Challenges at the interface of working between mental health services and criminal justice system

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Abstract

Background:
Provision of mental health reports for defendants in contact with the criminal justice system is problematic.

Aim
To explore factors that facilitate the flow of information on a defendant between the courts and the mental health services by:

- identifying key challenges to this information transfer from a court worker's perspective
- Exploring potential mismatches in the expectations held by the criminal justice system and the mental health services of the timeframes in which reports should be delivered.
- Exploring the perceived usefulness of reports

Method:
In part 1, questionnaires were distributed to a population of 2107 court workers. In part 2, monitoring forms were completed by court and health professionals on each report request made over a 7 month period.

Results:
Three key challenges to information transfer were identified:

- delays in report production
- perceived inadequacies in the report content and
- report funding

Perceived timelines with which respondents believed reports should be delivered varied and there is mismatch between the expectations of the two services on these timeframes. Perceptions on the usefulness of court reports also varied.

Conclusion
Poor interagency communications are caused by lack of a clear, shared protocol outlining agreed timelines, report content and lines of responsibility related to resource provision. Clear service level agreements are required between services to achieve clarity.

Declaration of interest.
none

Background

The prevalence of mental health issues in the prison population (Joint Prison Service and National Health Service Executive, 1999; Reed, 2003; Department of Health, 2007).
may partially be attributed to prisoners not being screened effectively for mental illness during earlier contact with the criminal justice system (CJS). For defendants to be effectively screened when passing through court, cooperation between the CJS and mental health services (MHS) is required. One dimension of this is the transfer of information on the mental health of the defendant between services in the form of written reports. Reports follow the assessment of the defendant by the MHS usually at the request of the court or other party. The report should enable the defendant to access the treatment they require and/or assist the sentencer in making an informed decision on an appropriate means of disposal. Reports range from written in depth psychiatric/forensic psychiatric reports provided by a psychiatrist in more serious cases to abbreviated, less detailed reports (screening or health and social circumstance (HSC) reports) for less severe conditions and provided by any mental health professional. Reports may also be made verbally to the court.

This dimension of interagency working has proved difficult in the past as might be expected of working between two public services so distinct in their expectations, priorities and working culture. In response to these difficulties, a partnership between the Criminal Justice System and The Mental Health Services was formed in a region of the SW of England and a pilot project was funded (South West Mental Health Assessment Pilot; 2007-2009) to implement a formal Service Level agreement (SLA) between the MHS and CJS to optimise the provision of reports.

To inform the nature of this SLA and evaluate its impact on interagency working, it was necessary to first identify the current challenges that face the assessment and advice provided to the CJS. Although it is widely accepted in practice that the provision of mental health assessment and report writing are unsatisfactory, there are few research studies that have explored this in any detail ((Vaughan *et al.*, 2003; Vaughan, 2004; Grondahl *et al.*, 2007). Vaughan, (2004), for example, evaluated a system in the courts in which abbreviated screening reports replaced unnecessary requests for lengthy and more time consuming full psychiatric reports. He found that introducing screening reports reduced the time spent by the defendant in the court and the number of adjournments necessary when waiting for reports to be completed. Similarly Grondahl *et al.* (2007) evaluated a scheme in which screening reports were introduced as a mechanism to determine if full forensic psychiatric reports were required. In this instance, the relevance of screening reports was evaluated, specifically the validity of the recommendations and the degree to which the recommendations of screening reports were followed. Findings showed that at the time of evaluation there was some lack of clarity around the purpose of screening reports and that the recommendations of the screening report were often not followed up.

The current paper builds on the findings of these authors. It aims to provide further evidence that will facilitate the flow of information on a defendant with a mental illness between the courts and the mental health services. One challenge to information transfer identified by Vaughan (2004) and Grondahl *et al.* (2007) is the delay in report writing. This has been addressed with varying success through the introduction of screening reports. The study presented in this paper will explore the challenges from the court's perspective, more widely to determine if delays are in fact the only issue that compromises information transfer.

The study also explores the nature of the delay in report writing in greater depth by testing the assumption that the perception of a delay, is not only a failure in service delivery by the MHS as suggested by Vaughan (2004), but may arise equally arise from a mismatch in the expectations held by the CJS and MHS of acceptable timeframes in which a report should be delivered.

Finally, the paper considers other potential mismatches in expectations between services,

specifically that surrounding the content and purpose of the report.

By addressing these three aims, the study will provide practitioners with evidence necessary to determine if screening reports are an appropriate and the only intervention necessary to improve information transfer between services.

Method

Prior to the implementation of the SLA, baseline data was collected in two streams (part 1 and part 2). Data were collected in Part 2 on expectations related to reports provision, through monitoring data on individual report requests over a fixed time period.

Part 1

To determine the range of challenges to information transfer between services, a questionnaire was distributed to court workers in all courts participating in the pilot project. These represented 7 magistrates' courts and 5 crown courts. All personnel in each court, likely to request reports from MHS, were selected (i.e., all judges, legal advisors, probation officers and defence lawyers). This represented a total population of 2107 court personnel (Table 1). A total of 479 questionnaires were returned representing a 22.5% response rate.

TABLE 1 HERE

The questionnaire was designed and piloted in conjunction with the project manager and steering group. These members represented both the health and court services. They formed a panel to review the validity of the questions based on their expertise and experience in both mental health and criminal justice services.

In open ended questions, respondents were asked to comment on:

* The adequacy of advice received from MHS?
* What is good about current provision?
* The limitations of current provision?
* How provision could be improved in the future?

A thematic analysis of these open responses was conducted. Only themes that relate specifically to interagency working are presented here.

Respondents were also asked to provide an overall rating (on a Likert scale of 1 to 5) of the usefulness of written reports provided by the MHS.

Part 2 Monitoring sheets

A second phase of data collection focussed on collecting information on each report request made by the CJS. A monitoring form template was designed that could be used to record key variables on each request for a court report. A supply of these forms was distributed to key contacts in each court participating in the project. The contact was requested to complete this form for every request for mental health report made of MHS and which was paid for directly by this court service. This precluded reports requested for and paid for by defence solicitors as well as reports paid for through legal aid. The data collection period was over a 7 month period. Forms were collected monthly from each contact. The form collected data from which information on perceived and actual delays in report writing could be assessed. These included the

- The type of reports requested
- When the report was requested
- When the completed report was expected to be delivered
- When the completed report was actually received

• The usefulness of the report

In a triangulation exercise to ensure that all report requests were recorded during the evaluation period, a similar and complementary monitoring form was distributed to key contacts in the mental health services from which courts in the study regularly requested reports. The form collected data on a range of variables including the:

• The type of report requested of the service by the courts
• When the report was requested
• When the completed report was expected to be delivered
• When the completed report was actually received

Monitoring sheets recorded defendants case and health record numbers (the latter anonymised) in order that duplicate cases recorded by both court and mental health service could be identified. The two monitoring forms were designed and piloted in conjunction with the pilot project manager and steering group. Forms were administered to all the court services participating in the pilot project and to MHS known to have contact with these courts. This comprised of two diversion/liaison services; two prison in reach teams, one community mental health ream, two medium secure units and one hospital psychiatric ward.

Sixty nine monitoring forms were collected in a 7 month period (see Table 2). The majority (65.2%; n=69) of requests recorded where for psychiatric or forensic psychiatric reports.

TABLE 2 HERE

Descriptive statistical data collected from Monitoring forms was processed using the package *SPSS 14.0.*

The monitoring sheets and questionnaires and associated electronic databases were stored securely in university offices under the custodianship of the report authors. Raw data in part 2 was only made available to the research team. Part 1 questionnaires were fully anonymised. Members of the court who provided completed monitoring sheets and the defendants associated with the record had the right to check the accuracy of data held about them and correct any errors.

Results:

Challenges that compromise information transfer.

The thematic analysis of open ended questions in part 1 of the study identified three key themes. As anticipated the delay in production of court reports was a predominant theme mentioned by respondents. However, two other central themes were raised namely:

• the content of the report itself
• the cost of the report

Each of these themes is described below.

*Theme 1: Delays in production of court report**s***

Delays in report writing was a strong and contentious issue reported by court personnel (178 respondents mention this theme). There was a clear consensus that length of time taken for reports to be returned by the MHS to the courts was unacceptable. Psychiatric reports were particularly problematic. Delays were attributed to a lack of mental health services or mental health service staff available to the court to perform assessment. Although, it was suggested that mental health professionals, responsible for compiling the reports, were not meeting court deadlines, court workers did recognize that delays may also be caused by a potential mismatches between the timescales expected by the court services and those recognised by the health services. Respondents also suggested that a lack of direct contact between individuals in the CJS and MHS, and reliance on an intermediary for interagency communication, was frustrating. They understood that delays could also be caused by the defendant not being known to the mental health service and that

defendants not attending assessment delayed procedures further.

Some respondents explored the impact of delays on the court processes itself with lengthy and multiple adjournments and delays in court proceedings as key outcomes. They indicated that the latter discouraged court personnel from requesting reports and that court cases often proceeded to sentencing without information on the mental health of the defendant as a result. They were aware that the latter posed a potential risk to the public and facilitated reoffending if defendant was released on bail. Participants were less vocal on the impact of delays on the defendant themselves but acknowledged that delays in court process subsequently impacted on the defendants and their potential treatment. Prolonged court processes meant defendants and their families remained unsupported, in stressed states, for longer than necessary. In some cases defendants remained on remand longer than a sentence commensurate with their offence. These were all outcomes respondents felt were caused by delays in report writing and which discouraged the court from requesting this advice.

Respondents offer a range of solutions to the perceived challenges of delays in report writing. They suggest an alternative fast track system, a service providing reports on the day or within the week that would reduce the demand for full reports. Short/brief reports (screening reports) or verbal reports were seen as means of attaining this. They also suggest that delays would be reduced if other professionals other than psychiatrists were able to provide these. The presence of a mental health professional dedicated to each court was also encouraged. The latter was a central theme discussed by respondents although the breadth of this theme is beyond the scope of this paper. Alternatively a named contact in MHS was seen as essential.

Attention to clear protocol was recommended with attention given to set timescales agreed by both the CJS and MHS. This should include the provision of a clear consent protocol to facilitate release of information by MHS to the CJS if required and the need for clear record keeping from the moment of arrest to disposal.

Theme 2 Content of report

The second theme identified in part 1 of the study related to the content of the report with 191 respondents mentioning this topic. Sentencers were clear about what they wanted a report to contain. They acknowledged that their own knowledge of mental health issues were insufficient and looked to reports to provide this information. They saw reports as resources through which they could better their understanding of the:

- case and the defendant
- up-to date account of the defendant's history, previous/current treatment
- relationship between the criminal behaviour and mental illness-culpability
- public risk
- treatment required and the effect of treatment on future offending
- Impact of sentence on defendant, a prison sentence in particular.
- moral issue of punishment versus treatment
- Wider range of sentencing options, especially in less severe cases.

There was wide variation in perceived quality/usefulness of reports, however, and whether reports in reality satisfied the above needs. Some court workers were very complimentary of reports, others less so. Those who felt reports to be useful, described these as clear and well written in lay language. Psychiatric reports were seen as particularly thorough. They valued the input of the expert in identifying the existence of a mental health issue in the defendant and felt provision was both professional and impartial. Reports were also seen as useful in differentiating mental illness from related drug and alcohol misuse.

For others, reports proved difficult to understand especially when using complex medical terminology.

Some reports were seen as vague, inconclusive with no concrete or practical advice relevant or useful as how best to proceed with defendant. The abbreviated reports (e.g. Health and social circumstance-HSC- and general practitioner reports) were described as superficial, identifying little more than the presence of a mental health issue. On the other hand, psychiatric reports could be longwinded and confusing. Sometimes the information within reports, and professional opinion expressed within them appeared conflicting.

Court workers were able to present clear strategies to improve the content of reports. They called for reports that more closely address the requirements of the court especially in terms of clear and concrete recommendations related to sentencing. They saw ready access to the report writer as desirable. A report writer on site, for example, would allow the court to clarify the report content if necessary.

Theme 3 Report Cost

A third key theme that arose from the data related to the cost of report provision. The cost of reports was described by 63 respondents, consensus being that funds available to courts to purchase reports were too low. Respondents identified a range of implications. Firstly, court personnel were loath to request reports because of their expense and some sentencers actively elected for prison as disposal as a cheaper alternative to obtaining a report. Secondly, the cost of the report was in itself inadequate to tempt psychiatrists to provide this service for the low fee offered. Some suggested that psychiatrists could charge more than suggested guidelines because of the shortage of psychiatrists willing to complete this function. Court workers reported that it was often unclear which service should pay for the report (legal aid versus the court, for example) and that the insufficient funds available to pay for reports meant that the court often refused to take responsibility for finding psychiatrists to conduct them.

Comparison of perceived and actual delays in report delivery

In part 2 the theme of delay was explored further. In monitoring forms sent to the courts, information was extracted on when the court worker expected the report to be returned and when the report was actually returned.

Expectation of when reports should be returned (as reported by court personnel)

Of 35 monitoring sheets returned by the courts, 29 recorded when the report was expected to be returned. Expectations varied widely and ranged from expectations that full reports be returned within 1 week (7 days) to more than three months (95 days). There was some consensus at around 6 -8weeks (42-56 days; 9 of the 21 reports) with an overall average (median) of 45 days (Figure 1).

Court personnel expected abbreviated HSC reports to be returned in a range from 1 week (7days) to 1 month (31 days); Some consensus was shown at between 1 and 2 weeks (7 to 14 days; 6 of the 7 reports) with a median of 10 days. The variation is less extreme than for full reports (Figure 1).

FIGURE 1 HERE

Actual time in which report returned (as reported by court personnel)

Court personnel were asked to record when reports were returned. This information was recorded for 24 of the 35 forms returned. The time in which reports were returned varied widely. For full reports this varied from just over 5 weeks (37days) to around 4 months (124days) with a median of 55.5 days (a figure higher than the 45 days in which reports were expected) (Figure 2). For HSC reports, the time of return ranged from 2 to 18 days, with a median of 10 days (the same as the expected return times).

FIGURE 2 HERE

Differences in time Between Court Expectations and reality

To determine whether there is potential for court personnel to be frustrated by a lack of timeliness in which reports are returned to courts, the expected and actual times in which reports are delivered are compared. A summary of reports that are delayed and those delivered in time or received earlier than expected is made in Table 3.

TABLE 3 HERE

A delay is defined as a negative mismatch between the expected time of delivery and the actual time of delivery. Of 22 comparisons, 10 delays are reported, 9 of which were delays in the return of full reports. Delays ranged from 30 days to 2 days. Twelve reports were delivered on time or earlier than expected (from same day delivery to 23 days earlier than expected);

Expectation of when reports should be returned (as reported by health personnel)
In monitoring forms sent to the mental health services, information was extracted on when the health professionals expected reports to be completed and when these were actually returned. There are data on 33 reports. Health workers expected reports to be returned between 0 and 262 days. On average (median), full reports are expected back at 55 days and HSC reports within 13 days (Figure 3).
FIGURE 3 HERE
Actual time in which report returned (as reported by health personnel)
There is information on actual dates of return in 29 monitoring sheets returned and times vary from the same day to 262 days. Health workers state that full reports are sent back in reality on average (median) in 43.5 days (Figure 4) (quicker than expected time of 55 days) and HSC reports are returned in 55 days (also quicker than anticipated).

FIGURE 4 HERE

Differences in time between health professionals' Expectations and reality

Comparison was made between data on 22 of the reports. Of these (Table 4), only 2 delays were reported (in the case of 1 full report and in 1 HSC report). From the perspective of health personnel, the majority of reports (90.9%) were recorded as being returned earlier than expected.

TABLE 4 HERE

Perceived usefulness of reports
The content of the reports were rated quantitatively by court workers in the questionnaire in part 1 of the study. Respondents were asked to rate on a 5point scale how useful they felt written reports to be generally. Most of the respondents rated the usefulness of written reports highly, i.e. 357 respondents rated the usefulness of the report as 1 or 2 (rating 1 being very useful) (77.5%; n=455) (Table 5).
TABLE 5 HERE

The usefulness of reports was confirmed in part 2 of the study, where court contacts were asked to rate the usefulness of the particular report they received (again on a scale of 1 to 5). All abbreviated HSC reports

were rated as either neutral (3 reports; rating 3) or less than useful (2 reports, rating 4) (Table 6). There was more variation in opinion when it came to the more detailed full psychiatric reports with 60% (12 reports; n=20) being rated as useful (ratings between 1 and 2). However, 30% of full reports (4 reports; n=20) were given neutral ratings on this scale (rating 3) and 10% (2 reports; n=20) were seen as not useful at all (rating 5).

TABLE 6 HERE

DISCUSSION

This study explored factors that facilitate the flow of information between the courts and the mental health services. From the perspective of court workers, three key challenges to this information transfer have been identified. These are the delays in receiving reports from the mental health services, the content of reports and the cost of the reports

Court personnel perceive there to be unacceptable delays when waiting for reports on the mental health of defendants. They see this as having a negative impact on both court process and the defendant themselves. By identifying delays as a key issue, and recognising that abbreviated reports such as screening reports are a way of alleviating these delays, respondents have confirmed findings of other studies nationally and internationally (Vaughn, 2004; Grondahl *et al,* 2007). They suggest other measures in addition to this that include a change in the division of labour surrounding report writing, moving towards a greater involvement of a wider range of mental health professionals. Recommendations also include a health professional in court or at least a named contact within the MHS and to whom assessments could be addressed. Clear protocols, in which joint expectations of appropriate timing are shared, are other ways respondents believe delays may be reduced. In general, therefore, respondents are looking towards improving and clarifying the systems of communication between services.

Although delays are reported as a key issue, actual delays in report writing may not be as wide spread as court workers perceive them to be. From the court workers' perspective, only just over half of full reports are delayed in reality and from the health services view point only 1 of 16 reports are delayed. The courts expect full reports to be returned on average within 45 days whereas health services expect these should be returned on average in 55 days. Furthermore, there is wide variation within the court responses themselves on what the expected time of report returns should be. The difference observed here between the expectations of health professionals and court workers points to a lack of consensus on the timeframes in which reports should be delivered. This may lead to the frustrations illustrated in the qualitative data presented in this article. There is a need to align expectations between services with clear and shared guidelines in which time frames are agreed and made transparent during interagency working and communications.

A failure of communication across services takes place in other ways at a number of levels. The study has shown that there is also a lack of shared expectation when it comes to the content of reports as well. Court workers list the information they required in a report to assist them in their decision making (e.g. an indication of the relationship between criminal behaviour and mental illness-, an understanding of public risk). Although reviews of reports lacked consensus and ratings of reports varied (See Table 5 and 6), it is suggested that not all reports provide the information the courts require. Variation in opinion suggests the quality and content of reports may differ from service to service and from one health professional to another. It may also occur because the purpose and scope of a psychiatric or other report is not understood equally across services and the feedback channels on the content of the report from the court back to the mental health service provider are not well developed.

As data suggests that reports are not standardised and that their quality may be a factor of the skill of the writer, a standardised reporting system with clear guidelines and training would be recommended for report writers to ensure that all reports are of the quality required. Report writers should also be reminded to consider the audience for whom they are writing in terms of both the content they provide and the

language they employ. Further research is also required to explore the shared understanding of the purpose of a court report by both services. An investigation of the current feedback mechanisms and ways of developing these is also required.

There is a potential conflict between the two challenges identified around delays and the content of the report. Some respondents suggest the increased use of abbreviated reports as a means of decreasing the number of requests for lengthier fuller psychiatric reports However, qualitative data and the ratings of HSC versus psychiatric reports (Table 6) suggest that respondents perceive more detailed reports as far more useful. Therefore, although it may be suggested that abbreviated reports be used as quick screening tool to pre-empt a full psychiatric report, the outcomes of such an intervention may not be wholly straightforward. This is confirmed by Grondahl *et al,* 2007 evaluation of screening reports who questioned the validity of the system and whether the use of screening reports was fully understood by court professionals. A further evaluation of the system in the UK context is now required.

Finally, the costs of reports and who pays for the report was the third challenge. Although extra financial resources may be a solution, clear communication on how financial resources will be managed and made available is likely to be equally if not more effective. Clarity on the level of fees and the key services to whom they will be directed could provide a sustainable and regular service. Block contracts pre agreed between CJS and MHS in which costs are predetermined and a set number of reports are purchased is one strategy. This would prevent the uncertainty around fees, failure by both services to seek out or provide reports and the difficulties in locating services to provide reports in sufficient time periods

Conclusion

The study has identified three challenges at the interface of interagency working between the mental health services and the criminal justice system. All three challenges (delays in report writing, the report content and the costs of reports) appear to be products of poor interagency communications and caused by a lack of a clear and shared protocol outlining the agreed timelines, court requirements and lines of responsibility related to resource provision. There is evidence that a mismatch in expectation around the content of reports and in expected time frames for report delivery may lead to frustrations that hinder interagency working. It is hoped that the Service level agreement drawn up as part of the South West Mental Health Assessment Pilot project will work towards achieving some clarity and improved systems that facilitate information transfer between services.

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LIST OF TABLES

Table 1: Distribution of returned questionnaires by type of court worker

Profession	Location	Number of questionnaires returned	% of total sample-
Judges	Crown courts	15	3.1
Legal Advisors	Magistrates' courts	24	5.0
Lawyers	Magistrates' and crown courts	33	6.9
Magistrates	Magistrates' and crown courts	379	79.1
Probation	Magistrates' and crown courts	20	4.2
TOTAL		479	100.0

Table 2: Type and number of reports requested by the courts over the evaluation period

	Frequency	Percent
psychiatric report	27	39.1
Forensic psychiatric report	18	26.1
health and social circumstance report	11	15.9
informal advice/oral report/other	5	7.2
clinical psychologist report	1	1.4
Type of report not specified	7	10.1
Total	69	100.0

Table 3: Differences in time Between Court Expectations and Reality

	Full reports	HSC reports	Total
Number of reports calculated as being delayed	9 (52.9%)	1 (20.0%)	10 (43.5%)
Number of reports calculated as being early or on time	8 (47.1%)	4 (80.0%)	12 (56.5%)
Total	17 (100%)	5 (100%)	22 (100%)

Table 4: Differences between the expected time of return and actual time in which reports are returned.

	Full report	HSC report	Total
Number of reports calculated as being delayed	1 (6.3%)	1 (16.7%)	2 (9.1%)
Number of reports calculated as being early or on time	15 (93.7%)	5 (83.3%)	20 (90.9%)
Total	16 (100%)	6(100%)	22 (100%)

Table 5: Perceived usefulness of written reports

	Frequency	Valid Percent
very useful (1)	191	42.0
2.00	166	36.5
3.00	75	16.5
4.00	14	3.1
not useful at all (5)	9	2.0

Table 6: Ratings by court personnel of the usefulness of full psychiatric versus HSC reports

	Full Psychiatric reports	HSC reports
very useful	6 (30%)	0
2.00	6 (30%)	0
3.00	6 (30%)	3 (60%)
4.00	0	2 (40%)
not very useful at all	2 (10%)	0
Total	20	5

[pic]
Figure 1: Box plot of days in which reports are expected to be returned to the court
[pic]
Figure 2: Box plot of actual times in which reports were returned to the court

[pic]
Figure 3: Box plot of times in which health personnel expect reports were returned to the court
*[pic]***Figure 4:** Box plot of times in which health personnel record reports to have actually been returned to the court

[pic]

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Professor A. Goode,
Chairman of the Editorial Board,
Medicine, Science and the Law,
c/o Barnsbury Publishing, PO Box 37389,
London N1 0WE.

Re: Resubmission of paper to Medicine, Science and the Law

Dear Professor Goode

Challenges at the interface of working between mental health services and the criminal justice system

Thank you for your comments on the above paper. They are very valid. We have addressed the issues the reviewers have made in the following ways:

Methodology and findings are somewhat confusing and it is difficult to following places. The paper would benefit form being shortened with important findings highlighted

I have clarified in the introduction what the key objectives of the study have been.

I have reworked the methodology to read more clearly and relate it back to the key objectives of the study, now stated in the introduction.

I have restructured the results section, to reflect the three key objectives, i.e. we present the findings pertaining to objective 1 and then followed by findings related to objective 2.

I have made the description of the qualitative findings of the study more succinct to draw out the key messages of the paper.

In the original version of the paper, I had added some quantitative data to substantiate 2 of the qualitative themes (report content and report delay). In hindsight, this has detracted from the key message and objectives of the paper. I have therefore removed data on the content of the report (i.e. presence of a recommendation in report) and reasons behind report delay (whether defendant is known to the mental health service). This has shortened the length of the paper and improved its clarity.

I am not sure if adding the quantitative data (table 5 and 6 reinforces or detracts from the argument. I have left this in for the time being but would welcome any advice here.

I have put in more illuminating table headings to aid clarification

I have reworked the discussion to highlight the key findings: i.e.

- Three key challenges to information sharing
- Mismatches in expectations on timeframes
- Mismatch in expectations on content report

Referencing is thin. On p5 reference is made to little research evidence; Implicit in this statement is the assumption that there is some-that being so, the sources should be quoted. This is an area that has been researched to some extent see Vaughan 2004 and Groundball 2007

In the background section I have introduced the work of Vaughan et al. 2003, Vaughan 2004 and Grondhal 2007 into the paper and have been explicit about how our research builds on their original findings.

On p5 the authors could perhaps comment on the low response rate and a figure should be given for the total number of questionnaires circulated. The whole paragraph needs rethinking as its purpose is not clear

I have clarified the sample description removing confusing detail around the representativeness of each personnel group within the sample. I have indicated the total population size to which questionnaires were administered and indicated the overall response rate.

Some points of grammar and style have been marked up on the manuscript
These corrections have been made.

I have clarified the labels of tables to make results clearer and corrected inconsistencies found in table format.

We feel the paper has benefited strongly from the comments made and would like to resubmit the paper as suggested by the Editor.

With best wishes

Sarah Hean

Days to return report

45

300

250

200

150

100

50

0

HSC reports

Psychiatric reports

Type of report

45

300.00

250.00

200.00

150.00

100.00

50.00

0.00

Days to return report

Psychiatric reports

Type of report

HSC reports

Type of report

Days to return report

100.00

80.00

60.00

40.00

20.00

0.00

16

12

1

Psychiatric reports

HSC reports

Type of report

Days to return report

120.00

100.00

80.00

60.00

40.00

20.00

0.00

12

Psychiatric reports

HSC reports