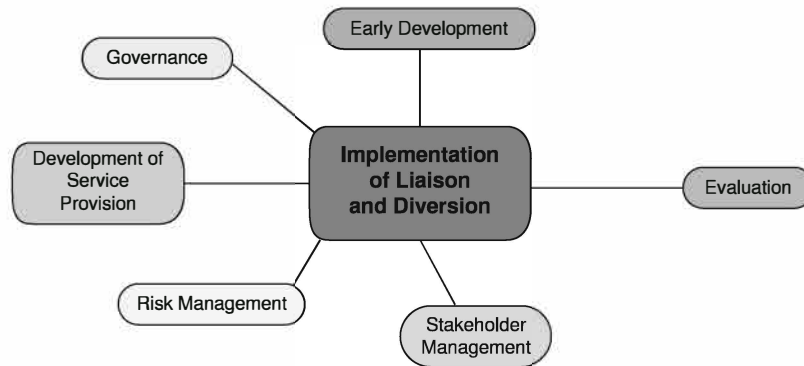


Figure 13.1 Mind map of early considerations

Governance of the service

Figure 13.2 shows the breadth of the task that we identified. One of the key challenges we encountered in working in a complex multi-agency environment

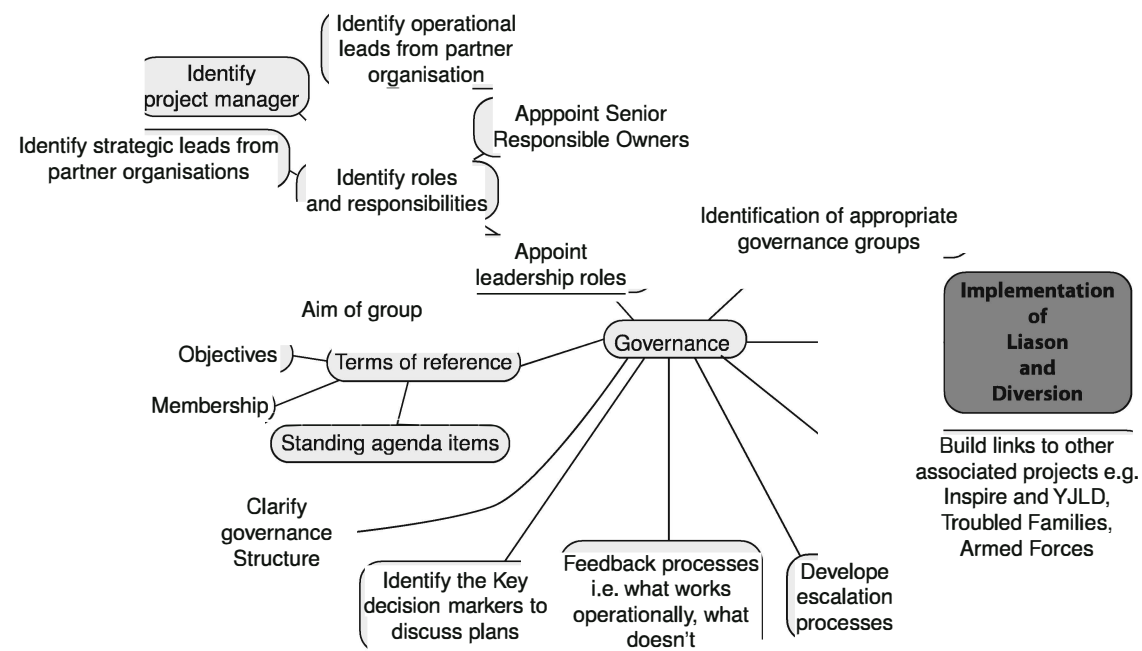


Figure 13.2 Breadth of identified task

was the need to establish clear and structured governance arrangements – see Figure 13.3 below. We recognised that clear lines of accountability, a shared ownership of service delivery, robust whilst measured monitoring arrangements, and a strong focus on shared outcomes were essential elements to success (Pakes and Winstone, 2009; Winstone and Pakes, 2010b).

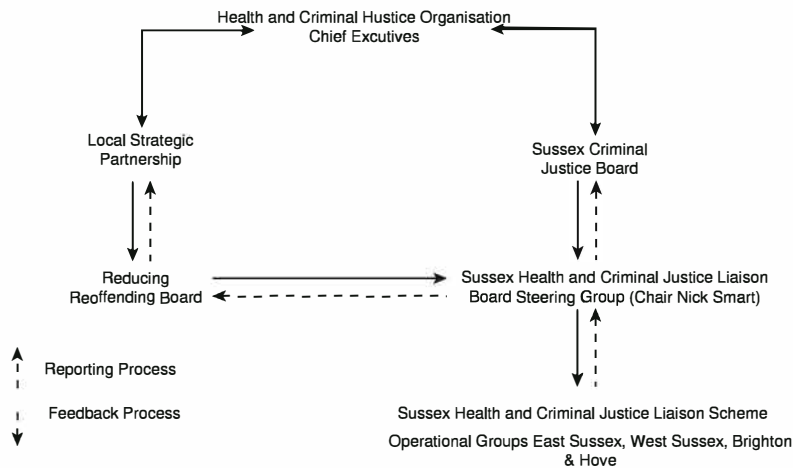


Figure 13.3 Complex multi-agency environment and emerging governance structures

Whilst governance arrangements were through a dedicated Steering Group, oversight of the scheme rested with the Sussex Criminal Justice Board (SCJB). This allowed any issues which were not capable of resolution by the Steering Group membership to be escalated to the SCJB. Initially there were two Senior Responsible Owners (SROs), from Sussex Police and Surrey & Sussex Probation Trust, who shared responsibility for the service, ensuring successful outcomes were achieved. This was supported by an experienced Project Manager, who had previously been responsible for the national Mental Health Court Pilot on behalf of HMCTS (see also Winstone and Pakes, 2010a). The professional relationships that developed alongside these formal structures were of equal importance in advancing the aims of the scheme, not least because when working well, these allowed for the informal resolution of issues without the need for escalation.

As time passed the governance arrangements transitioned into the existing criminal justice structures, utilising the SCJB to bring partners (across health and criminal justice including local authorities) together to share responsibility for the success of the service.

Whilst the current governance structure, in Figure 13.4 below, might look as if it has a solely criminal justice focus, the significant progress made in

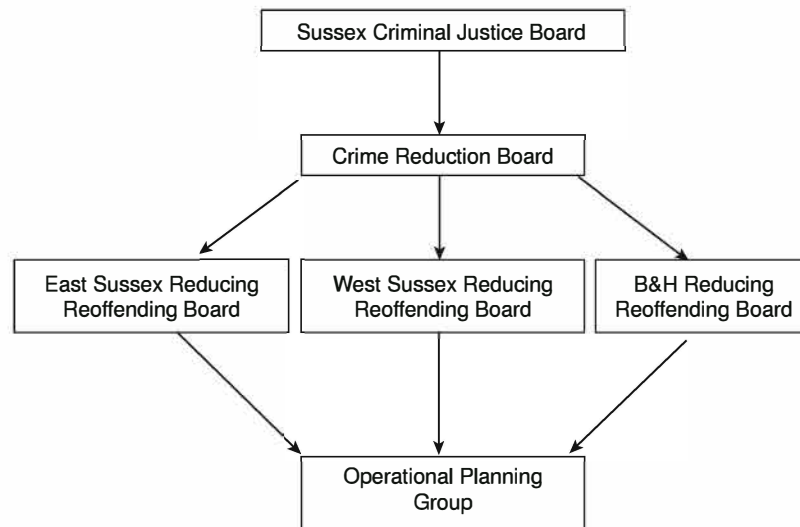


Figure 13.4 Current governance structures

Sussex in developing multi-agency relationships has meant that Sussex NHS Partnership Trust colleagues attend the meetings at all levels of the governance structure.

Each of the groups involved in the governance structure, whether original or current structures, had 'Terms of reference'. The definition of 'Terms of Reference' is:

Terms of reference describe the purpose and structure of a **project, committee, meeting, negotiation**, or any similar collection of people who have agreed to work together to accomplish a shared goal. (Wikipedia)

These terms of reference provided clarity around the objectives, roles and responsibilities of each of the groups including any potential overlaps that might need to be managed.

The terms of reference included:

1. **Aim of the group**, for example the Operational Groups in the original governance structure had the following aims: 'To take responsibility for operational delivery of the Sussex Liaison and Diversion Scheme on behalf of the Sussex Health and Criminal Justice Steering Group. To ensure the aims and objectives of the Liaison and Diversion scheme, as part of the wider Department of Health Liaison and Development network are achieved.'

2. **Core membership**, that is, the organisations and individuals involved in the group and the role that they play, for example, Chair. An example of the core membership of the original operational groups is set out below:
 - Sussex Partnership NHS Foundation Trust
 - CRI
 - Surrey & Sussex Probation Trust (Chair)
 - Addaction
 - Sussex Police
 - Youth Offending Service
 - Her Majesty's Courts and Tribunals Service (HMCTS)
 - Crown Prosecution Service
 - Local Authority
 - INSPIRE (Brighton)
3. **The core members** of the various governance groups changed as the project developed and were updated as and when new members were identified or the role of current members changed
4. **Objectives of the group** – in order that the group understood their shared purpose and the reason they had been asked to play a part in the governance of the liaison and diversion service.
5. **Standing agenda items** informed the purpose and function of the group and provided a framework for constructive discussion. Examples of standing agenda items included for example:
 - Updates from each hub
 - Case Studies
 - Review and update of Operational Policy
 - Lessons Learned
 - Data Review.

An early and arguably persistent challenge to the smooth running of the scheme was one of cultural difference. This was most evident between criminal justice and health colleagues (see Hean, Walsh and Hammick, this volume). In order to overcome this issue we had to make sure that there was a clarity about leadership roles across participating organisations and along with multi-agency 'buy-in' to the overall outcomes (see Winstone and Pakes, 2010b). Securing the attention and ownership of senior leaders from the key participating agencies was essential, as was an understanding of and respect for the differing cultures and values. There were times when we lost sight of shared goals and the resultant conflict and emergence of separate agendas had the potential to derail the project (Stone, 2003). Taking time to listen to and understand the differing perspectives of health and criminal justice organisations, whilst maintaining open and honest discussions, meant that potentially critical issues were resolved.

Organisational cultural issues aside, in delivering a project of this size and complexity there were inevitable tensions and areas of conflict within the partnership group. For example, it was necessary to incorporate national requirements into a locally developed service, which was designed to address local need. In this case there was a recognition that a compromise was required if the promised investment was to be secured. Senior leaders had to reconcile themselves to a shared vision and 'sell' this to other stakeholders. Throughout the life of the pilot, it was essential to maintain transparency and to manage expectations around deliverables. If these issues were to be resolved amicably time had to be dedicated to the development of trusting professional relationships, whilst consistent information had to be shared with all stakeholders in an accessible and timely way. By front-loading communications with the delivery of consistent messages and maintaining active participation with our stakeholder groups, we were able to drive key aspects of the project through ensuring major project milestones were fully met. Linking implementation into other key local priorities, for example IOM, further assisted in maintaining effective progress.

Critically, the context for delivery of the service was within a criminal justice environment. We faced the inevitable challenges of balancing the strong health values around choice and patient care with those of a criminal justice system which has a duty to hold individuals to account for their behaviour. The resultant and arguably healthy tensions surrounding this endured throughout the partnership.

Clarity about what success looked like for the scheme and for participating agencies was vital. For health there was an unequivocal focus on the needs of the individual and on improving their well-being whilst also (where consent was given), providing information to sentencers. This was shared by their criminal justice colleagues, who were equally clear that the information provided was helpful to managing the individuals' risk of harm and reoffending. Marrying the health goal with those of addressing criminal offending behaviour was required. Whilst it might seem obvious that in doing the former you will almost certainly achieve the latter, the reasons for commissioning the service do need to be recognised and understood by the offender themselves. Not least, because there is a financial cost to these interventions; a cost justified by the improvement in their well-being, a reduction in crime and that there are fewer victims, with the wider benefits of that to society as a whole.

All partners understood the need to support vulnerable offenders who struggle to access mainstream services in a different way to the 'norm'. Solutions to address this included the use of volunteers to support attendance and the broadest possible involvement of community and voluntary sector groups so that the diverse needs of offenders with complex needs could be met.

Escalation processes were developed to enable issues that could not be resolved at an operational level to be discussed by strategic leads. These processes were

clearly defined and included within the Operational Policy described later in the chapter.

Communication presented a significant challenge in sectors with differing cultures and the lack of a shared 'language'. Governance arrangements were designed to ensure that clear and consistent messages were released in a timely way across the partnership. However, despite a belief from the SROs that consistent messages were being delivered, the European Foundation for Quality Management (EFQM) assessment that was undertaken identified there was a lack of clarity and leadership in relation to the local Operational Groups. This resulted in an absence of local ownership of the project's aims, as members said they were unclear about their responsibilities for local delivery. This, in turn, meant there was an inability to engage local partners who had the potential to bring their additional resources to the scheme. The key challenge was identifying a lead for the operational groups who took proactive ownership and had an ability to provide the effective local leadership necessary to embed the scheme into the existing local health and criminal justice landscapes.

Alongside robust governance arrangements we identified that an Information Sharing Agreement was essential to the effective running of the scheme. Consultations took place with the various stakeholder organisations to ensure their organisational values and outcomes were reflected within the agreement. There was a significant level of compromise required along with a need to understand each others' cultures. Multi-agency events, together with a series of individual meetings with key delivery partners, formed part of these consultation arrangements. Training sessions and shadowing opportunities for operational staff were set up so that the proposed content could be tested and further honed. The Information Sharing Agreement was based on an existing similar agreement to which all members of SCJB were signatories. The resulting document was formally signed off by Chief Officers from Sussex Police, Surrey & Sussex Probation Trust and Sussex NHS Partnership Trust.

Early development

Figure 13.5 shows the way in which the early development of the scheme was conceptualised. The ambition for the scheme, from the outset, was to forge a strong alliance of interested partners across the sector for the delivery of a flexible, ageless service that responded to individual service user needs. At the outset of the project potential partners were brought together to build the initial business case into a project plan and in doing so to build the good relationships, respect and understanding which we recognised as essential to success. By applying project management principles we were able to complete a stock take of the current service, undertake a gap analysis and develop our understanding of the requirements for the new service.

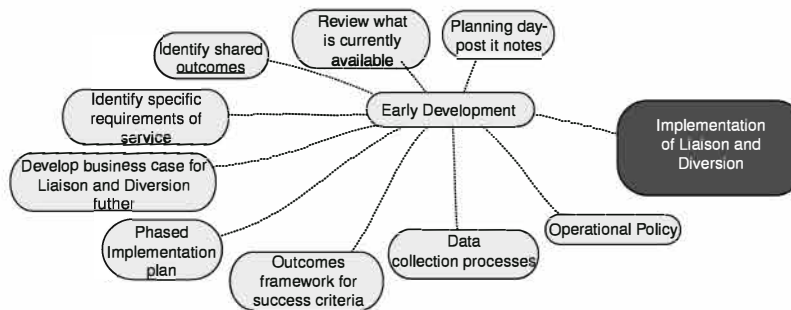


Figure 13.5 Early development of scheme

With a clear project plan in place we were able to monitor progress towards implementation. The main challenge was ensuring everyone owned their actions and made progress with them in between regular governance meetings. A common issue was that of reconciling the pull on senior resources to other projects and priorities. This was mitigated by constant contact, nudge / nagging and managing the tension between other priorities and in this way ensuring delivery was maintained in a timely way. Managing these different relationships required a variety of approaches. Sometimes it made sense to be direct; at other times a more circuitous route was needed and time had to be taken to acknowledge and empathise with the particular circumstances of the individual concerned. Knowing when and how to escalate was similarly key to the resolution of barriers to success.

By developing an understanding of the differing priorities, behaviours and personalities of key individuals, challenges were gradually overcome and the project plan kept on track without the need to escalate the majority of issues. Having the knowledge and confidence to flex individual ownership of actions as well as the actions themselves, whilst ensuring that the project remained on track for completion to the desired timescale was an important part of the project manager's role.

Development of service provision

Figure 13.6 illustrates the scoping of existing service provision to identify any gaps, and the likely fit with a new operating model was an early task for the project team. This led to discussions with the existing provider of services to all Sussex courts, Sussex Partnership Foundation Trust (SPFT). The Trust had a strong record of delivery of forensic health services locally and was keen to be involved with any extension of the service to include police custody suites. At the same time a judgement had to be made as to whether there were



Figure 13.6 Scoping of existing service provision

other service providers who were in a position to deliver the service from what would effectively be a standing start. Partners agreed that it was important to maintain service delivery whilst testing out new procedures and processes. This led to the extension of the existing Liaison and Diversion service delivered by SPFT.

In order to ensure that there was a true multi-agency approach to the service, SPFT joined the governance meetings and played an active role in the further development of the service. Criminal justice partners also played an active role in recruitment of the additional practitioners required for the service.

An immediate challenge to the development of the existing service was how best to prepare the staff group for a change to the focus and the scope of their roles. The volume and type of client and working pattern were both subject to change. Whilst familiar with a court setting staff had to have access to and to understand the different working arrangements in police custody suites. Throughout the project there were several change management processes undertaken as the service developed. Full mobilisation took time to achieve as SPFT had to increase their staffing capacity. This involved a lengthy recruitment process.

The existing forensic health team was employed on a pay band a grade higher than that the project team deemed appropriate for the revised service. We addressed this by conducting a review of the nursing roles and responsibilities attached to the service. In this way we were, over time, able to clarify a distinct role for the more experienced nurses who were on the higher banding. Notably that their role was extended to include a supervisory element.

All health practitioners received a bespoke induction programme, which included input from criminal justice agencies. Opportunities shadowing colleagues working in criminal justice agencies such as the police and probation service were linked to the programme. By offering similar shadowing

experiences to all key partners we were able to break down some of the myths surrounding different cultures and enable staff to build strong professional relationships and to see their own work in the context of outcomes for other agencies. Following successful negotiation with the police and HMCTS, arrangements for the co-location of health practitioners with police and probation colleagues was agreed. Health staff could access their own database from these sites whilst also being able to access information relevant to each assessment from their criminal justice colleagues. Whilst not every court or custody suite could easily provide office space for the practitioners, the project team recognised that provision of these facilities was essential to the success of the scheme. This was because staff were able to easily access the information they needed to do their job (Winstone and Pakes, 2010b) and because the close proximity of staff fostered good working relationships and information sharing.

Health practitioners required enhanced security clearance to be able to operate from police custody suites. While individual cases were being progressed (some took longer than others depending on their antecedent history) we decided to appoint a single point of contact whose role was to provide updates and challenge delays (see also de Lacy, this volume). In this way the team was able to fully function and a delay to implementing the service was avoided.

Prior to the formal launch of the new service we brought all the existing staff from health and criminal justice agencies together to 'walk through' plans for the new service. This was a Sussex-wide event held at a central training unit made available to us by Sussex Police. Over the course of a day staff worked through a mixed programme which included the exchange of information about different aspects of the service, group discussion and scenario planning. In this way the workforce were able to begin to develop working relationships and to gain a deeper understanding of the outcomes we were seeking to achieve.

The service specification clearly set out the problem we were seeking to address and what would be delivered. How this was to be delivered was incorporated into a new service role that was worked on by the group of agencies involved with the service, led by the Project Manager. The Operational Policy was key to ensuring that everyone involved understood their role and responsibilities and the inter-relationships between them. It was particularly important for the health practitioners to understand at what point referrals could be made to drug and alcohol workers. By working through interface issues with all participants we were able to ensure that the service users' experience of a potentially complicated and confusing system was as smooth as possible. We recognised that these interfaces were potential points of tension between agencies and that at each stage it was important to establish who was involved and why. It was equally important for us to develop a shared vision about what the service was there to do and what might be collectively achieved. The meetings

in which the Operational Policy was drafted proved to be a good place for these issues to be aired and different perspectives taken into account resulting in a final document that was fit for purpose.

We recognised scaling up a service to cover all Sussex courts and custody suites presented its own challenges. Sussex extends over 1,461 square miles. It is bounded to the west by Hampshire, to the north by Surrey and to the north-east and east by Kent. To the south lies the English Channel with the distance by road from the west to the eastern edges of the scheme being 65 miles, a journey time of just under two hours outside of summer coastal traffic. We were for the first time seeking to place staff on a permanent (rather than a call-out) basis in custody suites in Crawley, Chichester, Worthing, Eastbourne, Hastings and Brighton. This is a large geographical area with poor transport links other than along the coastal strip and north to London. We wanted our staffing plan to work in a way that ensured an equality of access to the service was in place and sustained. If it were to work the staffing plan needed to be flexible. We learned to our cost very early on that our failure to fully incorporate sick leave and annual leave into our business case had the effect of compromising some service delivery due to the lack of available staff.

Managing risks and issues

Figure 13.7 demonstrates the way in which the key aspects of the risk management plan were identified. Our project plan included a comprehensive register of risks to the project with example headings set out in Table 13.1 below. This was subject to regular review at the Steering Group. A more detailed example of a completed risk log can be found in Table 13.2 further on in this section. Our aim was to ensure that we were able to identify risks and could be confident that these were being managed effectively without the process being overly bureaucratic. Ownership of individual risks were allocated to the relevant agency who were asked to update on a regular basis

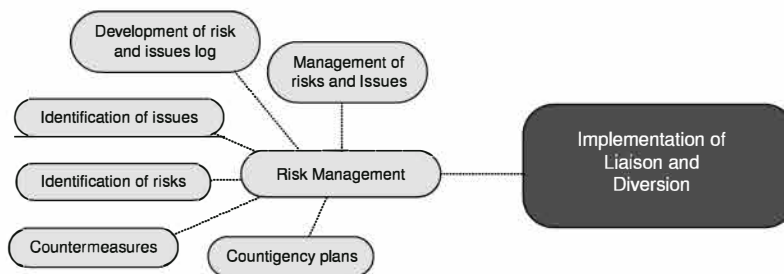


Figure 13.7 Key aspects of the risk management plan

Table 13.1 Comprehensive register of risks

Risk ID	Date Identified	Risk Description <i>Specify Risk / Cause(s) / Effect(s)</i>	Controls: In Place and Effective	Current		Score (IXL)	Controls: Underway or Planned <i>Include Date / Action Officer</i>	Next Review	Target		
				I	L				I	L	Date

The risk ID number enabled effective tracking of each of the risks with everyone being able to identify the risk through shorthand without lengthy description. The date identified was also a key piece of information to assist in monitoring the age of the risk.

Risks were described in terms of 'cause and effect', a clarity that was designed to enable everyone to understand risk both in terms of what it was, and the effect it would have if the risk came to fruition. There was considerable negotiation with partners until all were satisfied of the nature of the risk and that there was a commitment to it being managed. By way of example, one of the key early risks for the project included recruitment of practitioners to the liaison and diversion team. Recruitment itself presented a risk, and there was an additional risk attached to the clearance procedures required before practitioners could be allowed to work in a police custody setting.

Further, there was a need to manage elements of risk which inadvertently placed a spotlight on any one of the partner organisations who were delivering a key element of the service for example, focus on Sussex NHS Partnership Foundation Trust in delivering against the key performance indicators (KPIs). This needed to be balanced with ensuring that wider partnership KPIs were also identified and managed in terms of delivery. Controls or counter-measures in place included specific actions identified by partners to ensure the risk did not turn into 'a live issue'. For example, in the risk identified report (see Table 13.2 below) there are clear actions to mitigate these, which were then transferred over to the project plan to be monitored. Should additional actions emerge these were added to the Controls Underway or Planned column.

Risks were scored so that appropriate focus was given to priority areas in need of discussion. A red, amber, green (RAG) rating system was a visual way of highlighting the most important for close oversight by the Steering Group and the lead operational group. Risks that were rated green were monitored by the Project Manager to ensure that there was no change in the impact or likelihood scores and that progress was being made with resolution. Later columns in the log identify the target impact and likelihood scores which we anticipated could be achieved if and when the control actions were completed.

Table 13.2 Risks identified and action taken

Risk ID	Date Identified	Risk Description Specify Risk / Cause(s) / Effect(s)	Controls: In Place and Effective.	Current	Score		Controls: Underway or Planned. Include Date/Action Officer	Next Review	Target		Date
					L	(IXL)			I	L	
1	14/02/12	Risk Unable to provide robust information for the purposes of DOH evaluation Causes Lack of consistent information from CVO and statutory service providers. Quality of data collection within each organisation leads to inaccurate data being reported to DOH. Effect Funding is withdrawn by DOH and the project cannot continue into the 2nd year.	A data sharing protocol has been agreed across both health and criminal justice agencies and further work is being undertaken to identify specific details to support the protocol. A data quality action plan has been developed and significant improvements achieved. Action plan attached. A database is currently under development to significantly improve data collection processes.	3	2	6	Additional Actions: Contingency Discussion with OHRN to identify solutions to the issues being faced, understand whether other areas nationally having issues, have found solutions and to share lessons learned regarding data collection.	01/06/13	2	1	18/03/13

Risk type headings were designed to simplify what was in truth a very complex set of partnership arrangements. By keeping these simple the task could be more easily defined and ownership assigned accordingly. The headings used were Responsible Clinicians, environmental, process and evaluation, and below are some examples of the potential risks under each of the headings identified.

Responsible Clinicians

- Vetting nurses in advance of starting work.
 - Delays due to practitioners travelling significant distances between geographical sites.
- Insufficient staff available to cover annual leave and sick leave.

Environmental

- Private interview space available at Courts and Probation to enable practitioners to have confidential conversations with offenders requiring assessment.
- Access to police custody suites in the early stages whilst practitioners were building relationships with their Police colleagues.
- Parking at police custody suites/courts for practitioners.

Process

- Information sharing agreements in place to enable confidential health information to be shared with criminal justice partners.
- Reporting of Serious Untoward Incidents.
- Clarity of assessment processes and how relevant information would be shared with partners.

Evaluation

- Quality of data collection.
- Data collection processes taking up significant practitioners meaning they have less time to assessment individuals.
- Lack of clarity of evaluation requirements.

Essential to the risk management process was ensuring that highlighted risks were discussed fully in multi-agency meetings to gain consensus on the way forward. The logging and monitoring of the risks significantly supported development of the service.

Stakeholder Management

At the start of the project we drew up a map (Figure 13.8) of our stakeholders. This was a collaborative exercise involving all key partners. Through the

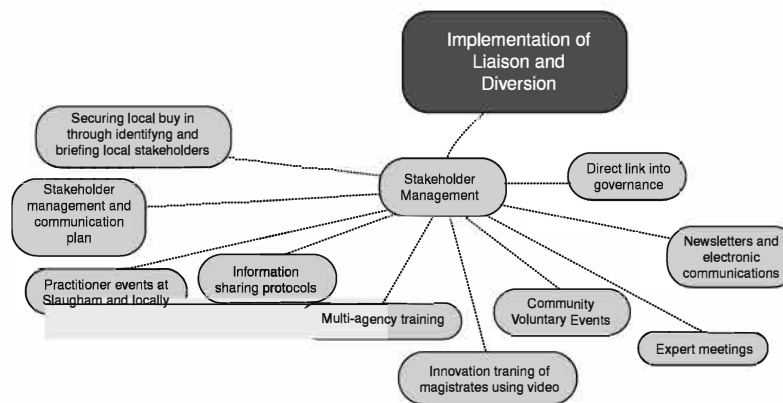


Figure 13.8 Map of stakeholders

stakeholder analysis we were able to identify local leaders who the service would be most likely to impact on. These included Directors of Public Health and Local Authority Chief Executive Officers for the three affected areas: East Sussex, West Sussex, and Brighton and Hove. Representatives from the project team held individual briefing sessions with these individuals who, seeing the benefits, were pleased to support the scheme. Similar discussions were held with police divisional commanders who were in a strong position to advise on the suitability or otherwise of our plans.

Key elements for consideration included:

- knowing who the stakeholders were
- identifying the appropriate stage to involve them
- assessing which stakeholders required active management, to be enlisted as necessary – those who needed to be kept satisfied and those who needed simply to be kept informed.

The easiest and most effective way to undertake the analysis was to plot stakeholders on the template shown below (Figure 13.9).

This created an instant visual map to enable both the steering group and the operational group leads to see immediately which stakeholders could influence the project along with those who had more of a stake in ensuring it was effectively managed and implemented.

In addition to the above map a stakeholder management plan was developed which included information as in Table 13.3.

The stakeholder management plan identified who would be communicated with, how and who was responsible for the communication.

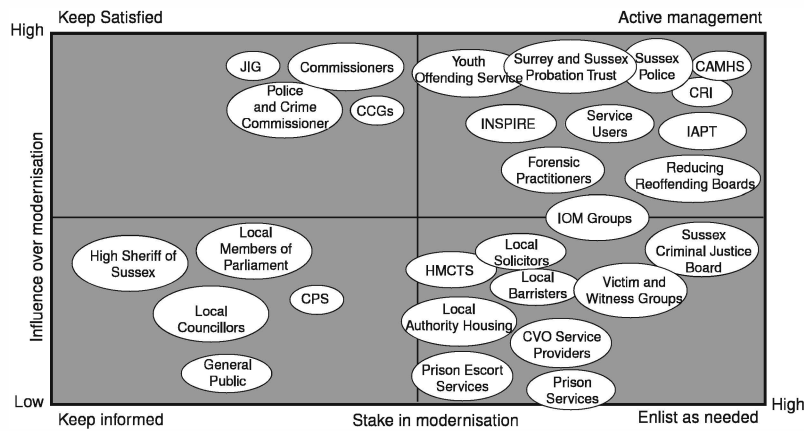


Figure 13.9 Map of stakeholders and proximal relationships

Table 13.3 Management stakeholder plan

Ref	Circulation	Information description	Information provider	Frequency	Method & media	Feedback method and media
	Local judiciary and magistracy group Local probation Local criminal justice boards Regional and area directors Presiding judges Defence solicitor Local court staff	Progress newsletter	Local co-coordinators	Monthly or as and when important information needs communicating	Email	Email

The earlier Mental Health Court evaluation conducted by Dr Jane Winstone and Dr Francis Pakes (2010a) identified that the following are core requirements of any future Mental Health Court:

- training and awareness events for practitioners and stakeholders
- identification of, and engagement with, local resources for signposting and referral of defendants.

These were included in the development of new Sussex Liaison and Diversion Service. The stakeholder management plan enabled events to be planned effectively and for us to engage with appropriate stakeholders. Our aim being to empower them to move forward and involve themselves with the service in whatever capacity seemed right.

A number of events were held ranging from provision of information to stakeholders, development workshops and training sessions for key operational staff to enable both the steering group and the operational development of the service. A good example of this is that a consultant psychiatrist from SPFT agreed to be videoed talking about forensic aspects of mental health with particular reference to severe and enduring mental health issues. We used this material in briefings with staff and a range of stakeholders including local magistrates.

Bespoke events were held with Community Voluntary Sector (CVS) colleagues to inform them of the services that were being developed and to invite them to consider how the services they offered might align with or contribute to the project. In this way we were able to identify and engage with those CV organisations that were willing and able to provide onward referral services for individuals assessed as having a specific need by the Liaison and Diversion practitioners.

Evaluation

In order to evaluate the effectiveness of any service or project, data collection is a core requirement, which in the case of this Liaison and Diversion service was complex due to the multi-agency nature (see Figure 13.10). Significant work needed to be undertaken initially in collaboration with the Department of Health to identify the core data requirements.

As a result of the Sussex history within the Mental Health Court pilot in 2009 significant elements of the data were already being collected by the service. However, there was a need to review information sharing policies that were in place to ensure they were fit for purpose.

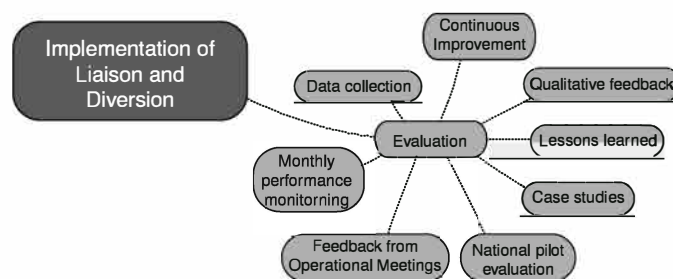


Figure 13.10 Data collection for evaluation

Additionally a review of the existing consent forms used by the service identified a need to ensure that the service user from whom data is being collected is aware that they were consenting to the sharing of data throughout their involvement with the service not just on the one occasion that they were asked to sign the consent form.

There were many challenges to overcome in securing the provision of robust and accurate data to evaluate the service which included:

- the format for data collection
- who would input the data being collected
- how could the accuracy of the data be monitored
- what mechanism needed to be in place to collect data automatically where possible
- who were the key people in each organisation to support the process
- what data was essential to monitor performance
- misrecording of information leading to significant amounts of data cleansing.

Key lessons learned included:

- The data needed to be input by someone other than the practitioners where possible to avoid unnecessary time being spent away from the key roles that the practitioners undertook within the service.
- Identifying ways of collecting the data from existing systems through the use of Information Technology (IT) could reduce the time involved within data collection.
- Ensuring the data is not being handled by several different organisations reduces the potential for inaccuracies/misrecording of data, for example in early development the data would be entered into a spreadsheet by the practitioners and then would need to be transferred over to another format for the purposes of the national evaluation. This led to inaccuracies which in turn took up extra resources in undertaking data cleansing. The more automated the data collection can be made the more accurate the data becomes.
- Having a multi-agency information sharing agreement was essential in supporting the evaluation process. This was also a joint Health and Criminal Justice information sharing policy which in itself supported the development of cross-cultural relationships between organisations.

A data report was produced in advance of each of the Steering Group and local Operational meetings to enable a review of performance and identification of potential issues to be addressed.

Another challenge, in terms of evaluation, is achieving robust and valuable service user feedback (see Pycroft and Green, this volume [PPI involvement]). There were many facets to be considered when we investigated securing feedback directly from the service users. For example, the timing of asking them for their feedback was crucial, as asking for it too soon might have unwittingly given the impression that the outcome of their pending case could be different if they gave positive feedback – an important ethical compliance issue. Leaving the request for feedback until after the case also presented a challenge as individuals simply wanted to move on. Various methods of collecting service user feedback were utilised, for instance, comment cards, invitations to organisations supporting service users to attend events, feedback from practitioners, and the later introduction of inviting service users to attend Operational Planning Group meetings.

An equally essential form of evaluating the service being provided is the completion of an Equality Impact Assessment (EIA) at regular intervals. Having the EIA completed and an action plan in place as a result supported the need to hard-wire equality into the service provision.

The ongoing evaluation supported continuous improvement and development of the service provision over a sustained period of time. This included regular identification of lessons learned through a number of forums including operational meetings and the regular steering group meeting which took place as part of the overall governance of the service. A lessons learned log was developed in a fairly simple format to make it easy for everyone to contribute to. The example format used is in Table 13.4 below.

Table 13.4 Lessons learned log

Issue	Lesson	Solution	Where identified
Lack of information about the local Community Voluntary Organisations available to support Diversion or Alternatives to Custody.	Need to find a centralised source of information that nurses can access to get a picture of the services available locally.	Find out if there is a CVO Forum Directory and/or web information available in each locality that nurses can access quickly and easily.	Slaughman Manor away day

Case studies were particularly valuable in being able assess the Liaison and Diversion service and the potential benefits that could be achieved as well as the lessons that could be learned. The practitioners developed case studies on a regular basis to enable discussions at the operational planning and steering

group meetings. Case studies were always anonymised and included information about the individual brought into the police custody suite, the alleged offence, the needs identified during the assessment and the outcome of the case including details of the sentence received where appropriate. Sufficient detail was included in each of the case studies to provide a clear picture of the process and context around the individual progressing through the criminal justice process.

In April 2014 the SCJLD scheme was renamed as the Police and Courts Liaison and Diversion Service (PCLDS) and became part of the national pathfinder programme (see NHS England, n.d.). As a result, the Sussex PCLDS will be subject to independent evaluation and will work with partners to provide data to the evaluators to enable national best practice to be further developed.

Conclusion

Government's acceptance of the recommendations contained in the Bradley Report and its willingness to invest in a number of national pilot schemes offered the established criminal justice partnership in Sussex a timely and valuable opportunity to expand the scope of the existing (rather limited) liaison and diversion services. For the first time an assessment and diversion service was available to all detained persons entering police custody, or transferring through for prosecution into their local court. Central to the success of the scheme was a shared vision which envisioned a seamless service across health and criminal justice organisations along with better health outcomes for people taken into police custody. Partners also saw wider benefits for society including confidence that individual needs were being met, offering the prospect that fewer might be sentenced to imprisonment with all the attendant costs and future risks to their health.

To secure the overall vision we needed to engage with key stakeholders on a regular basis. This meant sharing and defining how we would make it happen with a wider audience, which included community voluntary organisations. In this way we were able to sustain the necessary energy and momentum to deliver a project of this scale to a nationally determined timeframe and budget. Ours was a committed partnership of people from a number of local agencies, each of whom brought their different skills, experience and organisational cultures to the task at hand. An independent Project Manager was a further strength; ours came with previous experience of implementing a similar, though smaller-scale, scheme. Proven project management tools were utilised and combined with the necessary commitment, drive and use of interpersonal skills, notably: persuasion, influence, negotiation and judgment when necessary, to ensure commitment was maintained to the direction of travel.

Robust governance arrangements were secured by the early 'buy in' of senior leaders from our main delivery partners; police, probation, health (in its various forms) and HMCTS. These endured through the start-up and implementation phases before being successfully passed to the Sussex Criminal Justice Board and local Reducing Offending Boards where they remain to this day. Partnership decisions were informed by the collection and analysis of relevant data, which contributed to the overall national evaluation of the scheme.

Liaison and Diversion is now established in all Sussex Custody Suites and Courts. In addition to a health professional undertaking assessments, health outreach workers have been assigned to support individuals in accessing recommended treatment options. Health outreach workers or their equivalent are an essential component of any service for this vulnerable group (who typically struggle to access mainstream services). Liaison and Diversion remains aligned to partnership Integrated Offender Management arrangements. Sharing governance at a local (West Sussex, Brighton, East Sussex) level, and a pan-Sussex basis, ensures the energies and interest of both are maintained. Future joint commissioning of supportive interventions is also facilitated.

The Sussex journey to a seamless meaningful and effective Liaison and Diversion service continues. We will strive to improve on what we have developed to date. At a time when partners and structures will change (witness changes to probation services throughout 2013–2014), the lessons learned remain valid and are a solid foundation on which we will continue to build for the future.

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