**Evaluation of a liaison and diversion Court Mental Health Service for Defendants with Neurodevelopmental Disorders**

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# **Highlights**

# **Abstract**

## Aim

Neurodevelopmental disorders (ND) may present as neuropsychiatric problems as well as impairments of motor, cognitive, social and communication functioning. This study describes the introduction of a specialist service with expertise in ND into an existing court mental health liaison and diversion service to determine if the service would impact on the health needs or disposal outcomes of defendants.

## Methods

This study examined referrals of defendants with neurodevelopmental disorders over 30-months at a London Magistrates’ Court. The pre-existing Court Mental Health (CMH) service was enhanced to provide additional expertise known as the CMH+ND Service. We collected baseline data relating to mental disorder from the CMH Service using the existing minimum mental health service dataset, and compared this with data collected following the introduction of the CMH+ND Service.

## Results

We found rates of ND of 9.5% (n = 43) for the CMH service, and 9.5% (n = 79) for the CMHS+ND service. However, the rate of ADHD as a single diagnosis was 10% higher in the CMHS+ND service.

The CMH+ND service detected increased rates of depression compared with the CMH service in defendants with ND, with higher rates of depression in ND defendants in both iterations of the service. The rates of schizophrenia and delusional disorder increased in the ND group in the CMH+ND service, with significantly higher rates recorded for Non ND defendants across both the CMH and CMH+ND service. After first court appearance, there was a 10% reduction in custodial remands for defendants with ND who were seen by the CMH+ND service (34.2%, n = 25 in the CMH+ND service vs 43.8%, n = 14 in the CMH service).

## Conclusion

It is possible to successfully integrate practitioners with the expertise of neurodevelopmental disorders into existing liaison and diversion services. This service enhancement shows modest evidence of service effectiveness, including an increase in the detection of comorbid mental illness and a reduction in custodial remands. However, other models may also be useful and further work is now needed to understand whether an approach involving a cluster of Courts, as opposed to a single-site, can be effective for this group of defendants.

Keywords Attention Deficit and Hyperactive Disorder, Autism Spectrum Disorder, Court Mental Health Liaison and Diversion, Intellectual Disability, Neurodevelopmental Disorders

**What this paper addsEvaluation of a liaison and diversion Court Mental Health Service for Defendants with Neurodevelopmental Disorders**

1. **Introduction**

In England and Wales, Liaison and Diversion (L&D) Services operate in police stations and at court. Court L&D models have developed at different rates internationally and the first appeared over 100 years ago in Chicago, USA (Shepherd, 1923). They have to date, focused mainly on people who present with major mental illness (Andrew Forrester, Samele, Slade, Craig, & Valmaggia, 2017). Court L&D mental health models can be identified by their intended functions e.g., treatment, legal issues, liaison and diversion (James, 2006) or by the addition of a specialist service component (A. Forrester, Hopkin, Bryant, Slade, & Samele, 2020). The national L&D model in England and Wales was trialled in 2014, following the publication of Lord Bradley’s influential review of people with mental health needs or learning disabilities in the criminal justice system (Bradley, 2009). Prior to this, there had been a patchwork development and delivery of these services since the late 1980s, influenced by local interest (Srivastava, Forrester, Davies, & Nadkarni, 2013). The current operating model (N. England., 2019) includes the use of screening to identify specified vulnerabilities such as severe mental illness and to assess for levels of risk (Disley, 2016).

People with ND include those with intellectual disability (ID), autism spectrum disorders (ASD) and attention-deficit/hyperactivity disorder (ADHD) as described in DSM-5 (Association, 2013). They may present with neuropsychiatric problems, as well as impaired motor, cognitive, social and communication functioning. The provision of improvements across health, social care and the criminal justice system to support people with ND who are charged with offences, or have offended, are now part of an evolving international discussion (Hollomotz & Talbot, 2021),

Previous studies of ND amongst people attending courts have reviewed the prevalence of ID (Hayes, 1997; Vanny, Levy, Greenberg, & Hayes, 2009) or ASD (Kumagami, 2006) the characteristics of defendants (Vinkers, 2013) and ADHD symptom frequency (Andretta, 2013). Prevalence estimates from systematic reviews show wide variation. The rates for defendants with ND is reported between 10-20% (Marshall-Tate, Chaplin, McCarthy, & Grealish, 2020) with little data on the rates for defendants with ASD or ADHD within court settings. A lack of awareness and identification of people with ND within those providing L&D services means that this group may be missed, which will act to limit their participation in the court process (G. Gudjonsson, & Joyce, T., 2011; Søndenaa, 2010; Talbot, 2008). This group have poorer outcomes, and greater difficulties following court proceedings when compared with other defendants (Vanny et al., 2009). They also have an increased likelihood of recidivism and more restrictive or punitive sentencing (McCarthy et al., 2019; McCarthy et al., 2016) poorer mental and physical health (Hellenbach, Karatzias, & Brown, 2017) and potential miscarriages of justice through false confession (G. H. Gudjonsson & Sigurdsson, 1994).

The current national L&D model (N. England., 2019) describes a pathway for those with ID, however, there is little guidance on its implementation within existing L&D services and instead, this is largely left to local interpretation. However, implementation in some areas has highlighted some of the challenges for ID L&D services, including a lack of inclusion, challenges in identification and poor awareness of this group, underpinned by the inconsistent adapting of practices and information transfer partly due to the different agendas of agencies involved (Chadwick and Wesson, 2020). These challenges may go some way to explain why there has been little research to date regarding the identification of people with neurodevelopmental disorders (ND) within Court mental health services, with no explicit pathway for those with ASD and ADHD other than under the umbrella of ID specific pathways which may not be appropriate.

The key aim of this study was to integrate a specialist ND component (hereafter referred to as the CMH+ND Service) in parallel with an existing court mental health (CMH) L&D service, (hereafter referred to as the CMH Service) to address this service gap. This study describes the rates of mental disorder of court attendees and compares the CMH+ND Service with the previous CMH Service in one London Magistrates’ Court. It also describes the court pathway of the CMH+ND Service. In England and Wales, adult criminal cases begin in the Magistrates’ Court (‘the lower courts’) and more serious (‘indictable’) offences are sent to the Crown Court (‘the higher courts’)’

# **Methods**

## Enhancing the current Court Mental Health Service (CMH Service)

The CMH+ND Service was designed to complement the existing court CMH service as part of an integrated service response and it was modelled using national arrangements for service design in this area (N. England., 2019). In keeping with these national designs and policy, the ND component of the service was both multi-disciplinary and multi-agency (Bradley, 2009; Corston, 2007) and nurse-led.

The following roles specializing in ND were recruited to the CMH+ND Service :

* A Forensic Mental Health Practitioner (FMHP): a non-clinical post that provided assessment and therapeutic intervention of ND and a wider remit to increase awareness of the CMH+ND Service, assist with its implementation and ensure effective partnership working with other agencies and the officers of the court.
* A registered nurse (Learning Disability): to provide clinical assessment, review functional needs and consider reasonable adjustments to the court.
* A Consultant Forensic Psychiatrist with specialist accreditation in ND provided diagnostic assessments and professional reports for the court e.g., making clinical recommendations, reviewing fitness to plead (P. Brown, 2019; P Brown, 2019) and ability to effectively participate in the court process.
* A forensic psychologist to provide reports for the court and to conduct assessments including The Wechsler Adult Intelligence Scale Fourth Edition (WAIS-IV) (Drozdick, 2012) and Adaptive Behavior Assessment System Third Edition (ABAS-3) (Harrison, 2015) to measure intellectual and adaptive functioning.

 The service was provided on a full-time basis and also offered written or oral advice, evidence to the court, multi-disciplinary risk assessments (including self-harm and/or suicide & risk of future offending) and diagnosis of co-morbidities as required. The FMHP post was full time, whilst the psychologist attended court three days per week and the psychiatrist and nurse both worked one day a week. The CMH+ND service also provided information to support defendants about procedures and other agencies, or referred them to other clinical services, when this was required, running parallel to the existing CMH service.

## Procedure & Measures

The CMH+ND service was introduced in April 2017. The study followed a cohort from its introduction up to October 2019. A freedom of information (FoI) request[[1]](#footnote-1) revealed that there were 19, 422 Magistrates’ Court attendees during this period. Of these, 4.3% (829) had contact or were known to CMH+ND Service.

Baseline data from September 2015 and March 2017 were also collected before the introduction of the CMH+ND service. During this period, 452 attendees were referred to the CMH Service. Data were not available in this period for the total number of court attendees, disposal, needs and type of offences.

Data from the NHS minimum mental health data set (MDS) were used across both time frames and included a range of information - socio-demographics, mental health needs and vulnerabilities (e.g., risk of suicide and self-harm), alcohol and/or substance misuse, previous service use and decisions made at the first court appearance. This data is recorded directly by staff working in the CMH service. Recorded diagnostic information was collected using previous clinical records and reports, any screens or assessments undertaken by health care staff, and relevant criminal justice information, such as information regarding risk to self and/or others that is provided in the person escort records and interviewing the defendant.

Data were found not to be recorded in 12 cases for age, one case for gender and 44 cases for ethnicity. The FMHP records were used to input any missing diagnostic data to improve the completeness of the dataset. There was one missing case for anxiety and 8 missing cases for personality disorder in the CMH data and one missing case for anxiety in the CMH+ND group.

The referral process did not change with the introduction of the CMH+ND Service. Referrals came from several sources, including the CMH service, community mental health teams, General Practitioners, probation, solicitors, Magistrates’, prison mental health in-reach teams, court staff, police and Together a voluntary sector service.

## Ethical Considerations

This project was approved by the relevant local research clinical governance ethics committee at the South London and Maudsley NHS Foundation Trust (BDP/ROSE 200) as a service evaluation, which confirmed that full ethical approval was not necessary.

*2.4 Data Analysis*

Statistical analysis was undertaken using the Statistical Package for the Social Sciences

(SPSS v 25). Descriptive statistics were used to describe the data and chi-square tests used on categorical data to measure the differences between the two groups,

1. **Results**

Here, we firstly examine rates of ND including rates of mental disorder compared to the no-ND group for the whole period of the study.

Secondly, we look at the court pathway for the CMH+ND group of defendants and include offence type, pre-court decisions and disposal outcomes.

*3.1 Demographics*

On average the ND group were younger in both period of the study with the mean age of defendants with ND being 33 years old, (range 19-64 years) compared to 38 years old (range 18-76) for no-ND defendants. Female defendants with ND were significantly underrepresented with rates of 7.4%, (9), across both the CMH and CMHS+ND services compared to the rates of 19% for females with no-ND, (220), (*X2*, (1), = 10.281, p < .006).

*3.2 Overall Rates of ND*

The rates of recognised ND recorded during the time of the original CMH service were 9.5% (43) and 9.5% (79), for the CMHS+ND Service. In the CMHS +ND service, there were 13% fewer cases of comorbid ID and ASD and 3.5% of comorbid ID and ADHD. Rates were similar for comorbid cases of ADHD and ASD. The rate of ADHD as a single diagnosis was 10% higher in the CMH+ND Service. The rates of ND diagnoses are given in Table 1.

**Table 1 Rates of ND per individual defendant – Over whole study period from 2015 -2019**

|  |  |  |
| --- | --- | --- |
|  | CMH (before) n=43 | CMH+ND (after) n=79 |
| ASD  | 10, (23.3%)  | 22, (27.8%)  |
| ID  | 14, (32.6%)  | 29, (36.7%)  |
| ADHD  | 6, (14.0%)  | 19, (24.1%)  |
| ASD and ID. | 9, (20.9%)  | 2, (2.5%)  |
| ID and ADHD. | 2, (4.7%)  | 1, (1.3%)  |
| ASD and ADHD.  | 2, (4.7%)  | 4, (5.1%)  |
| All ND:ID-ASD and ADHD | 0, (0.0%)  | 2, (2.5%)  |

*3.3. Overall rates of Mental Disorder*

Specific disorders such as depression were recorded at higher rates for ND defendants in both phases, however, this did not reach significance. In contrast, schizophrenia and delusional disorders, alcohol and substance use were observed at much higher in the non-ND defendants during both phases of the study. In both phases, alcohol and substance disorders were recorded at much higher in the non-ND group.

**Table 2: Rates of identified mental disorder: Defendants with ND v No-ND (2015-2019)**

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|  |  |  |
| --- | --- | --- |
|  | During time of CMH Service  | During time of CMH+ND Service  |
|  | No ND (n=409)#398 - ## 335 | ND (n=43)# 41 - ##40 | X2 | No ND (n=750)#749. ##742 | ND (n=79)#78 |  |
| Schizophrenia delusional disorder | 151, (36.9%)  | 5, (11.6%) | *X*2 (1, *N* = 452) = 11.012, *p* < .001\* | 302 (40.3%)  | 22 (27.8%)  | *X*2 (1, *N* = 829) = 4.630, *p* < .031\* |
| Depression | 69, (16.9%)  | 11, (25.6%)  | *X*2 (1, *N* = 452) = 2.027 *p* < .155 | 236 (31.5%) | 33 (41.8%) | *X*2 (1, *N* = 829) = 3.463, *p* < .063 |
| Bipolar Affective Disorder | 35, (8.6%) | 1, (2.3%) | *X*2 (1, *N* = 452) = 2.61 *p* < .151 | 67 (8.9%) | 3 (3.8%) | *X*2 (1, *N* = 829) = 2.439, *p* < .118 |
| Anxiety Disorder1 | 30, (7.3%) | 4, (9.3%) | *X*2 (1, *N* = 452) = 216, p < .642 | 147 (19.6%) # | 13 (16.5%) | *X*2 (1, *N* = 828) = .461, *p* < .497 |
| Personality Disorder | 78, (19.6%) | 10, (23.3%) # | *X*2 (1, *N* = 439) = 1.060, p < .589 | 300 (40.0%) ## | 28 (35.4%) | *X*2 (1, *N* = 822) = .526, *p* < .458 |
| Alcohol Use | 178 (53.1%) | 12 (30.0%) ## | *X*2 (1, *N* = 375) = 7.651, *p* < .006\* | 354 (61.7%) # | 16 (20.3%) | *X*2 (1, *N* = 829) = .456, *p* < .499 |
| Substance Use | 215, (52.6%) | 13, (30.2%)  | *X*2 (1, *N* = 642) = 16.591, *p* < .001\* | 354 (61.7%)  | 28 (35.4%) | *X*2 (1, *N* = 642) = .621, *p* < .431 |

*3.4 Court Pathway during the time of the CMH+ND Service*

Here we examine the Pathway into the CMH+ND Service from police to the first appearance in court. This data was not available from the time when only the standard CMH service was in operation so not able to make a comparison.

## 3.4.1 Alleged offences for ND defendants within the CMHS+ND Service

Violence against the person and breach of court order were the most frequent charges for both ND and no-ND defendants and occurred at similar rates. Although not significant, defendants with ND had higher rates of being accused of possession of an offensive weapon, burglary, sex offences, harassment and robbery than defendants with no ND.

## 3.4.2 Pre court Police Decision within the CMH+ND Service (n =695, No ND 620 v 75 ND)

In the CMHS+ND Service, ND defendants were significantly more likely to have been bailed to appear in court (19), (25.3%), than those with no-ND (85), (13.7%).

## 3.4.3 Referral route to CMH+ND Service

Referrals of defendants with ND came from several sources, including the FMHP 51.9% (41) probation 16.5% (13), solicitor 8.9% (7), health agencies 7.6% (6), Magistrates’ 3.8% (3) and court detention staff, 6.3% (5). Other referral sources included prison, court detention staff, police, voluntary services, and self or family referrals. For no-ND defendants the referrals were also predominantly from the FMHP 56.1% (421), then the probation service and solicitor, both 9.9%, (74 & 73) the judiciary and health service, both 7.5% (56). Court detention staff were involved less in the referral of no-ND defendants 1.7%, (13).

## 3.4.4 Disposal outcomes for those defendants with ND versus no ND

After the first court appearance, custodial remand for defendants with ND was 34.2% (25), which was a 10% decrease in custodial remands compared to 43.8% (14) in the CMH cohort. Remand to hospital was uncommon at the first appearance. None of the ND group was remanded to hospital and only evident in defendants with no-ND at a rate of 1.6% (11) in the CMH+ND cohort.

1. **Discussion**

The introduction of the first dedicated CMH service with expertise in ND demonstrated that such specialist services can successfully integrate with existing liaison and diversion services, as has previously been achieved for other groups of vulnerable defendants (A. Forrester et al., 2020). This CMH+ND Service provided a multi-sector approach (including health and voluntary sector services) in line with current national guidance and policy (Bradley, 2009; Durcan, Saunders, Gadsby, & Hazard, 2014).

Defendants with ND across both services were significantly younger, while women were less likely than others to be diagnosed with an ND. This may be due to several factors but it is well recognised that ND such as ASD is diagnosed less in women (Gould, 2017). Diagnosing a specific ND in adults is complex and is made more difficult amongst court defendants. This is due to several factors including time limitations at court to undertake assessments in Court setting for this group of defendants who have high rates of comorbidity with other ND, mental disorders and substance and alcohol misuse disorders so involves a complex diagnostic assessment. Although the same rate of ND (9.5%) was found in both the enhanced and standard service, there were fewer diagnoses of comorbid NDs by the CMH+ND Service. This has implications for treatment especially for defendants with ADHD which was more likely to be recognised as a single condition by the specialist service so reducing the risk of potential misdiagnosis of a comorbid ND which may further complicate any intervention strategy.

The CMH+ND Service detected increased rates of mental illness in the ND defendants’ group when compared to the CMH service although this was not a significant finding. This may of course reflect a true increase in the prevalence of these disorders in this group over time. It may also however reflect improved detection of mental disorders through the expertise provided by the CMH+NT Service as the need for specialist services is well recognised for this group (Bouras & Holt, 2004; Eddie Chaplin, O’Hara, Holt, & Bouras, 2009), although less well understood for other ND such as ASD (E Chaplin, Spain, & McCarthy, 2019; Kelbrick & Radley, 2013). This study, therefore, suggests that the use of expertise in ND within liaison and diversion services may assist with the early identification of unmet health needs. This has many implications for earlier detection of mental illness in this vulnerable group of defendants leading to signposting and onward referral to community-based mental health services much earlier and ultimately improved health outcomes.

*4.1 Pathways*

In terms of the pathway, Pre-Court the ND Group were more likely to be bailed and once at court the referral pathway into CMH+ND Service had slightly higher rates of referrals from Probation & Court Staff, suggesting that evidence of successful integration of the new service. However, this needs to be interpreted with caution in the absence of prior referral data, patterns and trends before the study period. Disposals of people with developmental disorders have recently been included in new guidance for sentencing. A least restrictive approach is supported following appropriate consideration of factors such as risk, culpability and ongoing need for treatment (A. Forrester et al., 2020). Poor understanding of ND could lead to an increased likelihood of being remanded to prison, or of inappropriate sentencing, however, a key benefit of any future CMH+ND Service is that they are likely to assist in providing clinical advice to the Court to inform sentencing or disposals so that they are in keeping with up-to-date sentencing guidelines.

The 10% decrease in custodial remands following the introduction of the CMH+ND Service indicates that it may have had an important role in reducing custodial remands, thereby meeting a key policy objective (Bradley, 2009). This area requires further investigation to see whether specialist ND service models correlates with fewer restrictive decisions concerning disposal and sentencing. Another factor in the decision by the court are existing local service infrastructures. In many areas, there is a lack of availability of well-structured community services equipped with the expertise to provide appropriate services for defendants with ND. This is despite national policy to develop community based forensic services for those with ND (N. H. S. N. England., 2015).

*4.2 Limitations*

This study was able to describe changes associated with the introduction of the CMH+ND Service, however, a larger study with an experimental design would be required to demonstrate service effectiveness. As such, this study should be seen as preliminary feasibility work, the forerunner to future research in this area. This current paper does not offer a qualitative perspective, which would help to understand the experiences of staff and defendants and offer further context to the data.

Examining and developing the dataset, showed that not all variables in the dataset were fully completed. This is likely due to several factors including rapid turnover in the courts and prioritising the delivery of clinical services over the collection of data. With large service datasets often, there is inconsistency in inputting data. Where demographic data is missing it may be due to the briefness of contact, so only core information is recorded. The rates of court attendees in the CMH service were not known so we do not know if the proportion referred varied between the CMH Service and CMH+ND Service. As the CMH+ND Service was a new service it is may have received fewer referrals before reaching full operator capacity.

*4.3 Future implications*

The study has demonstrated that it is possible to provide integrated specialist services for vulnerable people with NDs within the current standard L&D model and that they can operate across several sectors. The service may have increased rates of identification of defendants with ND. The service may also have played a role in reducing the number of vulnerable people who were remanded into prison custody.

One of the main barriers to implementing such a model will be identifying sufficient professionals with the expertise to work in court settings with defendants with ND. We acknowledge there may be other models that should be considered, including enhancing the skills of existing services such as within Police stations. This could be particularly attractive to commissioners, given likely future resource limitations. It would be useful to understand whether such a specialist CMH+ND Service can operate successfully across a cluster of Courts rather than in only one court. We know that defendants with ND present with greater complexity than other mental health populations. The addition of ND expertise of professionals within existing CMH services is likely to result in increased understanding and sharing of knowledge across sectors within the criminal justice system, and in the long-term, this may help to reduce the use of inappropriate detention, both in prison and hospitals. We need further research to improve our understanding of the effectiveness of interventions relating to defendants with ND. Areas for investigation include the impact of specialist services on sentencing and the evaluation of multi-sector initiatives to reduce future contact with criminal justice agencies.

**Author contributions**

EC, JMc and AF conceptualised the study and were responsible for drafting the manuscript. All other authors made contributions to the editing and design of the manuscript during constructions and approved the final manuscript for submission. EC, KM-T, DH and BT were responsible for data ma

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# Appendix

Each Appendix appears on its own page.

# Footnotes

1Complete APA style formatting information may be found in the Publication Manual.

Table 1

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# Figure Captions

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