Exploring the potential for joint training between legal professionals in the Criminal Justice System and health and social care professionals in the Mental-Health Services

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Abstract

Effective screening of mentally-ill defendants in the criminal court system requires cooperation between legal professionals in the criminal justice system (CJS), and health and social care workers in the mental-health service (MHS). This interagency working, though, can be problematic, as recognised in the Bradley Inquiry that recommended joint training for MHS and CJS professionals. The aim of this study was to examine the experiences and attitudes of workers in the CJS and MHS to inform the development of relevant training. The method was a survey of mental health workers and legal professionals in the court. The results showed that showed both agencies were uncertain of their ability to work with the other and there is little training that supports them in this. Both recognized the importance of mentally-ill defendants being dealt with appropriately in court proceedings but acknowledged this is not achieved. There is a shared willingness to sympathise with defendants and a common lack of willingness to give a definite, unqualified response on the relationship between culpability, mental-illness and punishment. Views differ around defendants' threat to security. Findings suggest there is scope to develop interprofessional training programmes between the CJS and MHS to improve interagency working and eventually impact on the quality of defendants' lives. Recommendations are made on the type of joint training that could be provided.

Key words: Mental-health, criminal justice system, interprofessional training

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Introduction

The incidence of mental-illness within prisons in the United Kingdom (UK) is unacceptably high (Department of Health, 2007). To address this problem, screening, treatment and/or diversion of defendants to health and social care (HSC) services is required before prison, at the point of arrest or during court appearances (Staddon, 2009). Effective screening of mentally-ill defendants in the court system requires cooperation between professionals who work in the criminal justice system (CJS) and mental health service (MHS). This includes lawyers, judges and magistrates who are responsible for the legal aspects of the court appearance and mental-health nurses, psychiatrists, psychologists and social workers who are concerned with defendants' mental and social welfare. The screening process is ideally initiated by a court member who requests an assessment be conducted by the MHS, and the resultant written report about the defendant's mental-health is then shared between services, thus enabling defendants to access the treatment required and/or assisting the CJS in making informed decisions concerning the defendant. Challenges with interagency collaboration between the CJS and MHS, though, have been reported, such as report delays, unhelpful content, and inappropriate requests (Hean, Warr., Heaslip & Staddon 2009 a, b). These difficulties are not surprising, given the differences in expectations, priorities and culture amongst the two services.

Leaders in the MHS and CJS in South West England formed a partnership on a practice development project to address these difficulties in interagency working. The project, the SW Mental-Health Assessment Pilot (2007-2009) aimed to implement a formal Service Level Agreement (SLA) between the MHS and CJS to optimise the provision of mental-health reports. The SLA focused on improving interagency working, and resultant benefits for defendants included more timely completions of court cases, a reduction in adjournments and more timely access to treatment (Hean et al., 2009 a,b). In the course of conducting an external evaluation of this pilot project, the need for interprofessional education between members of the two agencies became apparent. The recent Bradley Inquiry (Department of Health, 2009) into the provision of mental health services for mentally-ill defendants, released at the time of the evaluation, confirmed this in their recommendation for joint training for MHS and CJS professionals. However, the Inquiry does not provide details about the nature of this training. For example, there is no indication if education should be multiprofessional (two or more professions learning side by side*)* or interprofessional (two or more professions learning with, from and about one another) (Freeth, Hammick, Koppel, Reeves & Barr, 2002, p6) . Nor does it consider outcomes of such joint training; for example, no distinction is drawn between participants learning about the role of the other professional group, learning to work with the other professional group, learning to substitute for the role of the other professional group or the provision of flexible career routes through which participants might cross from one professional group to the other (Finch, 2000).

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The wider remit of the external evaluation was to examine attitudes of MHS and CJS employees to the SLA and factors believed by the partnership to link to it. Data collected could also inform the development of interprofessional education initiatives. This paper reports on the following findings: the confidence of MHS and CJS professionals in working with the other agency, relevant training currently offered to professionals in these agencies, and attitudes and values that may underpin interactions during an interprofessional education activity.

The examination of attitudes and values is informed by theory that posits that group interactions, including interprofessional ones, are mediated by comparisons made by individuals between their own and other groups (Tajfel, Billig, Bundy & Flament., 1971; Stephan & Stephan, 1985). For example, the interaction between a psychiatrist and a legal advisor seeking information on a defendant may be enhanced if both parties perceive common ground between the two agencies or themselves as individuals. Ignorance of the other leads to assumptions that the groups are irreconcilably different. Acquired knowledge of the other group and perceived intergroup similarities create feelings of empathy and common identification (Pettigrew, 1997; Stephan & Stephan, 1985).

Method

The external evaluation of the SLA included a survey of MHS and CJS professionals in all courts and mental-health services participating in the SW Mental-Health Assessment Pilot prior to the implementation of the SLA. This consists of all courts and relevant mental health services serving the towns of Bristol, Bath, Southampton, Winchester, Portsmouth and the Isle of Wight.

Sample

The CJS sample consisted of seven magistrates and four crown courts. A questionnaire was mailed to all court personnel likely to request reports from MHS (judges, legal advisors, magistrates, probation officers and defence lawyers). This represented a population of 2107 court personnel (Table 1). A total of 479 completed questionnaires were returned (22.5% response rate). This low response can be attributed to a particularly poor response rate by probation officers (2.9%), which was likely due to limited access to this group in one region. The response rates for magistrates (379 of 1014 questionnaires distributed: (37.4%) and judges (16 of 27 questionnaire distributed: 59.3%) were high in comparison.

TABLE 1 HERE

The targeted MHS sample was all mental-health services with potential links with the courts during the pilot project. This included two liaison/diversion schemes (services populated by mental health professionals but based permanently in the court to promote interagency communication), two

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medium secure units (inpatient defendant care services for mentally ill offenders), and 24 community mental-health teams. A questionnaire was mailed to all MHS professionals likely to work with defendants (psychiatrists, nurses, social professionals and psychologists/psychotherapists). A total of 395 questionnaires were distributed and 146 were returned (36.9%) (Table 2). Although this response rate is typical of a postal survey, the low response rate may be a result of forensic clients having less prominence in the everyday work of some mental-health services in contrast to the prevalence of mentally-ill defendants in the work of CJS professionals.

TABLE 2 HERE

Data collection and analysis

Two service specific questionnaires were developed, each designed, piloted and validated in conjunction with the pilot project manager and steering group which had MHS and CJS representatives.

The CJS questionnaire consisted of a series of questions to assess confidence in dealing with the MHS and to examine respondents' value systems. To assess confidence dealing with MHS, respondents were asked to rate their ability to identify defendants with mental-health issues, their knowledge of how to get a defendant assessed, how often they needed mental-health advice about defendants but were unsure whom to approach, and to name a mental-health service to which they could refer defendants or from which they could obtain advice. Respondents were also asked to describe any training on dealing with mentally-ill defendants in which they had participated.

To explore respondents' value systems, CJS participants rated the importance of defendants' mental-health needs being dealt with appropriately in court proceedings, acceptability of mental-illness, normality of mental-illness, culpability of mentally-ill defendants, the dilemma of punishment versus rehabilitation and the danger posed by mentally-ill defendants.

The MHS questionnaire also consisted of a series of questions to assess confidence in dealing with the CJS and to examine respondents' value systems. To measure confidence in dealing with the CJS, respondents rated their knowledge of the CJS and ability to work with a defendant in contact with the CJS. They were also asked to describe any training they had received on how to deal with defendants. To explore respondents' value systems, MHS participants rated the importance that mental-health needs of defendants were met, normality of defendants, culpability of defendants, the dilemma of punishment versus rehabilitation and the danger posed by these defendants.

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In both questionnaires, respondents were asked to rate the frequency with which defendants were disposed of without adequate advice on mental-health and to describe the advantages/limitations of mental-health assessments as they were currently being done, and to provide suggestions for how their limitations could be addressed.

The majority of questions were structured with a 5 point Likert rating scale; the availability of a neutral category was perceived to be important given the complexity of the topic of mental health in the CJS. A small number of questions were open-ended. Statistical analysis used *SPSS 14.0.* A thematic analysis of open ended responses was conducted.

Research ethics approval was not required for this study because it was classified as a service evaluation. Nevertheless, the steering group monitored the ethical conduct of the evaluation in regards to confidentiality and anonymity.

Results

Confidence assessment

CJS professionals were unsure of their ability to identify defendants with mental-health issues, to obtain an assessment, and the frequency with which they have needed mental-health advice about a defendant but were unsure whom to approach. A median of 3 was recorded for all three statement responses. Only 56.1% of the sample could name a mental-health service available to which they could refer defendants or obtain advice if required (Table 3).

TABLE 3 HERE

This lack of confidence was also identified in the open-ended responses. Court professionals described their inability to identify a mental-illness and to seek advice on a defendant's condition. For example, they described difficulties identifying and dealing with conditions such as depression and anxiety. They also reported difficulties distinguishing mental-illness from alcohol abuse or learning difficulties, and dealing with the interplay amongst these conditions. This lack of knowledge challenged their ability to judge the impact of a custodial sentence or defendants' ability to comply with a community order. Professionals consequently had concerns about their ability to make an informed decision given the need to consider both treatment needs and punishment and public safety.

MHS professionals showed confidence in working with defendants in contact with the CJS (Median=2), but were less confident in their knowledge of the CJS itself (Median=3) (Table 4).

TABLE 4 HERE

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MHS professionals' responses to the open-ended questions also demonstrated a lack of knowledge of the CJS, which was attributed to their minimal contact with the CJS. Respondents described CJS professionals' poor understanding of mental-health services, which resulted in courts making unnecessary report requests and referrals to MHS, making inappropriate disposals in some instances, and failing to prosecute in others. Some felt there was an over emphasis on asking psychiatrists for advice when other HSC professionals were available.

Training

The majority of the CJS sample (78.9%) had never received training on dealing with mentally-ill defendants. Similarly, the majority of the MHS sample (67.8%) had never received training on how to support defendants in contact with the CJS.

The CJS professionals who had received such training described in-house training events, often part of wider training programmes (e.g. magistrate induction). Alternatively training was received in their professional role outside of the court services (e.g. by virtue of being teachers or HSC professionals in their normal day jobs)[1] Training was described as variable and limited. Informal learning took place through their own private reading or experience of working with mentally-ill defendants and the MHS. They provide little reference to interagency training in which shared opportunities to learn "with, from and about each other" occurred. An exception included a single mention of multi agency training. However, this occurred between police and magistrates with no mention of health service involvement. There was some evidence of health professionals delivering training to the CJS but this was usually members of liaison services wishing to raise service awareness.

CJS respondents requested training in the following areas: interpreting reports, information about MHS services available and when and how to access them, the nature of mental-illness and the impact on defendant offending behaviour, and appropriate means of disposal to deal with these types of cases.

MHS professionals who described training opportunities listed their own pre-qualifying training as a HSC professional. They occasionally also referred to participation in post qualification training. In-house training provided focussed upon dealing with violent behaviour. There was no evidence of the CJS running courses for the mental-health services. Some participants described informal learning initiatives through their work with defendants and participation in shadowing exercises within the courts. These opportunities were ad hoc with few formal opportunities for MHS staff to develop an understanding of CJS roles or processes. Mental-health professionals made little reference to interagency training but, where this did happen, it was quoted as being with police or other HSC

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services rather than with the court services. The MHS professionals asked for training on court processes in order to increase their understanding of CJS and felt MHS training for CJS professionals was required. They articulated the need for interprofessional training to facilitate understanding of each other's roles, provide opportunities to get to know court practitioners, and provide opportunities to produce joint guidelines

Acknowledging a common and important problem

MHS and CJS professionals both acknowledge that dealing with defendants with a mental-health issue is problematic with 43.7% of the CJS (median=2) and 45.2% (median=3) of the MHS sample stating defendants are disposed of without adequate advice on mental-health either very frequently or frequently . There was no significant difference between these ratings (Mann Whitney=23303.0; n=581; $p>0.05$).

Values. Both services agreed about the importance of mental-health issues of defendants being dealt with during court proceedings with 77.5% of CJS professionals (median=1; strongly agree) and 69.2% of MHS professionals (median=1; strongly agree) believing this to be very important. Despite both groups finding this important, the CJS find this more so than their MHS colleagues (Mann Whitney=28746.5; n=603; $p<0.05$).

CJS professionals strongly agree that mental-illness is like any other illness (median=1; strongly agree) and that anyone can suffer from this (median=1; strongly agree). There is agreement (although less strong) that mental-illness is common in the UK (median =2; agree) and that people with mental-illness could live in the community if supported (median=2; agree). Respondents take the middle ground when rating statements on issues of culpability and whether defendants be punished like other offenders (medians (and modes)=3 respectively; neither agree nor disagree). They believe that treatment should take priority over punishment (median=2; agree). There is little concern as to the danger mental ill defendants pose as respondents strongly disagreed with the statement that mentally-ill defendants were dangerous and should be avoided (Median=5; strongly disagree).

TABLE 5 HERE

MHS professionals strongly agree that mentally-ill defendants be treated with respect, that they share similar value systems and that rehabilitation is important (medians=1; strongly agree) but respondents again stick to the middle ground on issues of culpability, of safety when working with mentally-ill defendants and whether mentally-ill defendants need to be kept under strict observation (medians (and modes)=3; neither agree nor disagree).

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TABLE 6 HERE

Discussion

Court professionals do not rate well their abilities to identify a mental-health issue in defendants, to find advice on this and seek an assessment. Many are unable to name services from which they may obtain support. Their first concern, the ability to identify a mental-health issue, may be addressed through mental-health awareness programmes in which CJS professionals are trained to identify mental-health issues more effectively. Joint training is not an absolute requirement here and training could be delivered uniprofessionally or multiprofessionally, the latter bringing the range of legal professionals together (for the purposes of economies of scale) to learn about a particular condition. This would provide court professionals sufficient training to be able to substitute for the screening role traditionally played by the mental-health professional (Finch, 2000). A call for this type of training in the court context is reported elsewhere. In the United States, for example, Lamb, Weinberger & Gross (2004) called for police training in identifying mentally-ill defendants and Leslie, Young, Valent & Gudjonsson (2007), when exploring criminal barristers' perceptions of psychiatrists as expert witnesses, recommend training for legal professionals on the underlying scientific basis of psychology.

It could be argued, however, that mental health awareness programmes train CJS professionals to substitute to some degree for the screening role of mental-health professionals and that this training is a duplication of effort and costly. Joint training in these cases might be better directed at CJS concerns of how and from whom to get an assessment and concentrate less on giving the CJS professional specialist mental-health knowledge. Here, joint interprofessional training is a necessity, with legal professionals training alongside HSC professionals to learn to know about the role of the other agency and then how to work with these professionals (Finch, 2000).

Mental-health professionals are confident in dealing with mentally-ill defendants as individuals but lack confidence in working with the CJS as an agency. This reflects findings of Bush (2005) for example, who investigated forensic neuropsychological examinations in court and found that neuropsychologists perceive their court responsibilities as dramatically different from clinical work and that transition to forensic contexts is problematic. Further, in the UK, mental-health nurses in liaison schemes report themselves as outside the structures/supports of the health system, effectively transported into an alien culture. No consideration of interprofessional training is made in these studies. In others, however, there is evidence of interprofessional training bringing together professionals with whom mentally-ill defendants may well have contact (mental-health nurses, psychiatrists, social professionals and psychologists) (e.g., Barnes, Carpenter, & Dickinson., 2001; Priest, Robert, Dent, Blincoe, Lawton & Armstrong., 2008; Reeves, 2001 Whittington & Bell 2001).

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However, in these instances the input of court professionals (e.g. lawyers, magistrates, judges, probation officers, court ushers) remains absent.

Although low confidence ratings suggest training related to mental-health awareness or interagency working is essential, the vast majority of CJS professionals do not receive any training on this. For those that do, training is limited and seldom with professionals outside of the court environment. CJS respondents are clear that they want training in the area and are outcome/content orientated in the type of training wanted, e.g. they want guidance on appropriate means of disposal. This is in contrast to more process driven requests of MHS professionals, who have an awareness of the concept of interprofessional training and the need to develop an understanding of each others' working roles. Exposure to interprofessional education agendas driven by the UK Department of Health (Department of Health, 2001) may account for this. It is recommended that both the content and the processes suggested by CJS and MHS professionals be incorporated into their interprofessional training in the future.

In the development of common identification between CJS and MHS professionals in interprofessional training it is suggested that similarities in values between agencies be emphasized (Stephan & Stephan, 1985). Both agencies recognized the importance of mentally-ill defendants being dealt with appropriately in court proceedings but acknowledged that this is currently not achieved. The CJS professionals believe mental-illness is acceptable and normal. Similarly, MHS professionals believe in the respect and consideration defendants deserve. Although, there is a danger that these value statements are subject to self presentational influences, these professionals share compatible value systems. They are also unprepared to give a definite, unqualified response on the relationship between culpability, mental-illness and punishment. This may mean that they find these issues problematic. It may also mean that these statements are difficult to generalize when culpability and punishment depends on the nature and severity of both the crime and mental-illness. Either way, these are subjects with which both groups struggle and, along with other areas of commonality, are worth using as a starting point for interprofessional training.

In interprofessional training, it is equally important that differences between CJS and MHS professionals are demarcated. Seminal work by Tajfel et al. (1971) argues that in interactions between different social groups, members compare their own characteristics and those of the other group. They do so in order to establish their identity of self. It is important to this identity that they see themselves as distinctive from other groups on at least some characteristics. If they fail to find this distinctiveness, poor group interrelations may result (Branscombe, Ellemers, Spears & Doosje, 1999). So it is important that court professionals clearly distinguish their roles/characteristics from those assigned to mental-health professionals with whom they train and work. Similarly, mental-

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health professionals, especially those in the liaison services, need to be clear of the distinctive contribution they make. Although a full analysis of these perceived differences was beyond the scope of the data collected, there is some indication that not all perspectives are shared across services, specifically their views of the danger posed by the defendant. CJS professionals are confident of their safety in dealing with defendants. The MHS, on the other hand, are less confident, being ambivalent in their views on being on guard and keeping defendants under direct observation. These differences in opinion form a useful platform to explore the different experiences and worldviews represented within the two agencies and how these may impact on interagency working.

A key limitation to the study was the limited responses in certain groups within the sample. In the CJS sample, response rates were particularly low in probation and comparatively very high in the magistrates. Although magistrates do make up the majority of CJS workers in the overall population of court personnel surveyed (1014 magistrates in a population of 2010 - 48.1%), they are over represented in the sample (79.1% of personnel responding to survey). This means the opinions presented in this paper will be skewed towards the latter population group. Although open questions were informative, these address only superficially key interagency issues. These, and in fact the complex arena of mental health in the courts in general, deserve more in depth exploration, focused on interprofessional working/learning specifically. In-depth interview or focus group methods are recommended to further our understanding of the variety of professional cultures represented by respondents, their perceptions of barriers to working better together and/or developing and implementing interagency training and the outcomes this achieves.

Conclusion

This paper considered the view-points of MHS and CJS professionals who potentially work with mentally-ill defendants. A lack of confidence shown by the professionals and a lack of training in both agencies of the workings of the other agency supports Lord Bradley's call (Department of Health, 2009) for joint training and suggests there is scope to develop interprofessional training programmes to improve this confidence, develop services and eventually impact on the quality of defendants' lives. This lack of training in interagency working that is interprofessional in nature and that includes legal professionals from the CJS and HSC professionals learning alongside each other is notable in this study and the literature in general. It is recommended that interprofessional training supplement standard multi and uniprofessional mental-health awareness programmes. A starting point for such training is the obvious similarity in values between the two cultures and a common concern for the welfare of the defendant.

[1] Magistrates preside over courts where less serious public offences are heard and tried. They are employed on a part time basis and are lay members of the public. All trials will pass through the

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magistrates' court but more serious crimes will be referred on to Crown Courts presided over by legally trained judges.

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Table 1: Distribution of returned questionnaires by type of CJS professional

Profession	Questionnaires returned	% of total sample
Judges	16	3.3
Legal Advisors	24	5.0
Lawyers	33	6.9
Magistrates	379	79.1
Probation	24	5.0
Profession unidentified	3	0.6
TOTAL	479	100.0

Table 2: Distribution of returned questionnaires by type of MHS professional

Profession	Questionnaires returned	% of total sample
Psychiatrist	27	18.5
Nurse	68	46.6
Social Worker	18	12.3
Psychologist/Psychotherapist	7	4.8
Other	23	15.8
Total	143	97.9
Missing	3	2.1
Total	146	100.0

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Table 3: Distribution of CJS respondents' confidence ratings

Ability to identify a mentally-ill defendant		
	Frequency	**Percent**
Very high	27	5.6
2.00	149	31.1
3.00	191	39.9
4.00	86	18.0
Very low	18	3.8
Total	471	98.3
Missing	8	1.7
Total	479	100.0
Median	3	
Own knowledge of how to get an assessment for a mentally-ill defendant		
	Frequency	**Percent**
Extensive	21	4.4
2.00	142	29.6
3.00	146	30.5
4.00	94	19.6
Limited	67	14.0
Total	470	98.1
Missing	9	1.9
Total	479	100.0
Median	3	
Frequency with which needed mental-health advice about a defendant but unsure of whom to approach		
	Frequency	**Percent**
very frequently	31	6.5
2.00	117	24.4
3.00	131	27.3
4.00	110	23.0
Very seldom or never	79	16.5
Missing	11	2.3
Total	479	100.0
Median	3	

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Table 4: Distributions of MHS respondents' confidence ratings

Ability to work with mentally-ill defendants		
	Frequency	**Percent**
Very High	26	17.8
2	48	32.9
3	44	30.1
4	22	15.1
Very Low	6	4.1
Total	146	100.0
Median	2	
Knowledge of CJS		
	Frequency	**Percent**
Extensive	11	7.5
2	27	18.5
3	42	28.8
4	31	21.2
Limited	35	24.0
Total	146	100.0
Median	3	

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Table 5: Values of CJS professionals towards mentally-ill defendants

Item	Average rating (Median)	Measurement scale
IMPORTANCE		
The importance of defendants' mental-health needs being dealt with appropriately in court proceedings	1 (very important) (n=457)	Very important (1) to not very important at all (5)
ACCEPTABILITY OF MENTAL-ILLNESS		
Mental-illness is a medical condition like other illnesses"	1 (strongly agree) (n=476)	Strongly agree (1) to Strongly Disagree (5)
Anyone can suffer from mental-illness"	1 (strongly agree) (n=475)	
NORMALITY OF MENTAL-ILLNESS		
Mental-illnesses are very common in the UK population"	2 (agree) (n=471)	
People with mental disorders can live in the community, if they receive appropriate support"	2 (agree) (n=472)	
CULPABILITY		
People with mental-illness are to blame for the offences they commit	3 (neither agree nor disagree)(mode =3) (n=465)	
PUNISHMENT VS REHAB		
With mentally ill offenders, treatment should take priority over punishment	2 (agree) (n=468)	
Offenders with mental-illness should be punished like any other offender	3 (neither agree nor disagree) (mode=3) (n=470)	
DANGER		
People with mental-illness are dangerous and should be avoided	5 (strongly disagree) (n=473)	

(Corrigan, 2004; Hogue, Stephenson & Clark, 1993; Tanaka, 2003)

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Table 6: Values of MHS professionals regarding clients in contact with criminal justice system

Item	Average rating (Median)	Measurement scale
IMPORTANCE The importance that the mental health needs of defendants in contact with the CJS are met	1 (very important) (n=146) s	Very important (1) to Not very important at all (5)
NORMALITY		
Defendants in contact with the CJS should be treated with respect just like anyone else	1 (strongly agree) (n=146)	Strongly agree (1) to Strongly Disagree (5)
The values of the defendants in contact with the CJS are the same as the rest of us	1 (strongly agree) (n=139)	
CULPABILITY		
Defendants in contact with the CJS are victims of their circumstances	3 (neither agree nor disagree) (n=142)(mode =3)	
REHABILITATION		
Rehabilitation of defendants in contact with the CJS is a waste of time	5 (strongly disagree) (n=146)	
DANGER		
You have to be constantly on your guard with defendants in contact with the CJS	3 (neither agree nor disagree) (n=144)(mode=3)	
Defendants in contact with the CJS should be kept under strict observation	3 (neither agree nor disagree) (n=142) (mode=3)	

(Craig, 2005; Hogue et al., 1993)

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