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## Mental Health Court pilot: feasibility of an impact evaluation

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### Context

The Mental Health Court<sup>1</sup> model was piloted at magistrates' courts in Stratford, East London, and Brighton, Sussex. The pilot aimed:

- to develop a clear model, which identified defendants and offenders with mental health issues, assessed the extent of those issues, and ensured that the offender/defendant received the appropriate intervention(s);
- to identify the actual costs that would be incurred across the Criminal Justice System (CJS) and health services as a result of implementing the model.

The key elements of the MHC model in both areas were to:

- identify defendants with mental health and/or learning disability issues through screening and assessments;
- provide the court with information on a defendant's mental health needs to enable the court to effectively case manage the proceedings;
- offer sentencers credible alternatives to custody to support an offender with mental health/learning disability needs by way of a Community Order with a supervision requirement or mental health treatment requirement;
- offer enhanced psychiatric services at court;
- implement regular reviews of orders; and
- signpost those individuals not suitable for the MHC Community Order<sup>2</sup> to mental health and other services that could appropriately address their needs.

See Figure 1 for the pathways through the MHC (at Brighton and Stratford combined) taken by offenders and defendants. Throughput figures are taken from the process evaluation of the MHC pilot (Winstone and Pakes, 2010).

This study set out to explore the feasibility of evaluating the impact of the MHC pilot in Brighton and Stratford Magistrates' Courts on its completion. It also explored possible approaches for a mid-pilot economic appraisal of the costs and benefits of continuing the pilots. An impact evaluation would provide an assessment of the difference the MHC pilot makes to outcomes, by looking at what happens to those who go through the MHC compared to what would have happened had they not. The impact is the difference between the two. The outcomes of interest were:

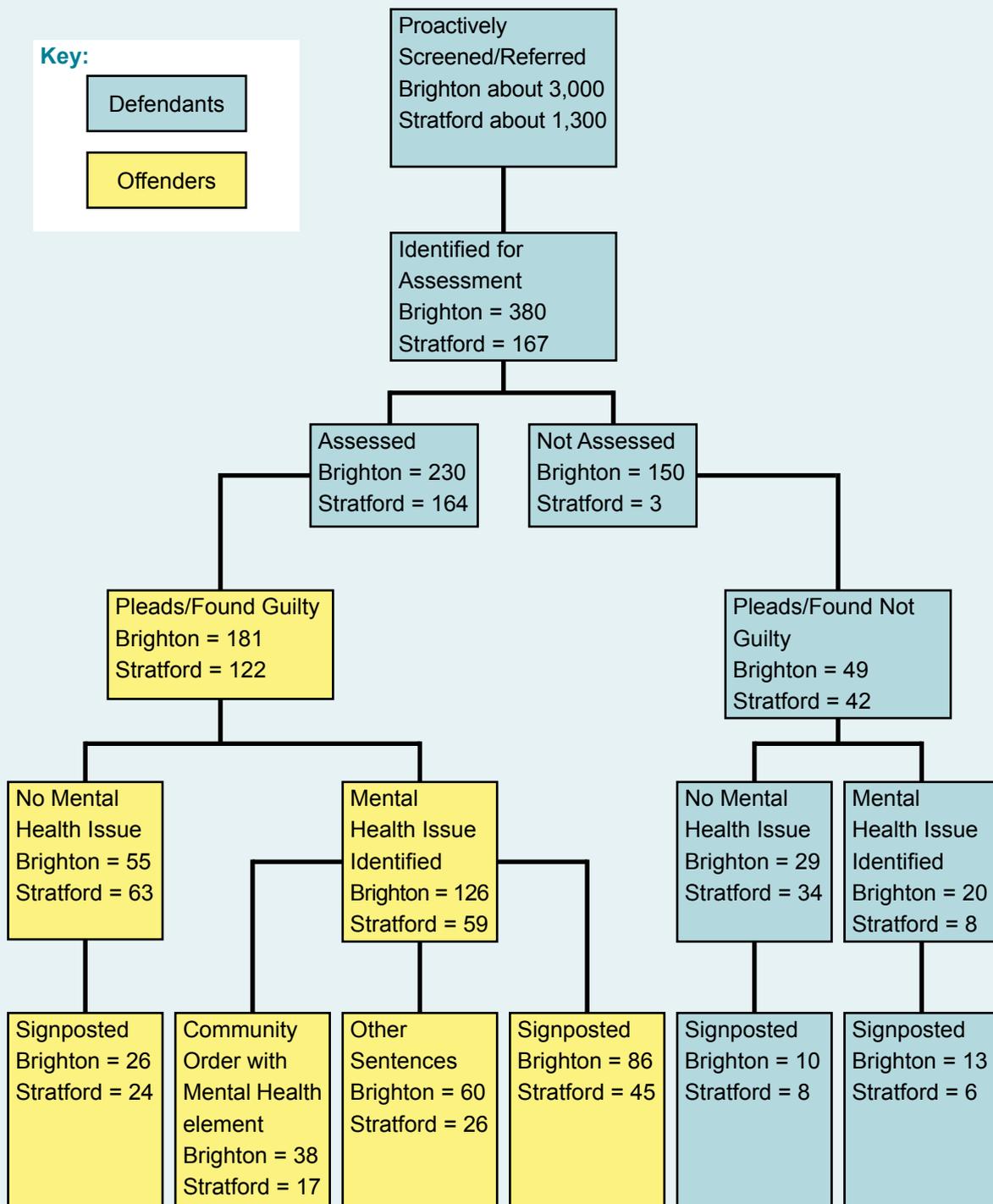
- to reduce reoffending;
- to reduce the perceived 'revolving-door syndrome', where people have repeat contact with the CJS over the course of their lives, by providing adequate support for mental health needs; and
- to improve offender and defendant access to mental health services.

1 Henceforth, the Mental Health Court pilots under review in Brighton and Stratford shall be referred to as MHC; any others shall be referred to as Mental Health Courts.

2 This group includes those found not guilty and those convicted but where Community Orders were not considered appropriate.

**Figure 1 Simplified process map of the MHCs**

Throughput based on figures from January 2009 to January 2010



An impact evaluation would aim to look at the MHC package as a whole, including all pathways shown in Figure 1. The following designs were considered for an impact evaluation.

- 1) **A Randomised Control Trial (RCT).** In an RCT, those who would be eligible for the pilot (those that are screened as having a mental health issue on contact with the CJS) would

be randomly assigned to 'treatment' or 'control' groups and their outcomes compared. The treatment group would receive the intervention (in this case go through the MHC, receiving signposting services and/or a Community Order) and the control group would not (in this case they would receive the standard non-MHC court approach, where some level of service is provided). This approach is common in drug

trials where volunteers are randomly assigned and given either the medication being tested or a placebo. The benefit of this design is that the comparator (control) group is created automatically as part of the pilot process.

- 2) **Comparison of the MHC with a court/area with no mental health service provision at court/police custody.** Some court areas in England and Wales had no mental health provisions at court or in police custody. Defendants who go to the MHC would be compared to defendants in a court area without an MHC, and without any other mental health service provisions at court/police custody. The defendants would be closely matched on factors which affect outcomes (e.g. previous and current convictions, gender, age, identified mental health issues). Areas would be matched on characteristics such as CJS practice and locality.
- 3) **Comparison of the MHC with a court/area with some mental health service provision at court/police custody.** Many court areas had some mental health provisions. These included police custody nurse schemes, which were generally delivered by private contractors. Although the focus of the schemes was often on physical health, they were also extended to mental health issues where expertise allowed (Henderson et al., 2008). Additionally, some areas had court liaison and diversion schemes. Although the particular models implemented differed, they were generally in place across police custody and court, and linked in with social and health services to meet clients' needs. Some also offered additional support and training for custody staff. Defendants going to the MHC would be compared to defendants in a court area without an MHC, but with some mental health service provisions at court/police custody. The defendants would be closely matched as above, as would the areas.
- 4) **A before-and-after design.** Defendants going to the MHC would be compared with defendants (matched as above) from the same court area who passed through the courts before the existence of the MHC.

Designs 2, 3 and 4 require some sort of comparator group of defendants, matched as closely as

possible on the personal characteristics of the defendants associated with reoffending and the area characteristics (such as criminal justice and mental health treatment practices and economic circumstances). This provides a way of minimising the effect of individual differences between defendants. When matching is used, this requires the use of statistical techniques to control for differences between the groups. A successful RCT design would not require this.

It was expected that there might be a high risk that an impact evaluation would not be possible; therefore a separate process and cost evaluation was carried out alongside this feasibility study. A process evaluation is not strictly an impact evaluation as the design does not allow for measurement of long-term outcomes. It uses methods such as interviews and basic data analysis to identify the perceived benefits of, and lessons learned from, the MHC, from the views of those involved (offenders, court staff, probation staff and so forth). This would allow for some information on the perceived effectiveness of the operation of the MHCs to be collected and to inform decision making in the event that an impact evaluation was not undertaken. Please see the separate report 'Process study to evaluate the Mental Health Courts pilot' (Winstone and Pakes, 2010) for details on the outcomes from this.

As the pilot had already been implemented at the time of this research, this study sought to identify whether sufficient information was available for a robust mid-pilot economic appraisal. This appraisal would support decisions on continuing, stopping or changing the pilot in the future. Two possible economic appraisals were considered.

- 1) **Cost-benefit analysis.** A cost-benefit analysis provides an inventory of all costs and consequences of two or more alternatives (such as Brighton MHC and Stratford MHC) to weigh the costs and benefits, which must be measured in the same units. For example, it can be used to estimate the monetary consequences of investing in a particular MHC.
- 2) **Cost-effectiveness analysis.** A cost-effectiveness analysis is a partial form of the cost-benefit analysis. The costs are usually measured in monetary units, but the

consequences are measured in units of natural (non-monetary) outcomes. In the context of the MHC, these could be such things as the number of defendants and offenders who receive access to mental health services, the probability of reoffending or the probability of imprisonment. The analysis can be used to identify which alternative can provide the most units of benefit for the same cost.

## Approach

In order to identify the possibility of undertaking the above designs, the following factors were assessed:

- the differences between practices at MHCs and other courts and the extent of those differences;
- the data that were available at the MHCs and other courts, and that would be needed for an impact evaluation;
- the possible impact of the MHC on criminal justice and mental health outcomes; and
- the way in which defendants are allocated to the MHC, particularly the impact this has in terms of random allocation and identifying defendants for matching.

In order to assess the above factors, information was gathered in the following ways:

- 20 face-to-face interviews with professional court users,<sup>3</sup> including magistracy, judiciary, Crown Prosecution Service (CPS), police, Serco and Reliance (prison transport and security services), stakeholders and mental health professionals (from the CJS and health services);
- five telephone interviews with those that were unavailable for face-to-face interviews;
- researcher expertise drawing on previous evaluation experience which includes the development and pilot of the Mental Health Effective Practice Audit Checklist (MHEP-AC, Winstone and Pakes, 2008) and standard version (MHEP-ACS, *ibid*) implemented across 101 mental health schemes in England;<sup>4</sup>

- researcher expertise drawing on current evaluations of mental health pilot schemes in the Central Criminal Court and Central and North West London (CNWL) NHS Foundation Trust;
- a literature review of the current published literature on Mental Health Courts;
- a review of existing relevant health and criminal justice datasets; and
- a review of MHC datasets.

## Results

### Impact

The literature review provided little evidence of the likely impact of the MHC pilot. This was because the evaluations were all carried out on Mental Health Courts in the USA, which differed substantially to the MHC pilot in Brighton and Stratford. None of the studies extracted on the Mental Health Courts in the USA provided information on levels of impact. A minimum impact of five percentage points was assumed based on other court and criminal justice (not Mental Health Court) studies in the UK, and published reconviction data for offenders in Britain (see for example, Jolliffe and Farrington, 2009 on community justice courts, and McSweeney et al., 2010 on dedicated drugs courts). The impact was the assumed difference in reoffending rates between those with a mental health issue going through the MHCs and those going through other courts. This would mean detecting a reduction in the reoffending rate from 39% to 34% over one year (based on 2007 national reoffending figures, Ministry of Justice, 2007) for those going through the MHC. Due to lack of evidence in the literature on the likely impact of an MHC such as in Brighton and Stratford, it may be that this estimate of impact was overly optimistic. In this case, the assumed sample sizes given below would need to be increased in order to increase the chances of detecting an impact. This would have implications for the timeframe and costs of the study. There was a relatively high risk that no impact would be detected, even if it existed, due to its likely small size.

The study would not be able to measure impact on mental health outcomes as there would be no easy way to obtain follow-up data one year after the defendant had passed through the court. There would be ethical issues around completing a follow-up mental health assessment with defendants a year

3 This includes courts where there was a mental health scheme and courts where there was no scheme.

4 For more information see the Bradley Report, 2009.

after they had passed through the court. Undertaking an assessment for the purpose of research runs the risk of bringing mental health problems that may be under control to the fore. Collecting data on access to mental health services over the period of a year would be problematic due to the number of organisations involved, and problems with attrition and linking information to criminal justice information. These issues were also noted in the literature review, where most studies focused solely on criminal justice outcomes, or short-term mental health outcomes (rather than over a year). In conclusion, estimating the impact of the MHCs is likely to be problematic, regardless of the impact evaluation design chosen. Due to the difficulties in capturing mental health outcomes as mentioned above, the sole outcome measured would be a reduction in reoffending rates.

### **Infeasible designs**

A before-and-after design was not feasible, as there were no baseline mental health data available covering defendants in the Brighton and Stratford areas who passed through the courts prior to implementation of the MHCs. A comparison of the MHCs with courts in an area with no mental health services would not be realistic. There would be a high risk that defendants in court areas with no services may have had access to services at some point, which would not be feasible to verify. Additionally, there would be ethical issues around identifying mental health issues but not providing any services to the defendant.

### **Feasible designs**

For any impact evaluation an estimated sample size of 2,292 (1,146 each in the treatment and comparator groups) would be required. Based on throughput at the MHCs at the time of research, generating a sample of this size would be expected to take around four years. However, a shorter timeframe may be feasible if throughput continued to increase in Stratford (or indeed altogether). If only one of the pilot sites was chosen (due to differences in the review process, which could affect results), the timeframe would need to be increased.

Based on the sample size required, the estimated resource requirements for feasible impact evaluation designs were as follows. An RCT would take at least seven to eight years and cost in the region of £1,000,000, based on one-year follow-up of

defendants/offenders. An area comparison of the MHC with an area with some mental health provision at the court would take at least 6.5 to 8.5 years and cost in the region of £200,000 to £300,000. An RCT would be more costly due to additional costs at the design and fieldwork stages, including training of staff in implementing randomisation.

All costs stated above were rough estimates. Exact costs would be determined by a range of factors that were not within the scope of this study to obtain.

### **Cost-benefit and cost-effectiveness analyses**

A mid-pilot cost-benefit and cost-effectiveness analysis of the MHC pilots would take six months and cost in the region of £40,000 to £50,000. If the analysis was to extend over the first 12 months of the pilot, the costs would increase considerably. Since the activity level data from the MHCs at Brighton and Stratford have already been collected there would be minimal risk in using the information to assess the cost-benefit and cost-effectiveness of the MHC pilot. One risk is whether the budget to perform the economic appraisal affords a valuable investment by the Ministry of Justice. Another is that it may be difficult to quantify some of the benefits of the MHC, given the difficulties surrounding identification of mental health outcomes such as mental well-being and access to services. If the decision was taken to proceed with the economic appraisal, the results could be used to inform subsequent decision making on whether to:

- continue with the pilot in Brighton and Stratford;
- compare the arrangements at Brighton and Stratford with other courts that do and do not have provision for managing defendants with mental health issues;
- implement MHCs across the UK.

### **Implications**

For any design it would not be possible to measure long-term mental health outcomes (see results section). An RCT may fail if the randomisation process was not undertaken correctly. It would require careful monitoring and assistance from the courts and police. An area comparison of the MHC and an area with some provisions is perhaps more

feasible, but would need to be monitored closely to ensure that the defendants were receiving markedly different treatments. It may also take longer than expected to gather the correct sample for matching of defendants in the two areas to take place. This would impact on costs. If the pilot was to be rolled out more widely, this may reduce the amount of time needed to complete an impact evaluation. However, one approach (either that of Brighton or Stratford) would need to be chosen. Given the lack of robust evidence on the likely impact of the MHCs there is a high risk that the sample sizes given would not be large enough to detect a reduction in reoffending if it was less than five percentage points.

It appears likely that an area comparison design would be the best design to take forward, as it is less costly than an RCT. However, this would still carry a degree of risk of not identifying any impact (as with any evaluation), and would have ethical implications to be carefully considered. Therefore, the process evaluation that was already underway may offer the best value for money, and does not rule out later implementation of an impact evaluation. It would also be useful as a precursor to an impact evaluation, to enable decision making on which review process operates better or is more likely to be used in future (at Stratford it was run by the courts, and at Brighton it was run by probation), or how feasible it would be to roll out the pilot more widely. If an impact evaluation was not taken forward, a regulatory impact assessment (in line with Ministry of Justice policies) should still be used to inform future continuation or roll-out of the pilot. A separate cost-benefit and cost-effectiveness appraisal would also be useful for considering the potential economic costs of continuing the pilot as opposed to regular court services. These latter two analyses could provide information on the potential effectiveness of the pilot in relation to signposting to mental health services and receiving a Community Order, as well as on measures such as reconviction, re-arrest and breach rates. However, they still run the risk of not being able to measure some of the harder-to-quantify benefits, such as mental health outcomes if repeat assessments of defendants are required.

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