
Inside Out

The case for improving mental healthcare across
the criminal justice system

Professor Charlie Brooker and Ben Ullmann
Edited by Gavin Lockhart



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Executive summary

From police stations to the courts, to prisons and probation programmes, offenders with mental health disorders pose enormous challenges for the criminal justice system. Surveys of custody records in two London police boroughs show that in one week, 14% of detainees had a self-declared mental illness and around 13% of calls made to the police each day were linked to disturbances by people with perceived mental disorders.^{1,2} Government policy is to divert mentally ill people from the criminal justice system in cases where the public interest does not require their prosecution. But advocates of this policy should not underestimate the difficulty of delivering it. Even those charged with improving specific sections of the criminal justice pathway have found this complexity challenging; Lord Bradley's review of the diversion of offenders with mental health disorders was due to report six months ago but has been delayed until later in 2009.

Although there are a number of services available in police stations and magistrates' courts to assess mentally disordered offenders and advise on their diversion from the criminal justice system, the current provision is patchy. Three out of four magistrates' courts have no court diversion schemes in their area to access.³ Since an estimated 269,000 offenders are identified with a mental health disorder at arrest (12% of all arrested offenders), this means that only 67,000 of them are able to benefit from such schemes.⁴

There are three justifications for providing appropriate treatment for offenders who generally have poorer mental health than the general population: the *moral case*, the *public health case* and the *economic case*. The moral case is that mentally disordered offenders should receive the same quality of care as the general population. The public health case is argued by those who see

the criminal justice system as an opportunity for early mental health intervention. The economic case is perhaps the least well-developed of the three: that investment in mental healthcare for offenders will ultimately lead to a reduction in crime. Although the authors of this report have produced evidence that the pre-sentence costs of mental illness are more than £27 million each year, mental healthcare costs are among the least studied costs of crime; existing literature is often more than a decade old and limited to case studies from the United States. But studies that do exist suggest that improved mental health services can help to reduce crime.

This report catalogues the obstacles to diversion and argues that early and more structured interventions by the healthcare and justice systems would improve care and cut the cost of crime. It highlights some of the best schemes in England and Wales and the great potential of a new model in mental health courts. (These are already operating in parts of America and are being piloted here, though on a very small scale.) In a study of one mental health court, the risk of offenders being charged with any new offence was about 34 out of 100, compared with about 56 out of 100 for those who were dealt with by a regular court, a 39% reduction. For violent crimes the figures were 6 out of 100 compared with 13 out of 100 respectively, a 54% reduction.⁵

Obstacles

The absence of clear accountability and firm financial incentives has prevented improvements across the criminal justice system. But there are specific shortcomings in the provision of mental health services for offenders – from police stations through to probation.

1 "Mental Health and Offending: background scoping slides", Prime Minister's Strategy Unit (unpublished), London: Cabinet Office

2 Care Services Improvement Partnership, *Choosing Health: Inside and Out*, 2005

3 Findings of the 2004 survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales, Nacro, 2005

4 Final report of the Strategic Policy Team project on mentally disordered offenders, *Home Office*, Unpublished

5 *Ibid*

Police and early diversion

Custody diversion teams were introduced in England, as their name suggests, in order to divert mentally disordered offenders away from the criminal justice system because of concerns about the amount of mental illness in prison populations. Early diversion of the mentally disordered from custody can be achieved at the police station, particularly for those arrested for minor offences and, in theory, sufficient resources already exist to do so. But there is evidence that the system is failing: mentally disordered offenders are being returned uncharged to the community without the opportunity for psychiatric or social intervention having been taken.

Police officers are often the first to be called to any incident of a person experiencing a mental health crisis, but they receive very little training in awareness and recognition of mental illness. Indeed, mental illness is a factor in many of the most serious cases of police misconduct investigated by the Independent Police Complaints Commission. Its predecessor, the Police Complaints Authority, found that about half of deaths in police custody are of people with some form of mental health problem.

Police officers also have limited time to process a person while in police custody; if there were a requirement to conduct more comprehensive health assessments, this could reduce the amount of time available to investigate a crime. Many police buildings are also unsuitable for providing healthcare to support an individual with mental health disorders.

Court diversion schemes

Despite promptings from the Home Office, Department of Health (DH) and academic institutions, the quality of diversion schemes is inconsistent.⁶

The Mental Health Act Commission's 12th biennial report, published in 2008, described current diversion schemes as having no ring-fenced funding, no blueprint and no clear accountability. As a result, there

are inconsistencies in delivery between areas and even individual schemes.⁷ The reasons for this situation include poor provision of schemes; lack of funding and facilities; staff shortages and lack of professional input; poor inter-agency working; lack of judicial awareness of court diversion schemes and lack of national guidance.

Prison

Services for prisoners with substance misuse problems and mental health disorders are delivered by numerous teams, some commissioned by the NHS and others by the Prison Service (part of the Ministry of Justice). This disjointed commissioning leads to teams (in-reach, primary care, drug services) working in relative isolation, with poorly co-ordinated, ineffective services and a lack of throughcare. The blurred line between primary and secondary care results in prisoners being passed between the two or even lost completely.

Prison officers have the most contact with prisoners day-to-day and as such can act as their primary carers. With such a high prevalence of mental health disorder in prisons (90% of prisoners have one or more mental health disorders), it is essential that prison officers have the skills to identify and deal with it. Training is not sufficient and in some cases is not compulsory. Consequently, prison officers do not feel qualified to deal with prisoners with mental disorders.

Probation

The problems that prisoners face on their return to the community are well documented. Some reports suggest that 40% of prisoners are homeless on release, but that stable accommodation can reduce reconviction rates by more than 20%. Despite this, research shows that only 19% of prisoners received help with accommodation before leaving prison and only a third of those who were homeless received help in looking for accommodation.⁸ Research into continuity of mental healthcare for ex-prisoners with psychosis found that of those who had been

6 *Improving Health, Supporting Justice: A Consultation Document*, Department of Health, 2007

7 *The Diversion of Individuals with Mental Health Problems away from the Criminal Justice System and Prison*, Partnerships in Care, 2008

released only 23% had an appointment with a mental health professional.⁹

A 2008 study of released prisoners in Washington State found that former prison inmates, whether mentally disordered or not, were at high risk of dying after release from prison, particularly during the first two weeks when the risk of death was almost 13 times more than that for other state residents.¹⁰ The leading causes of death among former inmates were drug overdose, cardiovascular disease, homicide and suicide. For offenders with mental health disorders, these factors are likely to be even more exaggerated.

Commissioning

The NHS is not involved in commissioning services throughout the pathway. For example, Counselling Assessment, Referral Advice and Throughcare Teams (CARATs) and probation services are commissioned by the regional National Offender Management Service (NOMS) office. This has negative implications for cost effectiveness, the provi-

sion of a more seamless service, service quality and information sharing.

Good practice

To address these obstacles, the authors looked at good practice in England & Wales and abroad, and highlighted a number of case studies from which lessons can be drawn.

Recommendations

To address the obstacles for mental health-care in the criminal justice system, and drawing on the lessons learnt from the case studies, the authors propose nine recommendations which cover five areas: police and early diversion, prison and commissioning, probation, courts and structural reform. Much of the onus for change is on the DH and Primary Care Trusts (PCTs). Across the pathway there are differing but crucial roles for the health service in changing the way the criminal justice system deals with

Case Study	Summary	Lesson
Policing strategy for mentally disordered offenders – <i>South Wales</i> and <i>Memphis, Tennessee</i>	When addressing offender mental health issues, the UK directs most available resources to the prison system. These case studies show how much earlier intervention can stop problems escalating	Early intervention by the police-led or healthcare-led crisis resolution teams at the pre-arrest, arrest or custody stages, can ensure appropriate service for mentally disordered offenders
Mental health courts – <i>Brooklyn, New York</i> and <i>San Francisco, California</i>	Mental health courts are one of the newest forms of "problem-solving courts" bringing new approaches to difficult cases where social, human and legal problems intersect The judge, prosecutor, defence lawyer, and other court staff often have special training in the use of community mental health services The Brooklyn study looks at the structures and processes typical of mental health courts while the San Francisco study examines their effectiveness at reducing recidivism	Mental health courts can ensure that mentally disordered offenders are linked with mental health services that not only provide them with the appropriate care but also relieve pressure on the prison service and help to reduce recidivism

8 Keil J, Bruton L, Thomas S and Samele C, *On the Outside: Continuity of care for people leaving prison*, Sainsbury Centre for Mental Health, 2008

9 Meizer D et al, "Prisoners with Psychosis in England and Wales: A one year national follow up study", *The Howard Journal*, 41, (1), pp 1-13, 2001

10 Binswanger I et al. Release from Prison – A High Risk of Death for Former Inmates, *N Engl J Med* 2007;356:157-65

Case Study	Summary	Lesson
Prison mental health services – HMP Bristol and HMP Nottingham Offender healthcare plan (including mental health) – Derbyshire PCT	These case studies show that although it is difficult for PCTs to prioritise funding for prison mental health, it is possible. The Bristol example highlights the way in which primary care resources have been integrated into an effective prison/provider partnership, while the Nottingham example shows the ability to articulate need to commissioners and have an impact on investment with clear clinical leadership	Better integration of resources can lead to more effective healthcare and mental health assessment for offenders in prison and other criminal justice agencies. Making offender mental healthcare a priority is possible through clear clinical leadership and the ability to articulate need to PCT commissioners
Offender healthcare plan (including mental health) – Derbyshire PCT	Although the offender population is known to experience significant health inequalities, often having needs which exceed those of the general public, few studies have examined the health of offenders within community settings The PCT and the National Probation Service in Derbyshire assessed the health needs of community offenders in both Nottinghamshire and Derbyshire. The findings have helped to develop an offender healthcare plan	Assessments of health needs usually focus on offenders in prison and yet research shows that offenders in the community also suffer significant health inequalities. Assessing offenders in the community and on probation can inform the development of a commissioning strategy for that neglected population

offenders with mental illness. The key recommendations are outlined here. A full set of recommendations is in Chapter 6.

Police and early diversion

Investment in offender mental health should allow earlier intervention at every stage of the pathway through the criminal justice system. It could significantly reduce the costs of acute admissions to either medium or high-secure NHS forensic services. The balance between community and custodial sentencing needs to be dramatically altered in favour of increased use of mental health treatment orders with the accompanying benefits of reducing the prison population and providing more cost-effective services. For example, the average cost of a custodial sentence is £13,125 per head while a community order costs £1,500-£4,000. Even with mental health treatment included the community order option

remains cheaper.¹¹ Further savings are possible as such a model is likely to reduce re-offending rates in some (but not all) cases.

PCTs should commission police custody diversion schemes

Offenders with a mental illness should be assessed routinely in police stations and courts and, where appropriate, taken into the NHS for care and treatment. Community mental health teams or assertive outreach teams could be re-directed to staff custody diversion schemes, both to assess and to provide assertive community-based intervention packages.

Give PCTs an incentive to transfer offenders with mental illness into treatment

PCTs should be given financial incentives to take offenders with mental illness out of the system at the earliest possible stage (police stations and courts) and into the NHS. However, the expert panel drew

11 Final report of the Strategic Policy Team project on mentally disordered offenders, Home Office, Unpublished

attention to serious deficits in the criminal justice system in mental health awareness, particularly among police custody sergeants, magistrates, prison staff and prison governors.

Pilot Mental Health Crisis Resolution Teams

A number of organisations have proposed the creation and development of “assessment suites” or “places of safety” separate from police custody suites.^{12,13} A report from South Wales proposes that staff at these suites should have training in control and restraint, de-escalation and assessment. Their primary functions would be to prevent self-harm and suicides in custody, and to provide multi-agency assessment, detoxification facilities and liaison with non-healthcare services such as housing.¹⁴

Courts

Our expert panel noted that courts had little accountability in relation to the sentencing of offenders with mental health needs. Judges have a number of options in relation to offenders with mental illness – court diversion, court assessment and referral, mental health courts, mental health liaison schemes – but no incentive to use one rather than another. Evidence about the effectiveness of these different options or models is sparse.¹⁵ Courts require dedicated mental health staff to work with them, so that offenders can either be placed in forensic secure accommodation or, where the mental disorder is less serious, be referred to an appropriate mainstream mental health/drug service with appropriate monitoring. Brooklyn Mental Health Court, which requires people on treatment orders to return to court every week, provides an example of such arrangements.

Expand mental health court pilots

Mental health courts have the potential to reduce reoffending by those with severe

mental illness. The relationship between offending and mental health status is not necessarily straightforward. Improved mental healthcare will not automatically reduce reoffending, nonetheless when offending is not “goal-directed” and clearly results from the impact of a mental health disorder, such an outcome is likely.

The reduction in reoffending among clients of the San Francisco Mental Health Court was between 25% and 39% after 18 months. If a similar reduction in reoffending were seen among offenders with severe mental illness in England & Wales, the number of recidivists would fall by 1,500-2,700 each year. In terms of recidivism costs this would result in an annual saving between £95 million - £180 million.¹⁶ The authors recognise that mental health courts are not appropriate for all mentally ill offenders and that they are not without costs. But evidence reviewed in this report suggests that the Department of Health and Ministry of Justice should radically expand the very small-scale pilots planned for later in 2009.

Prison and commissioning

Since taking over the commissioning role for offender health in 2006, PCTs have had much to do. Not only have they received little incentive to invest in offender mental health, but also very little support to undertake this function in what is a specialised area of healthcare that is new for many of them. Yet PCTs should be commissioning services for offender mental health across the whole criminal justice pathway and not focusing resources solely on the prison population.

Prison mental health services are still underfunded and they have little national guidance on how they should operate. Most in-reach teams are provided solely by nurses, however as this report shows, sound clinical leadership within a multi-disciplinary team, as in Nottingham, can be highly effective. That strong clinical

12 South Wales police model

13 Bather P, Fitzpatrick R, Rutherford M, *Briefing 36: Police and Mental Health*, Sainsbury Centre for Mental Health, 2008

14 South Wales police model

15 Scott D, et al. *The Effectiveness of Criminal Justice Liaison and Diversion Services for Mentally Disordered Offenders: A Systematic Review of the Evidence*, Unpublished 2008

16 See Appendix 1

leadership is urgently required is underlined by the fact that not one mental health nurse consultant works as a specialist in prison mental health. This report also shows that a sound commissioning provider partnership and an integrated use of resources, as in Bristol, can lead to a well-funded service.

Even if prison mental health were adequately funded, the commissioning of such services would still be taking place in an environment that is too complex. Drug treatment services in prison, for example, are currently commissioned through both the health service and the prison service. The authors understand that Lord Patel is currently reviewing the way that funding is allocated to drug treatment services in prison; we hope that he recommends clearer commissioning pathways.

Integrate mental health services in PCT commissioning

Services for prisoners with mental health disorders are delivered by numerous teams some commissioned by the NHS (such as in-reach teams), others are commissioned by the Prison Service, part of the Ministry of Justice. This disjointed commissioning leads to poorly co-ordinated, ineffective services. Where possible all mental health services and resources should be delivered by one team, commissioned by the NHS.

Probation

Although very little is known formally about the prevalence of mental health disorders among offenders who are being managed in the community, the general health inequalities that they experience are among the highest of any group. The assessment of health needs in Derbyshire suggests that up to 30% of probation caseloads are people who, in the past, have had formal contact with mental health services. The prevalence of both alcohol and drug problems is higher than this. There have been no formal estimates of personality disorder in this group. A further difficulty, restricting

even those known by probation services to have a mental health disorder, is their lack of access to services, especially psychological therapies.

The Department of Health should instruct PCTs to provide full health needs assessments for offenders

Resources for offenders with mental health disorders are focused myopically on the prison population. The prevalence of mental illness for offenders on probation is also high and if health is to be improved (and costs reduced) resources must be spread along the whole pathway. The offender health directorate of the Department of Health should instruct PCTs to conduct health needs assessment for offenders on probation in order to include them in PCT's offender mental health strategy.

Structural reform

Responsibility for policy relating to the mental health of offenders rests with the Department of Health and specifically its offender health directorate. The fact that offender health is a separate directorate makes it difficult to integrate mainstream health developments in prisons, such as increasing "access to psychological therapies" and "reducing health inequalities". For example there is scant reference to offenders in the DH's review of progress in reducing health inequalities.

Amalgamate offender health into the Department of Health

As long as offender health remains a separate unit, offenders with mental health needs will not receive equivalent services to those available in the community. We recommend that offender health should be integrated into the department as a whole and its resources reassigned to major policy programmes, such as mental health and public health. If such a change were made, it is likely that wide-ranging offender health plans, such as the one in Derbyshire, would

spread across the country more quickly than at present.

This report is a call to action on behalf of a forgotten minority, not simply because it

is right to promote equality of care for the individuals concerned, but also because it would reduce the cost of offenders with mental illness to their victims and to taxpayers as well.

1

Introduction

Nine out of ten prisoners in England and Wales are estimated to have at least one mental health disorder. In July 2007, Policy Exchange published its first report on mental health in the criminal justice system, *Out of Sight, Out of Mind*, which assessed the state of mental healthcare in prisons. The report concluded that although treatment had improved over the past decade, mental healthcare in prisons was not receiving the attention it deserved, and it made a number of recommendations for improving the situation.

But the story of offenders with mental illness is not confined to prisons. There are a number of other places where offenders with mental illnesses come into contact with the criminal justice system, including police custody, the courts and probation.

Table 1 highlights the large number of offenders with Mental Health Disorder (MHD) who are coming into contact with the

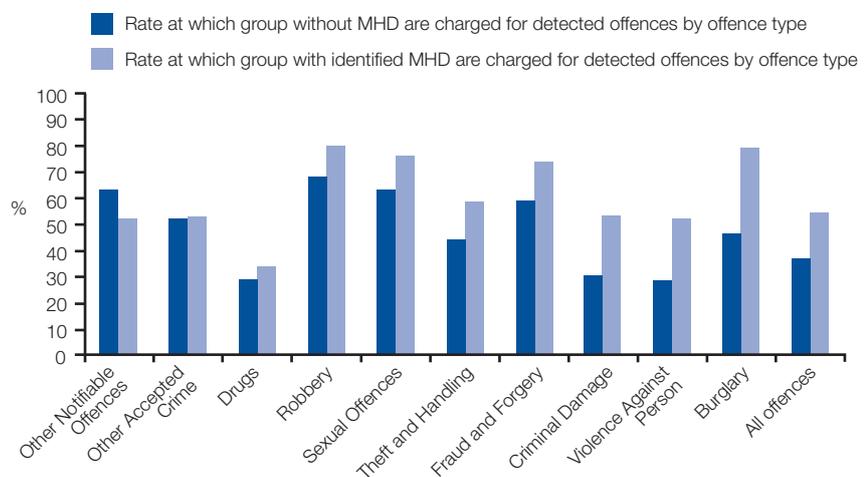
criminal justice system but not ending up in custody. And there is evidence to suggest that these offenders are being treated differently when charged. Across all but one type of offences, offenders with MHD have a higher rate of charge after arrest than those without MHD (Figure 1).

This report focuses on contacts at these “non-prison” locations, outlining their limitations in dealing with the mentally disordered, and using examples of good practice from the UK and abroad to suggest improvements. First, we summarise briefly the academic literature on the impact of mental health disorder on offending and its associated economic costs.

The relationship between mental illness, crime and offending

The link between mental disorder and crime, especially violent crime is a subject of frenzied debate in the media. It is also a

Figure 1: Comparative rate at which offenders with MHD and non-MHD are charged for detected offences, by offence type¹⁷



¹⁷ Final report of the Strategic Policy Team project on mentally disordered offenders, Home Office, Unpublished

Table 1: Rates of identified mental health disorder (MHD) at different stages of the Criminal Justice System (CJS)¹⁸

CJS stage (national totals for all offenders where available)	Proportion identified as having a mental health disorder/Action taken	Number of mentally disordered offenders (annual estimations)
Arrests	Between 7% and 15% of arrestees are identified by custody officers as having MHD	269,000
Pre-charge disposals		
No further action	17% of those identified with MHD have no further action taken following arrest	46,000
Caution	9% were cautioned	24,000
Fixed Penalty Notice for Disorder	6% were issued a PND	15,000
Charged	40% of those identified with a MHD by police are charged	108,000
Community sentences (169,000 sentences given annually to general population)	33% of OASys assessments completed at Pre-Sentence Report (PSR) or during supervision in the community had a psychological or psychiatric diagnosis at the start of their community sentence	56,000
Custody (99,000 sentenced to custodial sentences annually)	28% of OASys assessments completed at PSR or during supervision on licence had a psychological or psychiatric diagnosis at the start of licence	28,000

central question for criminal justice policy-makers. What is the relationship between mental health disorders and violent behaviour? And would improved treatment of mental health reduce levels of offending?

The most robust work in this area suggests that although most people with mental health disorders are not violent, the likelihood of their being so is greater than for those without. Persons with severe mental illness –

most particularly schizophrenia and schizoaffective disorder – are at increased risk, compared to the general population, of committing violent crimes. Research groups working in societies at very different levels of development, with distinct cultures, health, social service and criminal justice systems have independently made the same finding.^{19, 20}

The proportion of all crimes and of violent crimes committed by persons with major

¹⁸ Final report of the Strategic Policy Team project on mentally disordered offenders, Home Office, Unpublished

¹⁹ Arseneault et al, 2000; Brennan et al, 2000; Tiihonen et al, 1997; Wallace et al, 2004

²⁰ Researchers have examined different cohorts and samples using various experimental designs including prospective, longitudinal investigations on birth cohorts and population cohorts, follow-up studies comparing patients and their neighbours, random samples of incarcerated offenders and complete cohorts of homicide offenders

mental disorders varies from one country to another. There is also a growing body of evidence showing that persons with severe mental illness are at increased risk of being victims of aggressive behaviours and crimes.²¹ Rates of victimisation vary from place to place, but the factors involved are similar and include the victim's own aggressive behaviour towards others, illicit drug use, a co-existing personality disorder, homelessness and the combination of different factors.²²

The costs of mental health disorder and offending

Cost-benefit analysis measures both the effectiveness of an intervention and whether its benefits are greater than the costs. Despite the widespread use of economic techniques in other policy domains, there have been very few economic evaluations of criminal justice interventions so far.

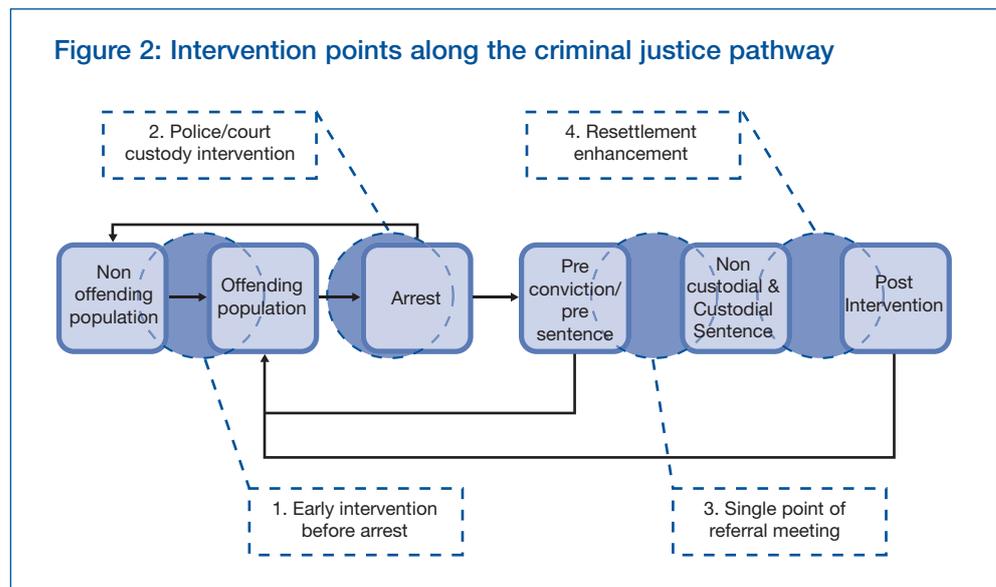
Preliminary unpublished research by Symmetric SD, a consultancy specialising in managing change in health and social services, suggests that appropriate early intervention for dual diagnosis before or at the time of arrest could reduce reoffending by 14%; it would be many times more effective at reducing reoffending than intervention at a later stage along the criminal justice pathway.²³ Further analysis

of these figures will be available later in 2009.

The costs of mental healthcare are among the least studied costs of crime. Most of the literature is more than a decade old and limited to case studies from the United States. But the studies that do exist suggest that improved mental health services can help to reduce crime. For a £1 investment in treatment, studies have found savings of £4 to £7 on crime and criminal justice costs. In 1985 it was estimated that the cost of mental illness in America was \$129.3 billion. Over \$17 billion of these costs were related to crime. The National Mental Health Association's Labor Day 2001 Report concluded that the US economy could cut its losses by half with an increased investment in the prevention and treatment of mental illness.

A study examining the public mental health system in King County, Washington (including Seattle) showed that changes in treatment affected not only mental health outcomes, but also incarcerations for violent and non-violent crimes. The study of 47,300 people examined jail utilisation, health services provided in jail, use of state mental hospitals and county mental health outpatient services.²⁴ It suggested that changes in public mental health treatment may lead to reductions in crime.

Figure 2: Intervention points along the criminal justice pathway



21 Silver et al, 2005; Teplin et al, 2005; Walsh et al, 2003

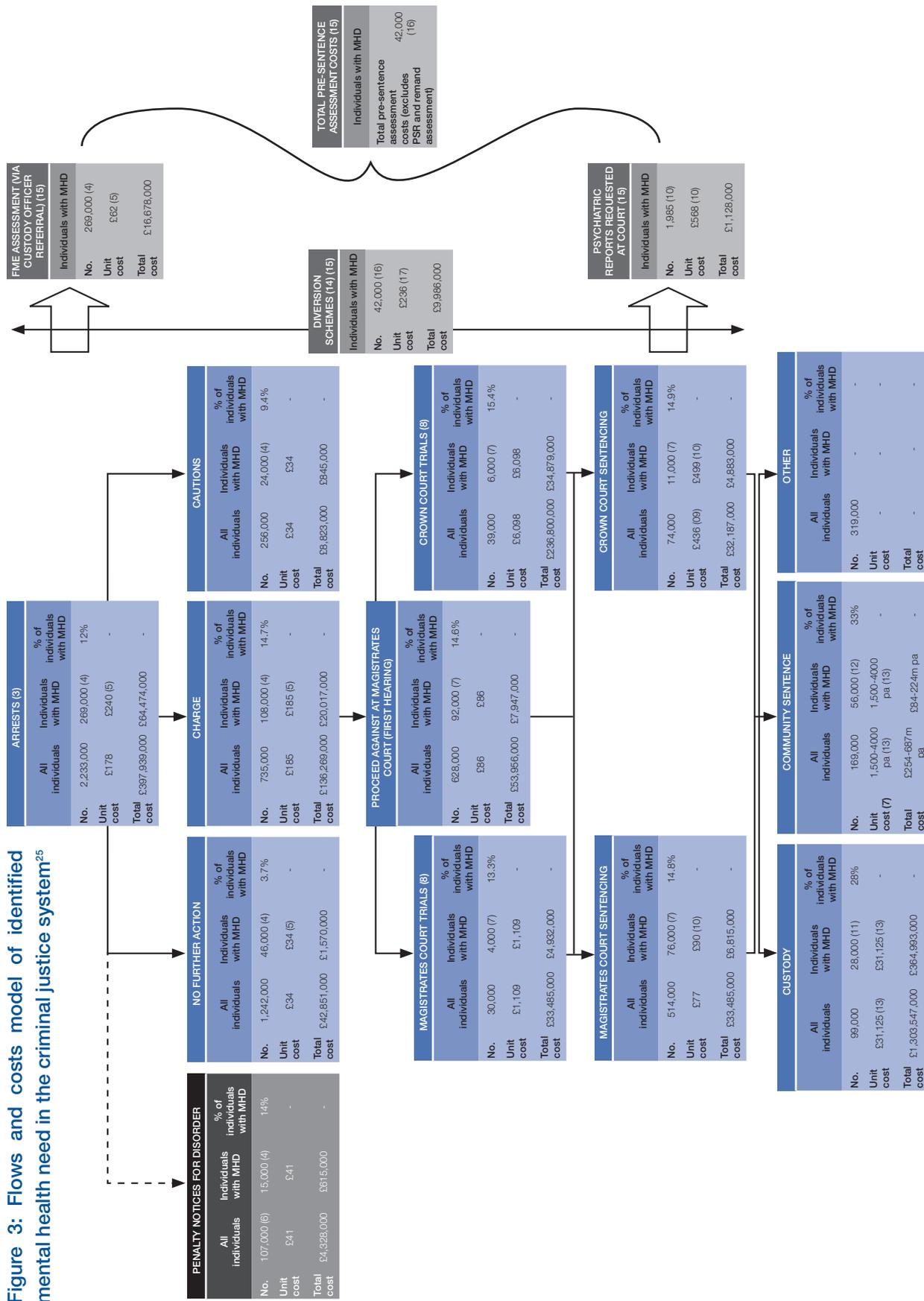
22 Honkonen et al, 2004

23 www.symmetricd.co.uk

24 Norton E, Domino M, Morrissey J, "How Mental Health Treatment Reduces Crime", *Academy Health*, 21, no 1576, 2004

25 Home Office, Flows & costs model of identified Mental Health Need in the Criminal Justice System, Unpublished

Figure 3: Flows and costs model of identified mental health need in the criminal justice system²⁵



Notes to Figure 3

- 1 Numbers are for all offenses excluding summary motoring and non-motoring.
- 2 Numbers and unit costs for all 'all individuals' are taken from the Home Office Criminal Justice System Model managed by the Office for Criminal Justice Reform – Finance and Strategy Unit, unless otherwise stated. The model is in the process of being quality assured and validated so figures provided here are provisional and may be subject to revision.
- 3 Figures are arrests ending up in the police station.
- 4 Figures based on the average percentage of offenders flagged by screening processes as having a mental health risk in three forces (Devon and Cornwall, Metropolitan Police Service and West Midlands) and disposal rates for this group.
- 5 Figures based on 2003/4 data on cost of FME service in Avon and Somerset, Hertfordshire and Essex police forces.
- 6 Number provided by Sentencing Police and Penalties Unit, Home Office. The figure is provisional and may be subject to revision (2005 data). Note that the 'all individuals' total of the post-arrest actions (penalty notice, no further action, charge and caution) does not sum to 'all individuals' number of arrests as the figure for penalty notices is generated from a separate source.
- 7 Data for numbers of individuals with MHD is unavailable at this stage. Estimates were made based on proportions for 'all individuals'.
- 8 Number of trials is much lower than number of first hearings as large proportion of individuals plead guilty at their first hearing and go straight for sentencing. Number of trials is only those cases where the case has been contested (i.e. a not guilty plea has been entered, although this may change to a late guilty plea during the course of the trial).
- 9 Costs for Crown Court sentencing are based on unverified costs and timing data and are likely to be an overestimate. Data from the Department of Constitutional Affairs on timings are unavailable at the time of writing this report.
- 10 This is an average unit cost weighted by numbers receiving a psychiatric report and numbers not receiving a psychiatric report. Costs assume that the number of reports prepared at crown and magistrate Courts are a factor of the volumes at which offenders with MHD progress to the Crown and Magistrates sentencing. Numbers of reports commissioned at Courts/year provided by HM Courts Service.
- 11 This figure is estimated using figures from internal SPT analysis of OASys dataset for 2004/5 financial year. This figure of the % of offenders who have recorded a score of 1 or 2 as a result of current psychiatric or psychological diagnosis during an OASys assessment to the point of starting license following a custodial sentence.
- 12 As above, except this is a % of offenders who have recorded a score of 1 or 2 as a result of current psychiatric or psychological diagnosis during an OASys assessment at the point of starting a community sentence (either CRO, APO, CPRO or DTTO).
- 13 Unit costs provided by NOMS Finance.
- 14 These figures are additional costs. They have not been included in other unit costs because no verifiable data is available on when people are diverted (operational policy differs locally, with some schemes taking the majority of referrals from policy custody, whereas others receive majority referrals from court, some schemes also receive post-sentence referrals).
- 15 These figures exclude treatment costs and costs of transfer.
- 16 Figures based on annual number of referrals managed by 9 diversion schemes grossed to estimate national average.
- 17 Figure based on average unit costs of conducting assessments at 3 diversion schemes.

Costs of Mental health and the Criminal Justice system

Figure 3 describes the costs of mental illness and the criminal justice system.^{26,27} The costs – based on 'known' health need rather than 'actual' need because of underreporting of mental health needs – are significant. Total annual pre-sentence costs are estimated to be at least £27,792,000. This figure does not include costs of treatment.

This overall figure is made up of three different types of costs. Assessment costs at custody (£16,678,000), diversion scheme costs (£9,986,000) and the cost of psychiatric reports requested at court (£1,128,000). Although the costs per case are often relatively low, the number of offenders with a mental illness who pass through the system is high. For example, at least 12% (269,000 people annually) of those arrested have a mental illness and nearly a 14% of cases at trial have a mental illness (92,000 each year).

understood. There is, however, considerable evidence that persons with severe mental illness, particularly those with schizophrenia, are at increased risk of engaging in aggressive behaviour towards others. Large numbers of patients in general adult psychiatric services are committing crimes, including assault or being victimised themselves, yet mental health policy and practice in the UK does not take account of this.

The next chapter examines in detail the different steps on the pathway of mentally disordered offenders through the criminal justice system and the difficulties encountered in each part. Chapter 3 takes a closer look at NHS services and the ways in which services for mentally ill offenders are shaped by commissioners and national priorities. Chapter 4 provides case studies, both from the US and the UK, illustrating some of the barriers that have had to be overcome to provide high quality care. These case studies include examples of intervention at each juncture of the criminal justice pathway. Chapter 5 sets out the authors' detailed recommendations for improving the delivery of mental healthcare in the criminal justice system.

Offending and the importance of mental healthcare

The mechanisms that connect mental disorder and violence are not yet thoroughly

26 Home Office, Flows & costs model of identified Mental Health Need in the Criminal Justice System, Unpublished

27 The costs have been generated from unpublished research that uses the Home Office Criminal Justice System Model

2

Mental health and the criminal justice system

There are five main points where mentally disordered offenders come into contact with the criminal justice system: police, courts, prison, release and probation. Figure 2 represents this typical pathway. They may encounter NHS treatment in the community or prisons, and they can be diverted from the criminal justice system to the NHS by the police and the courts.

After arrest, the three principal locations for the recognition and subsequent diversion of those with mental disorder are the police station, the magistrates' court and the remand prison reception area.

1. Police

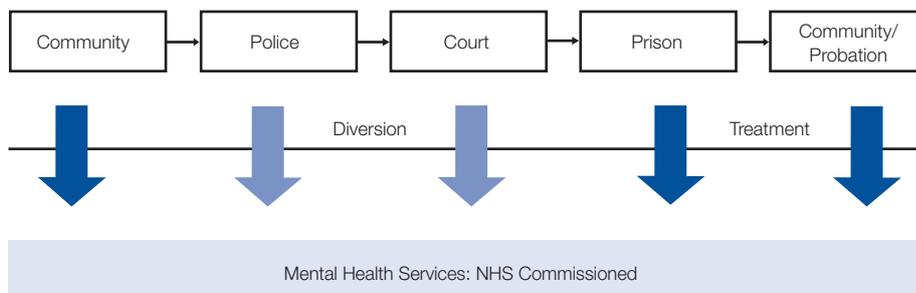
Current provision

The police are commonly a first point of contact for a person in a mental health crisis. A Home Office review in 2006

showed that out of 2,230,000 arrests between 7% and 15% involved a person with a mental health disorder.²⁸ There are many reasons for this: people may be detained for their own safety or the safety of others; police may accompany social workers to a person's home for a mental health assessment; or it may become clear that somebody who has been arrested for a criminal offence is suffering from mental distress.

A large volume of police work relates to initial contacts and interactions with people who have a mental health problem or who are emotionally vulnerable. Under Sections 23 and 26 of the Police and Criminal Evidence Act police can search and arrest someone whom they consider to be in need of possible police intervention, either as the result of a public request, from an agency such as a local authority or their own identification.²⁹

Figure 4: The offender mental healthcare pathway



²⁸ Final report of the Strategic Policy Team project on mentally disordered offenders, Home Office, Unpublished

²⁹ Bather P, Fitzpatrick R, Rutherford M, *Briefing 36: Police and Mental Health*, Sainsbury Centre for Mental Health, 2008

Where an individual is suspected of having a mental health problem and is in need of immediate care or control, the police can use Section 136 of the Mental Health Act 1983 to take the person from a “public place” to a “place of safety” for up to 72 hours. Where the person is not in a public place, the police may use Section 135 to gain access to his home or property by force following the granting of a court warrant.³⁰

“ There is evidence that the system is failing: mentally disordered offenders are being returned to the community uncharged, but without the opportunity for psychiatric or social intervention being taken ”

Sole place of safety

Under the Mental Health Act, someone in a public place who is deemed to be in “immediate need of care or control” can be taken to a designated place of safety. A person can be detained for up to 72 hours while he or she is assessed and arrangements for any necessary care are made. Places of safety include hospitals or nursing homes for people with mental health needs, but 11,000 people are detained in police cells as places of safety each year.³¹

In a 2004 study of nine court diversion schemes by Nacro, the crime reduction charity, 34% of respondents said that their area was using police stations as their “sole place of safety”.³² Many police forces report that they have no alternative to using police stations as places of safety due to the absence of appropriate facilities within health settings.³³ However, there is widespread agreement that police cells are not an appropriate place to carry out a mental health assessment as being in a cell can worsen some individuals’ mental distress. As many as 200 patients a year commit suicide within two days of leaving police custody.³⁴

The Joint Committee of the House of Lords and House of Commons on Human

Rights Deaths in Custody 2004-05 agreed, stating:

“People requiring detention under the Mental Health Act should not be held in police cells. Police custody suites, however well resourced and staffed they may be, will not be suitable or safe for this purpose. In our view, there should be statutory obligation on healthcare trusts to provide places of safety, accompanied by provision of sufficient resources from the government.”

Arrest

When mentally disordered persons are arrested and taken to the police station custody suite, sufficient resources should theoretically be available to ensure assessment and transfer to healthcare facilities where appropriate. Under Code C of the Police and Criminal Evidence Act 1984, the custody sergeant, if he suspects that a person might be mentally disordered, is obliged to seek the services of an appropriate adult to represent the subject’s best interests.

In police custody, healthcare is conducted under the supervision of forensic medical examiners (FMEs) who are responsible for assessing whether a detainee is fit for questioning by the police. FMEs who have approval under Section 12 of the Mental Health Act 1987 are also responsible for assessing whether a person should be detained under the Act.³⁵ Where the FME thinks admission to hospital may be appropriate, he or she may advise the custody sergeant to contact an approved social worker to arrange a Mental Health Act assessment. Such an assessment can lead to compulsory admission under the powers granted by Part II of the Act or to voluntary admission.

The police may decide to take no further action, to caution, or to charge and bail; all these courses of action will permit hospital admission. If detention in custody is inevitable due to the seriousness of the charges, the police can send along a form

30 Ibid

31 Bather P, Fitzpatrick R, Rutherford M, op cit, 2008

32 *Findings of the 2004 survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales*, Nacro, 2005

33 Bather P, Fitzpatrick R, Rutherford M, op cit, 2008

34 www.independent.co.uk/life-style/health-and-wellbeing/health-news/mental-health-campaign-police-should-not-have-care-of-mentally-ill-398952.html

35 Bather P, Fitzpatrick R, Rutherford M, *Briefing 36: Police and Mental Health*, Sainsbury Centre for Mental Health, 2008

providing notification of their concerns about mental health when the prisoner goes to court.

With a few exceptions, medical provision within police custody is commissioned by local police forces.

Obstacles to diversion

Custody diversion teams were introduced in England to divert mentally disordered offenders, particularly those arrested for minor offences, away from the criminal justice system and custody because of concerns about the growing numbers of mentally disordered prisoners. In theory, sufficient resources should already exist at the police station to effect such diversion. But there is evidence that the system is failing: mentally disordered offenders are being returned to the community uncharged, but without the opportunity for psychiatric or social intervention being taken.

Police officers are often the first to be called to an incident of a person experiencing a mental health crisis and they spend significant amounts of time interacting with people with mental health disorders, yet they receive very little training in the awareness and identification of mental health issues, learning difficulties and social care needs. In fact, mental illness is a factor in many of the most serious cases of police misconduct investigated by the Independent Police Complaints Commission. Its predecessor, the Police Complaints Authority, found that about half of deaths in police custody are of people with some form of mental health problem.

Police officers have limited time to process a person while in custody. If they were required to conduct more comprehensive health assessments, this could reduce the amount of time available to investigate a crime. Police custody suites may not have adequate health facilities to support an individual with mental health disorders for long periods.

A senior officer in ACPO and Scotland Yard's lead on mental health has said that the police are increasingly being left "holding the baby" when it comes to looking after mentally ill people – something they are not trained to do – because health and ambulance services treated them as low priority.³⁶ Relationships between police forces and health and social services are often difficult. Mental health services rarely use police stations as places from which people can be diverted to appropriate care and support. Police stations rarely refer people with drug problems to mental health services for investigation of any mental health difficulties that may underlie their substance abuse.³⁷

2. Courts: Diversion and Liaison and Mental Health Treatment Requirements

Development of diversion and liaison schemes

Those offenders with a mental illness who are not diverted by the police or do not have their charges dropped will continue to the courts. The courts have a number of options available to them under the Mental Health Acts 1983 and 2007 and many have diversion or mental health liaison schemes. In many of the schemes surveyed by HM Inspectorate of Prisons in 2007, any agency could refer an individual for diversion, but there were few formal strategies for ensuring that the individuals were referred. The evidence suggests that many mentally disordered offenders bypass the current diversion schemes and are placed in unsuitable prison accommodation. This is primarily due to limited awareness among the judiciary, perceived lack of capacity in secure mental health hospitals, the unwillingness of primary care trusts to fund such placements, lack of willingness by mainstream community-based mental health services to take people onto caseloads (i.e. those committing less serious offences) and problems within the system for diagnosis and referral.

³⁶ Independent, www.independent.co.uk/life-style/health-and-wellbeing/health-news/mental-health-campaign-police-should-not-have-care-of-mentally-ill-398952.html (last accessed 22.12.08)

³⁷ Bather P, Fitzpatrick R, Rutherford M, op cit, 2008

Definitions of “diversion” and “liaison”

Diversion from courts removes people with mental disorders from the criminal justice system either to hospital or a suitable community placement. There are three principal reasons why diversion is necessary. First, when those with mental disorders fall through the net of psychiatric services they tend to gravitate towards the criminal justice system; secondly the standard of healthcare provided in prison is poor; and thirdly, because prison healthcare centres are not recognised as hospitals for the purposes of the Mental Health Act 1983, treatment for mental disorder cannot be given against a prisoner’s will unless this can be justified under common law.³⁸

Diversion differs from liaison, but may be complementary to it. Liaison services link offenders into appropriate community services and typically deals with offenders whose mental state is not poor enough to justify a hospital admission. It requires collaboration between various agencies on behalf of the individual in order to provide continuity of services and care and to avoid duplication, whether in the criminal justice system or the community. With the advent of prison in-reach (services provided in prison) and rehabilitation and resettlement teams, liaison now also refers to the function of linking offenders with mental health services in the prison at their point of entry, and importantly, with community services at their point of release.³⁹

Development of diversion schemes

The first diversion scheme was introduced in 1989, with joint Home Office and Department of Health funding. In 1992, the Reed Report reviewed services providing health and social care interventions for mentally disordered offenders. It advocated diversion, identified best practice and barriers to providing for mentally disordered offenders, and highlighted areas for development.

After publication of the report many schemes were established with the aim of placing mentally ill offenders into mental health services, as opposed to the criminal justice system. By 1997, there were 190 diversion schemes but by 2004 these had fallen back to 140.⁴⁰ In 2008, the Secretary of State for Justice commissioned a review, led by Lord Bradley, into the diversion of offenders with mental illness from the criminal justice system.

Problems with current court diversion schemes

Despite promptings from the Home Office, Department of Health and academic institutions, the quality of diversion schemes is inconsistent. In a recent consultation document “Improving Health, Supporting Justice”, the Department of Health commented:⁴¹

“People brought before the courts can present with a range of differing health and social care needs, including mental health and substance misuse issues. These needs can often go unrecognised and therefore unmet, with the offender given a custodial sentence when a hospital order (under the Mental Health Act) or a community order with a treatment requirement would be more appropriate. Although the various court diversion schemes in existence all have different systems and protocols (itself a problem) a number of common problems do arise.”

The Mental Health Act Commission’s twelfth biennial report, published in 2008, described current diversion schemes as having no ring-fenced funding, no blueprint and no clear accountability. As a result, there are inconsistencies in delivery between areas and even individual schemes.⁴² The reasons for the situation include poor provision of schemes; lack of funding and facilities; staff shortages and lack of professional input; poor intera-

38 Birmingham L, “Diversion from Custody”, *Advances in Psychiatric Treatment*, vol 7, pp 198-207, 2001

39 *Review into the current practice of court liaison and diversion schemes*, Centre for Public Innovation, 2005

40 Brooker C, Ullmann B, *Out of Sight, Out of Mind: the state of mental healthcare in prison*, 41

41 *Improving Health, Supporting Justice: A Consultation Document*, Department of Health, 2007

42 *The diversion of individuals with mental health problems away from the criminal justice system and prison*, Partnerships in Care, 2008

gency working; lack of awareness of court diversion schemes and no national guidance.

Poor provision of schemes

Research by Nacro in 2004 found that three out of four magistrates' courts have no court diversion schemes in their area to access.⁴³ Since an estimated 269,000 offenders are identified with a mental health disorder at arrest (12% of all arrested offenders), this means that only 67,000 of them are able to benefit from such schemes.⁴⁴

The nine court diversion schemes reviewed in the Nacro study exemplified the national variation in service: some receive referrals from a wide range of local agencies – police, courts, probation, community mental health teams, social services – while others have more limited sources of referrals – typically from the police, courts and probation. The term “court” diversion schemes can therefore also be misleading as court is just one of the stages at which referral to schemes takes place.

Lack of funding and facilities

Primary care trusts (PCTs) are responsible for commissioning and providing mental healthcare across the offender pathway. Although funding for prison mental healthcare is ring-fenced and centrally allocated, it is not recurrent and all other aspects of offender mental health provision is left to local PCT discretion. There are “no obvious financial incentives for them to commission mental health services to provide diversion and liaison schemes”.⁴⁵

The Nacro survey of more than 60 court diversion/criminal justice mental health liaison schemes found that funding levels were mostly constant, but that some schemes' funding had decreased – often because of a trust-wide funding deficit or the diversion of resources to prison in-reach – and these were struggling.⁴⁶

Staff shortages and lack of professional input

The Centre for Public Innovation found that diversion schemes ranged from single-staff to multidisciplinary teams. All had at least one community psychiatric nurse on the team, with one exception where a forensic psychologist was the lone member of staff.⁴⁷ A quarter of court diversion schemes had seen a decrease in staffing levels in the previous year.⁴⁸ Just under a third (30%) of schemes cited staffing issues as a barrier to the operational success of the schemes.⁴⁹ Half had no input from either a psychiatrist or a psychologist.⁵⁰

Awareness of court diversion schemes

There appears to be a lack of awareness among the judiciary and others of the availability of diversion schemes or forensic psychiatric hospital beds. In 2006 1,440 mentally disordered offenders were moved from the penal system into forensic psychiatric services. More than a third of those (473) were initially sentenced to time in prison and later transferred to hospital, compared to the 21% (303) who were diverted into forensic psychiatric care at the point of sentencing. Only two of the 23 primary care trusts assessed by the prisons' inspectorate in 2007 were aware of diversion schemes in their area.⁵¹

No national guidance

One of the biggest problems with assessing the effectiveness of court diversion and liaison schemes is that there is currently no co-ordinated performance monitoring; there is no national performance management framework in place. The work of these schemes is not grounded in the wider performance management and monitoring of either mental health or the criminal justice system. As such, it is not possible to say clearly whether a scheme is effective or not, or to describe what causes a scheme to be effective or whether it is “value for money”. This is generally true of mental health service provision across the whole pathway.

43 Findings of the 2004 survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales, Nacro, 2005

44 Final report of the Strategic Policy Team project on mentally disordered offenders, *Home Office*, Unpublished

45 Rickford D, Edgar K, *Troubled Inside: Responding to the Mental Health Needs of Men in Prison*, Prison Reform Trust, 2005

46 Findings of the 2004 survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales, Nacro, 2005

47 *Review into the Current Practice of Court Liaison and Diversion Schemes*, Centre for Public Innovation, 2005

48 Brooker C, Ullmann B, op cit, 2008

49 Rickford D, Edgar K, op cit, 2005

50 Brooker C, Ullmann B, op cit, 2008

51 *The diversion of individuals with mental health problems away from the criminal justice system and prison*, Partnerships

A joint Home Office and Department of Health review in 2005 found that “targets, performance management and outcome analysis were generally not in place and that many places in England and Wales had no court diversion services at all”.⁵² Schemes are particularly vulnerable to closure if they have no operational protocol in place and/or no steering group overseeing the work of the scheme.⁵³ The report by the Centre for Public Innovation noted: “Clearly defined outcomes for the schemes were rare. Many found it difficult to articulate the intended outcome of the scheme for the clients and the wider mental health service system. In general, outcomes were referred to and measured in terms of inputs and outputs. For example ‘we see 200 individuals, refer on 15 and case-manage 50’.”⁵⁴

3. Prison *Development of prison mental healthcare*⁵⁵

In 1996 the responsibility for all prison healthcare rested with the Home Office and the Prison Service not the Department of Health and NHS. In that year, David Ramsbotham, then Chief Inspector of Prisons, published a highly critical report, *Patient or Prisoner?*, which drew attention to the inadequate care for the mentally disordered in prison; the lack of suitable training for medical and nursing staff and isolation from new clinical developments; the lack of continuity of care between prison and community; and ignorance of the needs of specific groups of prisoners such as women and young people.⁵⁶ Despite these unsatisfactory standards, his report pointed out that mental healthcare in prison was more than twice as expensive per person as that provided by the National Health Service for the general population.

The principle of equivalence

Ramsbotham noted that prison could exacerbate mental health disorders with

long-term impact on the individual concerned and the community into which he or she was released.⁵⁷ *Patient or Prisoner?* declared: “Prisoners are entitled to the same level of healthcare as that provided in society at large. Those who are sick, addicted, mentally ill or disabled should be treated...to the same standards demanded within the National Health Service.”⁵⁸ It recommended that the NHS should take over responsibility for prison healthcare and outlined several ways of doing so.

The following year, the Health Advisory Committee for the Prison Service published its report, *The Provision of Mental Healthcare in Prisons*.⁵⁹ This also drew attention to the poorly co-ordinated delivery of healthcare in prisons and the need for more effective through-care and after-care arrangements.⁶⁰ Prisons, it said, should “give prisoners access to the same quality and range of healthcare services as the general public receives from the NHS”.⁶¹

These two documents paved the way for the transfer of responsibility for healthcare in prisons from the Prison Service to the National Health Service.

The transfer of prison healthcare to the NHS

To address the issues raised by *Patient or Prisoner?*, a joint Prison Service and NHS executive working group was established to develop practical proposals for change. The resulting report, *The Future Organisation of Prison Healthcare*, conceded that prison healthcare varied considerably in terms of organisation, delivery, quality, effectiveness and links with the NHS.⁶² It acknowledged that an extensive programme of change was required but rejected calls that the NHS should assume sole responsibility for all prison healthcare – on the ground that differences in workplace culture might lead to healthcare staff working in prisons being marginalised. It recommended that the two organisations should be jointly responsible for identifying the health needs of prisoners

52 Brooker C, Ullmann B, op cit, 2008

53 Findings of the 2004 survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales, Nacro, 2005

54 Review into the current practice of court liaison and diversion schemes, Centre for Public Innovation, 2005

55 A recent report by Policy Exchange, *Out of Sight, Out of Mind*, documented a frank assessment of prison mental healthcare, including a historical look at its development as well as current progress and shortfalls. The report examined the issues surrounding prison mental healthcare in more depth than is possible here, but the main findings will be looked at here as an important part of the offender mental healthcare pathway

56 HM Chief Inspector of Prisons, *Patient or Prisoner?* HM Inspectorate of Prisons, 1996

57 Ibid

58 Ibid

59 *The Provision of Mental Healthcare in Prisons*, Health Advisory Committee for the Prison Service, Home Office, 1997

60 Birmingham L, “The Mental Health of Prisoners”, *Advances in Psychiatric Treatment*, 9, 191-201, 2003

61 *The Provision of Mental Healthcare in Prisons*, Health Advisory Committee for the Prison Service, Home Office, 1997

62 *The Future Organisation of Prison Healthcare*, Joint Prison Service and National Health Service Executive Working Group, Department of Health, 1999

in their area and, thereafter, for the planning and commissioning of appropriate services.

The working group was clear that systems for dealing with the high incidence of mental health disorders in prisoners were underdeveloped. Two major issues were screening arrangements to identify the need for mental healthcare at reception and the inadequate level of care-planning that takes place generally within prisons.⁶³ The report recommended that to improve this situation the care of mentally ill prisoners should be developed in line with national standards.⁶⁴

The advent of mental health in-reach

Two years later, *Changing the Outlook* – a Department of Health policy document – developed a more specific policy for modernising mental health services in prisons.⁶⁵ The foreword reaffirmed the principle of the National Service Framework underpinning the strategic direction of service development and set out a vision for the next three to five years. It recognised that this was likely to be a major challenge given that mental health services in prisons were ineffective and inflexible, and “struggling to keep pace” with developments in the NHS at large.⁶⁶ The report called for a “move away from the assumption that prisoners with mental health disorders are automatically to be located in the prison healthcare centre”; suggesting greater use of primary care, in-reach services, day-care and prison-wing treatments that mirror community-based mental health services.⁶⁷

To enable prisoners with mental health disorders to remain in their normal location in prison required the establishment of multidisciplinary mental health in-reach teams to provide specialist services to prisoners in the same way as community mental health teams do to patients in the community.⁶⁸ These teams were funded by local primary care trusts. Although it was anticipated that all prisoners would eventually benefit from the introduction of in-reach services, the early focus of the teams’ work was on those

with severe and enduring mental illness. A target was set that promised 300 more staff to provide in-reach services by April 2004, so that 5,000 more prisoners with a severe mental illness would receive better care and treatment and have a care plan on release. This has now been met and there are 70 in-reach teams working in prisons consisting of a core of psychiatric nurses, although access to other professionals such as psychiatrists, clinical psychologists, occupational therapists, drugs workers and counsellors is scant.⁶⁹

“ The working group was clear that systems for dealing with the high incidence of mental health disorders in prisoners were underdeveloped ”

By April 2006 responsibility for prison healthcare had been transferred fully to the NHS. There has clearly been some improvement in mental healthcare provision and a greater acknowledgement of the health needs in prison, however serious deficiencies still remain.

Problems with prison mental healthcare Multidisciplinary teams

Services for prisoners with mental health disorders are delivered by numerous teams some commissioned by the NHS (such as in-reach teams), others commissioned by the Prison Service, which is part of the Ministry of Justice. This disjointed commissioning leads to poorly co-ordinated, ineffective services.

Training for Prison Staff

Prison officers have the most contact with prisoners day-to-day and as such can act as their primary carers. With such a high prevalence of mental illness it is essential that prison officers have the skills to identify and deal with mental illness. Training is not sufficient and in some cases is not

63 Ricketts T, Brooker C, Dent-Brown K, “Mental health in-reach teams in English prisons: Aims, processes and impacts”, *International Journal of Prisoner Health* 3(4) 234-247, 2007

64 Brooker C, Sirdifield C, Belshaw L, *A Review of Mental Health Service Provision in the Lincolnshire Prisons*, University of Lincoln, 2008

65 *Changing the Outlook: A strategy for developing and modernising mental health services in prisons*, Department of Health, 2001

66 Ibid

67 Ibid

68 Community mental health teams comprise a variety of professional backgrounds and aim to provide one point of access to mental health services for adults assessed as suffering from a severe mental health problem

69 *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

compulsory. Prison officers do not feel qualified to deal with prisoners with mental disorders.

Funding

Funding should be based on rationally assessed needs, rather than historical precedent from the days when the Home Office allocated funds to the Prison Service. The staffing levels of prison in-reach teams are far below their equivalent in the community where there is much less mental illness. A sophisticated health needs assessment should be undertaken in order to find the real funding necessary for providing for the prison community.

4. Release and probation

The problems that prisoners face on their return to the community are well documented. Some reports suggest that 40% are homeless on release but that stable accommodation can reduce reconviction rates by more than 20%. Despite this, research shows that only 19% of prisoners received help with accommodation before leaving prison and only 33% of those who were homeless received help looking for accommodation.⁷⁰

A 2008 study of released prisoners in Washington State found that former prison inmates were at high risk of death after release from prison, particularly during the first two weeks. In that period, their risk of death was almost 13 times that of other state residents, with a markedly elevated relative risk of death from drug overdose. The leading causes of death among former inmates were drug overdose, cardiovascular disease, homicide and suicide. For offenders with mental health disorders, these factors are likely to be even more exaggerated.

In 2008 the document *Refocusing the Care Programme Approach* from the Department of Health suggested that the criteria for eligibility for the new approach should include a diagnosis of severe mental disorder, risk of

self-harm, history of offending and substance misuse. It recommended multiple service provision from different agencies, for example housing, employment, criminal justice and voluntary agencies.⁷¹

In 2006 the Prison Service issued an order on continuity of healthcare for prisoners that provides guidance on transfer and discharge of prisoners.

These policies have at least ensured that continuity of care is on the healthcare agenda for the prison population. However, in practice it can be hard to implement. A review of London's prisons reported that in-reach teams found it difficult to engage with community mental health teams and organise care when a prisoner was released. Also some care coordinators were reluctant to continue responsibility for their clients when they went into prison. In some instances, this was a practical difficulty as clients were located in a prison a long distance from their home and where their care co-ordinator was based.⁷²

Care Programme Approach

Through the care programme approach (CPA), offenders with a severe mental illness are supposed to be linked to mainstream mental health services on release from prison.⁷³ The aim of the CPA is to provide on-going integrated and effective aftercare for prisoners with mental health, substance misuse or co-existing problems. However, research into continuity of mental healthcare for ex-prisoners with psychosis found that of those who had been released only 23% had an appointment with a mental health professional.⁷⁴ Furthermore, prisoners with low-level mental illness are not put on the CPA. The offender mental healthcare pathway (DH guidance on best practice) advises that those with "mild" mental health disorders should be left to make an appointment with the GP themselves. But even

70 Keil J, Bruton L, Thomas S and Samele, *On the Outside: continuity of care for people leaving prison*, Sainsbury Centre for Mental Health, 2008

71 Ibid

72 Ibid

73 The CPA is the case management system adopted by all secondary care mental health services in the community (outside prison) in England. A care co-ordinator is appointed to link various elements of care and to organise multidisciplinary reviews of care. CPA should involve both users and carers in planning and reviewing

74 Melzer D et al, "Prisoners with Psychosis in England and Wales: A one year national follow up study", *The Howard Journal*, 41, (1), pp 1-13, 2001

with mild mental health disorders, an ex-offender will be likely to lead a chaotic lifestyle and be particularly vulnerable in the first two weeks on release from prison. Many offenders who are given the opportunity to stay in touch with a professional will not do so.⁷⁵

Probation

Very little is known about the formal prevalence of mental health disorders for offenders being managed in the community and probation staff receive little mental

health training in their preparatory course. A recent health needs assessment suggests that up to 30% of probation caseloads are people who, in the past, have had formal contact with mental health services.⁷⁶ Clearly, the prevalence of both alcohol and drug problems is higher than this. There have been no formal estimates of personality disorder in this group. A further constraint, even on those known in probation to have a mental health disorder, is lack of access to services especially to psychological therapies.

75 Keil J, Samele C, *Resettlement Needs of Female Prisoners*, Sainsbury Centre for Mental Health, 2008

3

The NHS and offender mental health

Although PCTs assumed responsibility for the mental healthcare of offenders in 2006, there has been little support provided for commissioners who, in many cases, were undertaking a completely new role. This is especially true when the needs of community-based offenders with mental health disorders are considered. Commissioning of general healthcare for offenders is still weak. Provision of mental healthcare for offenders remains of marginal interest to PCTs, little information is shared between agencies (case management and partnership work) and funding is based on historical arrangements rather than current needs. Responsibility for policy rests with the Department of Health. But the fact that offender health is a separate directorate within the DH makes it difficult to integrate mainstream health developments into prisons, such as increasing “access to psychological therapies” and “reducing health inequalities”.

A recent study in the East Midlands has shown that there is highly variable investment by PCTs in offender mental healthcare across the pathway.⁷⁷ PCTs have received little incentive to invest in offender mental health and also very little support to undertake what is a specialised area of healthcare that is new for many of them. PCTs should be commissioning services for offender mental health across the whole criminal justice pathway and not focusing resources solely on prison, but commissioners struggle with this broader agenda. One reason for this is the lack of guidance

on the function of prison mental health in-reach services and, indeed, court diversion schemes.

Tackling health inequalities

Since the publication by the Department of Health in 2003 of *Tackling Health Inequalities: a programme for action*, the Government has focused on reducing health inequalities in society at large and believes that it has made significant progress. The DH has recently produced a review of progress, *Tackling Health Inequalities: 2007 status report on the programme for action*.⁷⁸ This report included 82 targets designed to reduce health inequalities. Only three of these targets, listed below, refer specifically to offenders even though standardised mortality rates for people released from prison are 3.5 times higher than the general population and in the first two weeks following release ex-prisoners are nearly 13 more times more likely to die than the general population.⁷⁹ In addition, the general health status of those on probation has been shown to be significantly worse than that of social class V (the most deprived) in the general population.⁸⁰

Three offender health-related commitments from *Tackling Health Inequalities: 2007 status report* are to:⁸¹

1. Support vulnerable groups through the Supporting People programme, including teenage parents, victims of domestic violence and ex-offenders, as

76 Brooker C, Syson-Nibbs L, Barrett P and Fox C, “Community Managed Offenders’ Access to Healthcare Services: report of a pilot study”, accepted for publication, *Probation Journal*, 2008

77 Brooker C, Belshaw L and Fox C, *Prison Mental Health Spend in the East Midlands 2007-2009*, University of Lincoln, 2008

78 *Tackling Health Inequalities: 2007 status report on the programme for action*, Department of Health, London, 2007

79 Binswanger et al, *Release from Prison — A High Risk of Death for Former Inmates*, *N Engl J Med* 2007;356:157-65

80 Brooker C, Syson-Nibbs L, Barrett P and Fox C, “Community Managed Offenders’ Access to Healthcare Services: report of a pilot study”, accepted for publication, *Probation Journal*, 2008

81 *Good Practice in Prison Health*, Department of Health, 2007

well as independent living within communities for older, disabled and vulnerable people.

2. Increase participation of problem users in treatment programmes, maintain the proportion successfully completing treatment programmes, further expand the drug treatment workforce, and improve access to treatment programmes, driving down the waiting lists across all treatments.
3. Address prisoners' mental health needs by providing all prisoners with severe mental health disorders with a care plan by 2004.

The commissioning of offender health programmes is a recent imperative and targets for health inequality reduction feature insignificantly for this group. If offenders are not included in major government health programmes and if commissioners are inexperienced in offender health needs, it seems likely that PCT plans to address this area will remain a low priority. In the complex world that is PCT commissioning it is hardly surprising that PCTs focus on their target list of 'must-do's' and omit

areas of investment that are perceived as optional.

World-Class Commissioning and Lord Darzi's review

According to the Department of Health, world-class commissioning will transform health and care services by applying a more strategic and long-term approach. "The world class commissioning programme is designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way anywhere in the world."⁸⁴

If world-class commissioning is to be developed for the offender mental health system it is essential to:

- develop a common understanding of need;
- develop an integrated care pathway currency;
- agree a national approach to incentives (tariff or otherwise);
- secure a strong contractual, performance and regulatory framework for the whole system using and developing information and benchmarking.

Box 1: Offenders' health⁸²

- There are more offenders with mental health disorders serving community sentences (33% of all those serving community sentences) than serving custodial sentences (28% of all those in custody)⁸³
- An estimated 269,000 offenders are identified with a mental health disorder at arrest accounting for between 7-15% of all arrested offenders
- 90% of all prisoners have a diagnosable mental health problem, substance misuse problem or both
- It is estimated that 5,000 (7%) prisoners are seriously mentally ill
- 80% of prisoners smoke
- About 0.3% of the male prisoners and 1.2% of females are HIV positive
- 24% of prisoners have injected drugs
- A fifth of prisoners who misuse illicit drugs by injection (about 16,000 prisoners) are infected with hepatitis B and 30% with hepatitis C
- Around 2% of remand prisoners attempt suicide in any given week
- Suicide rates in prison and following release are at least six times as high as rates in the general community

⁸² All figures from Ministry of Justice and Department of Health

⁸³ These figures are based on 59,000 assessments of offenders given community sentences and 23,000 assessments of offenders given custodial sentences during 2004-05. All assessments were completed either at pre-sentence report or during supervision in the community. For offenders given custodial sentences, supervision in the community means the start of the period of supervision on licence

⁸⁴ World-Class Commissioning, Department of Health, 2008; www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm

Figure 5: The features of world-class commissioning⁸⁵



Research by Policy Exchange suggests that commissioners lack the information, the tools and the expertise to drive complex service change.⁸⁶ Some health experts blame this on the reorganisation of commissioning at a local level, which led to the loss of expertise. There is also a skills gap and a power imbalance between primary care trusts and large hospital trusts. The criminal justice system is complex and, where little incentive exists, it can be difficult for PCTs to engage with organisations within it.

The decision-making processes in PCTs are the subject of particular criticism; they are seen as slow and ultimately indecisive when dealing with changes that have the potential for significant benefits. The perception is that commissioners, like managers, too often focus on the imperative of balancing the budget and resist costly changes. The problem can be compounded when PCT commissioners and PCT providers sit too close together (it is still not uncommon for both organisations to have the same finance director, for example).

In 2008, the Government published the final report of the NHS review, conducted by Lord Darzi, *High Quality Care for All*, which provides an opportunity to rethink the organisation of health service delivery.

Commissioning healthcare for offenders

Since commissioning for criminal justice and mental health was only formally transferred to the NHS in April 2006 some offender health experts believe it is too early to assess its effectiveness. All PCTs with a prison in their area should have commissioned health needs assessments of their prison populations, which in turn should have led to the development of local health delivery plans for each prison. But offender health commissioning is not only in its infancy, it is also complex: up to four or five providers may be involved but all working in isolation of one another. Nor does the NHS performance management framework give PCTs any incentive to invest in offender mental health services.

⁸⁵ NHS Confederation
⁸⁶ Barlow J and Burn J, *All Change Please*, Policy Exchange, December 2008

Funding for commissioning responsibilities

The NHS has provided additional funding in order to meet commissioning needs.⁸⁷ Overall spending on prison healthcare has increased from £118 million in 2002-03 to nearly £200 million in 2006-07. By 2005-06 nearly £20 million was being invested recurrently in mental health in-reach. While acknowledging the improvements, the thematic review of mental health by the prisons' inspectorate, remained critical of the gaps in provision – there was still too much unmet and, sometimes unrecognised, need in prisons.

Out of Sight, Out of Mind suggested that funding for prison mental health services was totally inadequate. A Sainsbury Centre for Mental Health publication, *Short-changed*, is also strongly critical of the total amount spent on prison mental health and the regional variation in spending patterns.⁸⁸ The DH recognises that when prison healthcare commissioning was transferred to the NHS, funding arrangements were based on historical information, and there is a need to recognise that many establishments have expanded, escort costs are now included in healthcare budgets and overcrowding pressures have changed the demographics of many prisons. In addition, only prison mental health funding is centrally allocated by the DH and any other offender mental health services have to be paid for from existing PCT budgets, which have not been increased specifically for this purpose.

Disjointed commissioning between mainstream mental health services and different parts of the criminal justice system

The main PCT commissioning focus to date has been for mental health services in prisons, however for what is a complex arena there has been little support for PCT commissioners. Offenders have mental health needs outside of prisons too, so there is a real need for commissioner competency in areas without prisons as well. The NHS is

not involved in commissioning services throughout the pathway. For example, Counselling Assessment, Referral Advice and Throughcare Teams (CARATs) and probation services are commissioned by the regional National Offender Management Service (NOMS) office. This has negative implications for cost effectiveness, the provision of a more seamless service, service quality and information sharing.

Case management and partnership work

The Department of Health partnership strategy suggests that a key component will be support for “aligned commissioning” (the joint efforts of organisations to share information about commissioning intentions, service and delivery plans, and to monitor outcomes) to shape and guide the relationship between NOMS and NHS commissioners. This will help to co-ordinate decisions over the development of services and monitor performance. We agree with the Sainsbury Centre for Mental Health that the idea of “aligned” commissioning between the NHS, local authorities and criminal justice services has potential, but it will not work without clear goals, proper guidance and a high priority from government.

Current offenders with mental health needs often get lost in the gaps between the NHS and the criminal justice system. A case management model (such as the offender management system or the one offered by assertive outreach teams) would be better placed to do this. A common theme that emerged from our round table discussions with specialists in the field was that improved partnerships and joint working with better understanding of other's roles and responsibilities (with mechanisms for raising concerns) would enable unified approaches. This includes policymaking within the DH offender health unit itself, which is too isolated from mainstream policy – such as reducing health inequalities.

87 Hayton, P., and Boyington, J. (2006). Prisons and Health Reforms in England and Wales. *American Journal of Public Health*, 96:10, 1730-1733.

88 Brooker C, Duggan S, Fox C, Mills A and Parsonage M, *Short-changed: spending on prison mental health care*, Sainsbury Centre for Mental Health, 2008

Resettlement services before release from prison are poor, partly because early discharge planning has not improved. Offenders are often not registered with a GP before release and prisoner movement around the prison estate hinders continuity of care and effective discharge planning.⁸⁹

Performance management

In 2007 the Department of Health issued 31 (non-mandatory) performance indicators for monitoring offenders' health needs. These include management of medicines; service-user involvement; health needs assessments; access to mental health services and primary care mental health. The extent to which PCTs use these performance indicators is unreported and use of them is not mandatory.

The National Offender Management Service and the Care Services Improvement Partnership (CSIP) jointly published a report addressing community primary care access for offenders in the West Midlands. This document includes nine recommendations that support the achievement of five public service agreement targets.⁹⁰ The recommendations focus on raising awareness about offenders' poor access to health services including GPs, the provision and access of information that can be used to inform on the services needed, the development and monitoring of appropriate care pathways and the consideration of approaches that will support the access of offenders to primary care.

A lack of good practice throughout the criminal justice pathway

There is a slowly emerging idea of good practice: the DH offender mental healthcare pathway of 2005 set out guidance for best practice at every stage of an offender's journey across the criminal justice system; the document provides guidance on expectations for staff working with offenders both before entrance to prison and on their release.⁹¹ Another document, on good practice in prison health, contains 50 case studies gathered for a survey commissioned by the offender health unit. The document lists a wide range of projects from across the country that have sought to improve offenders' health, including supporting older prisoners, tackling substance misuse and mental health. They are focused on prison-based initiatives rather than mental health needs in the community.⁹²

Although there are many shortcomings in the delivery of such services there are a small number of sites in the country where good practice has developed, some of which we highlight in the following chapter.

Since 2006, the NHS, through PCTs, has taken over the responsibility for the commissioning of mental healthcare for offenders. The focus to date has been largely the provision of mental healthcare in prisons, largely, one suspects, because this budget is provided directly by the Department of Health. PCTs have also been slow to respond to the mental health needs of those in community settings, whether custody in police cells, appearances in court or community-based offender management.

89 Keil J and Samele C, "Resettlement Needs of Female Prisoners", accepted for publication, *Journal of Forensic Psychiatry and Psychology*, 2008

90 The five are PSA16: Increase the proportion of socially excluded adults in settled accommodation and employment, education and training; PSA17: Tackle poverty and promote greater independence and well-being in later life; PSA18: Promote better health and well-being for all; PSA23: Make communities safer; PSA25: Reduce the harm caused by alcohol and drugs.

91 Brooker C and Stoddart Y, *Offender Mental Health Care Pathway*, Department of Health, 2005

92 *Good Practice in Prison Health*, Department of Health, 2007

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Case studies and good practice

The case studies discussed in this chapter cover various parts of the offender mental healthcare journey and overall commissioning. The case studies are divided into five groups:

1. Policing strategy for mentally disordered offenders – South Wales and Memphis, Tennessee
2. Police diversion schemes – Northern Ireland, South Birmingham and London
3. Mental health courts – Brooklyn and San Francisco
4. Prison mental health services – HMP Bristol and HMP Nottingham
5. Offender healthcare plan (including mental health) – Derbyshire PCT

Case study set 1: Police strategy for mentally disordered offenders

A large proportion of mental health resources for offenders is directed to prisons. An offender will often come into contact with mental health services for the first time on entry to prison. As the case studies from South Wales and Memphis, Tennessee show, much earlier intervention is possible. The South Wales Police use a crisis resolution team led by healthcare professionals who, in partnership with the police, can provide immediate mental health services as well as training for police officers. In Memphis, Tennessee, police officers have been given awareness training to improve the way that they provide for mentally disordered offenders.

Lesson: Early intervention by police-led or health-led crisis resolution teams at the pre-arrest, arrest or custody stages, can stop problems escalating and ensure appropriate services are provided for mentally disordered offenders either before they are sent to prison or released back into the community without charge.

South Wales Police

In 2007, South Wales Police proposed a new model for working with mental illness, known as MH-PRIME (mental health – problem resolution in multi-agency environments).⁹³ It operates on three levels: community, crisis and care. The community and care levels deal with non-offenders with mental illness and are outside the scope of this research.

The report concluded that the later risk was identified and support provided, the greater people's long-term dependence on, and requirement for, top-end service provision will be. If mental health is seen as a positive state of mind, deviations from that state will not come to the notice of a healthcare professional until a person is in crisis or a serious crime has been committed.

The crisis level deals with the point where decisions are being made about detention under the Mental Health Act or by the police following a community disturbance or sometimes a criminal event. This is often the point where formal action is requested or is necessary because of an unforeseen crisis. At this time, mental health service users and those exhibiting signs of mental distress may require rapid

93 *Today's Communities, Tomorrow's Minds: Mental Health and Public Safety in Wales*, South Wales Police, 2008

support and assessment. In South Wales, the local mental health services take the lead in acting promptly to defuse situations causing concern.

To facilitate the MH-PRIME model the report proposed the formation of regional mental health crisis resolution teams or MH-CRTs (formally referred to as mental health criminal justice liaison teams). These teams would provide a healthcare-led partnership service to meet the needs, promote the interests of and protect the lives of people with mental health disorders.

“ As part of the Memphis Police Department’s community policing initiative, the programme brings together law enforcement personnel and mental health professionals, consumers, and advocates for the common goals of improving understanding of mentally ill individuals and their families ”

The teams would build on the working relationships between existing police staff and health based management teams and provide additional services, for example, a mental health nurse for those held in custody. They would also provide training for probation, police custody staff, court staff, magistrates and those involved in providing social care to those in the criminal justice system with complex mental health conditions.

The teams would liaise with services including those providing court diversion and pre-sentence reports, pre-charge advice to the Crown Prosecution Service and prison in-reach. They would provide a vital service for those in crisis who have been arrested and would be able to provide pre-charge advice to the CPS where those services do not exist.

The cost of establishing a MH-CRT based on the Mersey Care NHS Trust is estimated to be £311,000. The proposed level for Wales would be one for each regional centre. On

the assumption that five are recommended the estimated minimum cost would be £1.55 million. If using the same criteria for England and Wales (total of 14 regions) the cost would be £4.35 million. This represents 0.004% of the total NHS budget.

Memphis Police

More than a decade ago, the shooting of a mentally ill person by a police officer in Memphis, Tennessee, prompted the development of an innovative programme for the improvement of the police response to and diversion from jail of mentally ill people in crisis. The team evolved and currently operates through a partnership between the Memphis chapter of the Alliance for the Mentally Ill, the University of Memphis, and other local mental health providers. As part of the Memphis Police Department’s community policing initiative, the programme brings together law enforcement personnel and mental health professionals, consumers, and advocates for the common goals of improving understanding of, and safety and service to, mentally ill individuals and their families.

The crisis intervention team is staffed by police officers with special training in mental health issues. Besides their regular patrol duties, team officers provide a specialised response to “mental disturbance” crisis calls. For general patrol, the officers are assigned to a specific area; however, crisis intervention team officers have citywide jurisdiction to answer these specialised calls.

When police emergency dispatchers are notified of an incident that may involve a person with mental illness, they assign that call to a crisis intervention team officer. The team officer goes immediately to the scene, assesses the situation to determine the nature of the complaint and the degree of risk, intervenes as necessary to ensure the safety of anyone involved, and then determines and implements an appropriate disposition. The

officer may resolve the situation at the scene through de-escalation, negotiation, or verbal crisis intervention. Alternatively, the officer may contact the case manager or treatment provider of the person in crisis, provide a referral to treatment services, or transport the person directly to the psychiatric emergency department of the University of Tennessee Medical Center in Memphis for further evaluation.

The crisis intervention team is currently composed of approximately 180 patrol officers out of a police force of 1,800. The team provides 24-hour coverage in each of the city's seven precincts and officers respond to about 7,000 specialised calls a year.

Patrol officers volunteer for the programme. If selected, they receive an initial 40 hours of specialised training from mental health providers, family advocates, and mental health consumer groups at no charge to the police department. The officers learn about mental illness, substance abuse, psychotropic medication, treatment modalities, patients' rights, civil commitment law, and techniques for intervening in a crisis. However, advocates of the crisis intervention team are quick to point out that it is more than a training program. Among law enforcement officers it promotes a philosophy of responsibility and accountability to consumers of mental health services, their relatives, and the community.⁹⁴

Case study set 2: Police diversion schemes

Only a few of the custody suite (and police) diversion schemes have been properly evaluated – in Northern Ireland, South Birmingham and London.

Northern Ireland

The scheme, which began in June 1998, shares some features with the diversion-at-the-point-of-arrest model. It comprises a

rapid screening and mental health assessment at the earliest point of contact with the justice system, plus a mechanism for appropriate referral or diversion to health and social services. It is based in the largest of four police stations in Belfast, which operate under the Police and Criminal Evidence (NI) Order 1989, and which provide specialised questioning, identification and treatment of mentally disordered suspects. Two community mental health nurses operate the service with support from forensic psychiatry. The nurses liaise with forensic medical officers, police officers, court officials, probation officers and a range of health and social services professionals and voluntary agencies.

South Birmingham

South Birmingham's diversion-at-the-point-of-arrest scheme began at one police station in 1992 by providing a community psychiatric nurse to assess detainees, so that court diversion could be put into practice if justified. The station was part of the West Midlands Police "E" Division and covered a sector of the city centre and rural areas of North Warwickshire and Worcestershire. An initial evaluation of the scheme's first 12 months was promising and it was extended to other police stations.⁹⁵

The service is unique in that the nurses also co-ordinate follow-up care and provide ongoing advice and support to offenders, the police and healthcare professionals. They screen the custody record forms of all detainees for four factors: a history of mental illness and/or learning disability; an "odd" crime; a violent crime; unusual behaviour leading to referral by the police.

During the first 18 months, the nurses screened 4,917 custody record forms, 787 (16%) of which met one or more of the assessment criteria. These defendants were typically single, unemployed males in their early 30s; 26% of them were living alone and 18% were homeless. Nearly three-quarters had an institutional history,

94 Cochran S, Williams Deane M and Borum R, "Improving Police Response to Mentally Ill People", *Psychiatric Services*, 51, pp 1315-16, October 2000

95 Riordan S, Wix S, Kenney-Herbert J and Humphreys M, "Diversion at the Point of Arrest: mentally disordered people and contact with the police", *Journal of Forensic Psychiatry*, vol 11, no 3, pp 683-690, December 2000

including 44% who had been psychiatric inpatients. The 91% prevalence rate for mental disorder among those assessed in this study is similar to the most recent rates reported by police liaison schemes in England (85% and 90%). Importantly, almost half of the mentally disordered offenders were identified from the routine screening of custody record forms rather than a recommendation from the forensic medical officer (or the police or other criminal justice personnel). It is also worth noting that the FMOs missed a significant proportion of potentially more severe cases.

The service appears to be detecting and assessing most, if not all, offenders with significant levels of mental disorder, a large proportion of whom may require specialist health and social services intervention. The findings illustrate that mental illness among many detainees went undetected by custody sergeants and/or FMOs, but was identified accurately by the mental health nurses who also achieved considerable success in linking offenders to health and social services. Evidence to support their successful diversion from the courts is less conclusive.

Importantly, the nurses developed close and mutually supportive working relationships with other health and social service professionals and a wide range of people in the justice system. Key stakeholders indicated that the newly developed scheme has played an important, perhaps pioneering role in terms of developing and facilitating a much needed liaison between psychiatric services and the criminal justice system. But it is difficult to gauge the long-term impact of the scheme on the two systems of service provision, particularly in the absence of a fully integrated forensic mental health service in Northern Ireland. Nonetheless, this model of inter-agency working has developed within a region of the UK often considered more strongly associated with division and civil unrest than partnership, and it is possible that the

integrated health and social services in NI contributed positively to this development. The service also appears to have promoted a better understanding of the relationship between mental illness and crime and its prevention. Realistically though, many initiatives set up in isolation from mainstream services often fail to achieve their long-term goals, and this is particularly true of nurse-led schemes which are most effective when fully integrated with local psychiatric services or staffed by (senior) psychiatrists.⁹⁶ Thus, a community forensic mental health service and/or a reconfiguration of existing services would provide much needed support for the new scheme. A significant proportion of MDOs – including a sizeable group of violent offenders and those committing acts of self-harm – are unlikely to receive appropriate health and social care unless there are significant changes to general mental health service provision. These findings suggest the need for a radical rethink and an informed public debate about how more positive outcomes may be achieved in this population.

London

A London diversion scheme was established in three police stations in Westminster – Charing Cross, West End Central and Marylebone. Initially one forensic community psychiatric nurse was engaged to work exclusively on the project; after a year a second was added. They were attached to the local community mental health and social services teams and they had immediate access to the local forensic service for advice and support. Regular reviews of the project were conducted by a steering group, which involved representatives from the police stations in question, New Scotland Yard, the management of the forensic medical examiner services and from local health and social services, and a senior local forensic medical examiner.

In 31 months, 712 cases were assessed, an average of 23 a month. The majority

96 Birmingham L, Diversion from custody, *Advances in Psychiatric Treatment*, 7, 198, 2001

were male, young and unemployed, nearly half did not have permanent accommodation and drug use was relatively common. More than half had a history of previous psychiatric admission and a substantial minority were still nominally under the care of psychiatric services.

In 61% of cases the person had a record of previous convictions and 31% of convictions involved violence; 10% were on bail for other matters at the time of their arrest. At this arrest, 33% were charged with summary offences.

Case study set 3: Mental Health Courts

Mental health courts are one of the latest examples of “problem-solving courts” which bring different approaches to difficult cases where social, human and legal problems intersect. Pioneered in the United States, a handful of communities have created specialised mental health courts to address the complex issues that mentally ill offenders present. Although each jurisdiction has developed its own variation of a mental health court based on local needs and realities, they share several basic features. Such courts are only now being piloted in England and Wales.

Mental health courts handle only cases involving offenders with mental disorders. The judge, prosecutor, defence lawyer and other court staff often have special training in, and are familiar with, community mental health services. The court staff collaborate with community providers to provide a therapeutic intervention that may include medication management, substance abuse treatment, housing, job training and psychosocial rehabilitation. Offenders can have their charges or jail sentences deferred if they agree to participate in services. The goal is to prevent criminalisation and recidivism, reducing pressure on the prison system.⁹⁷

The Brooklyn study looks at the structures and processes typical of mental health courts which contribute to their effective-

ness, while the San Francisco study examines the effectiveness of mental health courts in reducing recidivism.

Lesson: There are basic concepts typical of mental health courts that can ensure that mentally disordered offenders are linked with mental health services which not only provide them with the appropriate care but also relieve pressure on the prison service and can help reduce recidivism.

Brooklyn

The Brooklyn Mental Health Court is a specialised court that responds to the problems posed by defendants with mental illness in the criminal justice system. Addressing both the treatment needs of defendants with mental illness and the public safety concerns of the community, the court links defendants suffering from serious and persistent mental illnesses (such as schizophrenia and bipolar disorder) who would ordinarily be on their way to prison to long-term treatment as an alternative to incarceration.

Key principles

To achieve its goals the Brooklyn Mental Health Court has adopted several operating principles that have proved successful at other problem-solving courts:

- Detailed screening and assessment to create individualised treatment plans
- Frequent judicial monitoring to keep the judge engaged with the defendant and emphasise for the defendant the seriousness of the process
- Accountability of the defendant for his or her actions
- Co-ordination of services with a broad network of government and not-for-profit service providers to address problems that defendants face, including substance abuse, homelessness, joblessness and serious health problems

⁹⁷ Watson A, Hanrahan P, Luchins D, Lurigio A, “Mental Health Courts and the Complex Issue of Mentally Ill Offenders”, *Psychiatric Services* 52 pp 477-481, 2001

Box 2: Case study of Mr B, Brooklyn Mental Health Court client

At the time of his first court appearance, Mr B was a 28-year-old, single, unemployed African-American man of Haitian descent living with his parents. He had graduated from university with a degree in business and management, having received a full basketball scholarship. After graduation, he was pursuing a career in entertainment and business. He began to have conflicts with his parents, leading his father to call in the police and his mother to obtain an order of protection. The police were called again during an altercation with his father, leading to arrest and a 60-day sentence at the Brooklyn House of Detention. During this time, he first began to experience overt signs of psychiatric illness, although he did not recognise it then. He began to think that people were out to get him and that he was not safe, became unable to sleep, had constant racing thoughts and was socially isolated, paranoid and suspicious.

Around his 40th day of incarceration, he became overwhelmed by fear that he was doomed and tried to commit suicide. He recalled that he was smoking a cigarette as he wound a sheet around his neck; the next thing he remembers was corrections staff coming into his cell because it was on fire. He was charged with arson, found unfit for trial, sent to Kirby Psychiatric Center for treatment, and bailed out by his father after he was returned to prison on Rikers Island. At Kirby and Rikers he received medication for bipolar disorder, which he continued to take for at least a while after being released.

Mr. B's legal aid attorney persuaded the judge handling his arson case to transfer it to the mental health court, even though the court's policies in effect at that time did not permit arson cases to be considered, and in July 2002 he became one of the court's first clients. He lived at home while he was under the court's supervision, attending weekly individual therapy sessions and receiving case management services. He never missed a court appearance and consistently received positive reports from his treatment provider and ICM. The Brooklyn Mental Health Court clinical team had concerns throughout his term of court participation that he was not truly engaged in treatment, however, but maintaining an adequate level of superficial compliance that would permit him to resolve his criminal case satisfactorily. He was never employed while under court supervision but reported that he had been accepted to graduate school and would begin school in the fall of 2003. In August 2003, Mr B became the second graduate of the Brooklyn Mental Health Court.

The programme structure is as follows:

- Treatment mandate: misdemeanour offenders, 12 months; first-time felony offenders, 12-18 months; repeat offenders, 18-24 months. Individualised treatment can include mental health treatment, substance abuse treatment, intensive community-based case management services and supported housing
- Pleas: a guilty plea is required to participate, but the plea can be vacated upon successful completion
- Graduation: participant must comply with the treatment mandate and cannot commit any new offences. Misdemeanour offenders and first-time non-violent felony offenders: guilty plea vacated and all charges dismissed. Predicate felons and first-time violent felony offenders: felony guilty plea vacated with misdemeanour plea remaining in place; violent offenders will receive probation
- Jail/prison alternative for program failure: sentences are determined on a case-by-case basis at the time guilty plea is taken and program participation begins

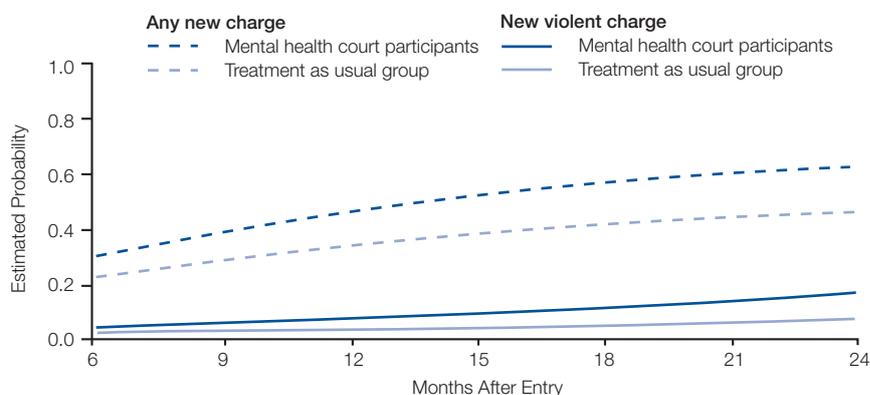
- Clinical and judicial monitoring during program participation: all participants appear in court every two weeks for the first three months, then monthly thereafter. More frequent court appearances are required for non-compliant participants. The clinical staff meet with participants on every court date and more frequently as needed. The clinical staff communicate with all service providers at least weekly; providers give written monthly reports as well. The clinical team summarise all input from providers in written reports at every court appearance.
- Rewards, sanctions and clinical responses: compliance is rewarded with praise from the judge, less frequent court appearances and certificates for completing quarterly phases. Noncompliance may result in clinical responses (such as a change in treatment or other services), admonitions from the judge, more frequent court appearances and other sanctions that the judge feels may help to motivate compliance. Short stays in jail are possible.

San Francisco

The San Francisco Mental Health Court was established in early 2003. Its mission is to connect criminal defendants who have serious mental illness to treatment services, to find dispositions to their criminal charges that take mental illness into consideration, and to decrease their chances of returning to the criminal justice system. The court anticipates that relapses may occur and it emphasises positive reinforcement for successes rather than sanctions for failures. Participants who successfully maintain a sustained period of stability “graduate” from the mental health court.⁹⁸

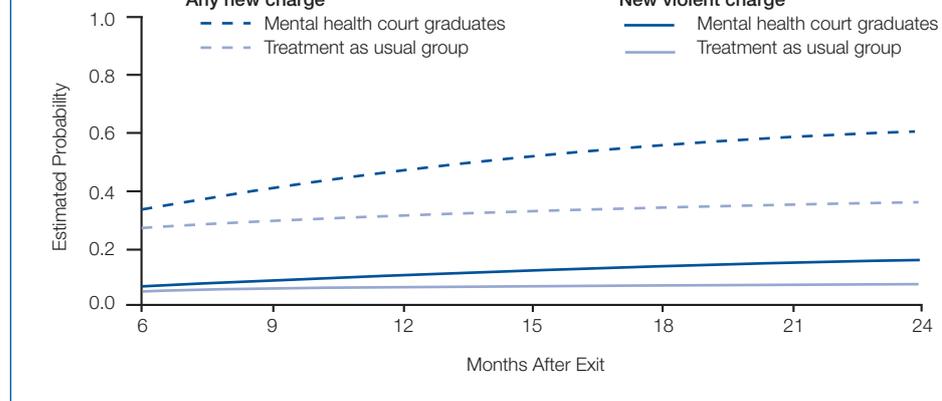
The results from the study support the effectiveness of the court in reducing the involvement of persons with mental disorders in the criminal justice system. Based on all of those who enrolled in the mental health court, regardless of whether they successfully completed the programme, participants achieved a longer time without any new charges (violent or otherwise) compared with similar individuals who did not participate in the programme. For example, at 18 months, the likelihood of mental health court participants being charged with any new crimes was about 26% lower than that of comparable individuals who received treatment as usual, and the likelihood of

Figure 6: Estimated cumulative probability of a new charge for criminal defendants with mental disorders participating in mental health court or receiving treatment as usual, as a function of mental health court status and months after entry



98 McNeil D and Binder R, “Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence”, *Am J Psychiatry*, 164: pp 1395-1403, September 2007

Figure 7: Estimated cumulative probability of a new charge for criminal defendants with mental disorders participating in mental health court or receiving treatment as usual, as a function of mental health court status and months after graduation



mental health court participants being charged with new violent crimes was 55% lower than that of individuals who received treatment as usual.⁹⁹

Further analyses showed that persons who completed the mental health court programme maintained reduced recidivism when they were no longer under the supervision of the court, in contrast to comparable persons who received treatment as usual. By 18 months, the risk of mental health court graduates being charged with any new offence was about 34 out of 100, compared with about 56 out of 100 for those who did not participate, a 39% reduction. For violent crimes the figures were 6 out of 100 compared with 13 out of 100 respectively, a 54% reduction.¹⁰⁰

These findings provide evidence of the potential for mental health courts to achieve their goal of reducing recidivism among offenders with mental disorders. Moreover, since the mental health court participants in the San Francisco study included a substantial proportion of individuals who had been charged with serious or violent crimes, it appears possible to expand the mental health court model beyond its original clientele of persons charged with non-violent misdemeanours.¹⁰¹

Case study set 4: Prison mental health services

The following case studies, from HMP Bristol and HMP Nottingham reveal that although it is difficult for PCTs to prioritise funding for prison mental health, it is possible. In both examples, provision has expanded significantly. The Bristol example highlights the way in which primary care resources have been integrated into an effective prison-provider partnership while the Nottingham example shows the ability to articulate need to commissioners and have an impact on investment with clear clinical leadership.

Lesson: Better integration of resources can lead to more effective healthcare and mental health assessment for offenders in prison and other criminal justice agencies. Making offender mental healthcare a priority is possible through clear clinical leadership and the ability to articulate need to PCT commissioners.

HMP Bristol

HMP Bristol is male local prison in the South West where mental healthcare has improved considerably since 2005. The changes have largely been brought about by the PCT chairing a development pro-

99 McNeil D and Binder R, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence", *Am J Psychiatry*, 164: pp 1395-1403, September 2007

100 Ibid

101 McNeil D, Binder R, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence", *Am J Psychiatry*, 164: pp 1395-403, September 2007

gramme with wide representation including service users. Not only has investment in prison mental health increased significantly (an original in-reach team of four whole-time equivalent staff increased to 12.5 staff, the new funding coming from redesignated prison primary care resources) but also a new court assessment and referral service was established in 2005 enabling the production of a joined-up care pathway for offender mental health. The old in-reach team has abandoned the “in-reach” name to reflect the fact that it now offers advice to other criminal justice agencies apart from prison and is now known as the criminal justice liaison service. In planning these services the PCT, perhaps unusually, has clearly articulated the principles on which service delivery is based. The foremost principle, that of healthcare equivalence, is expressed as followed:

“The service will provide access to mental health services comparable to that available within the NHS within the constraints of custody.”

Health improvement and care at HMP Bristol has changed markedly since 2005. This is partly in response to previous assessments and developments in national policy but mostly due to the innovation and hard work of staff at the prison. A formal healthcare partnership board was established between HMP Bristol and Bristol PCT and prison healthcare is represented on a number of PCT committees such as the clinical governance working group and the clinical audit and effectiveness group. There is greater integration of prison healthcare staff into local professional networks than before. Since April 2007 primary care medical services have been commissioned by the PCT; most mental health services are provided by the Avon and Wiltshire Mental Health Partnership (they all should be by the end of 2008).

Its key performance indicator profile reveals that it is improving, for example, it is able to both recruit and retain staff. The last HM Inspector’s report in March 2008 commented:.

“Mental health services had improved considerably since our previous inspection (2005). An in-reach team had been established and two well qualified and experienced registered mental health nurses provided a high level of care to prisoners. The team worked well with the primary care mental health team and there was evidence of good multidisciplinary joint working between all those involved in the care of prisoners with mental health needs. Access to professional training for staff was fully supported and provided where necessary. Mental health awareness training for generic prison staff was provided through a rolling programme delivered by members of the mental health team. Day care was now provided.”

PCT Commissioning

During 2006-07, the PCT chaired a development programme working with the prison, PCT, service users and Avon and Wiltshire Partnership mental health staff to develop a comprehensive mental health service for the prison. An early decision was to develop a mental health service presence at Bristol Magistrates’ Court. This was set up in 2005, funded by Bristol PCT and provided by Avon and Wiltshire Partnership. The court assessment and referral team consisted of two full-time senior nurses; a full-time team leader; a part-time administrator; with further funding secured for a learning disability specialist. These services are mainstream service provision, not forensic.

A care pathway model was planned linking the court to the prison. The prison mental healthcare pathway model was designed and based on mainstream

mental health principles. An important principle within the model is ensuring that mainstream mental health services accept and maintain their responsibility for clients within prison where appropriate. Primary and secondary healthcare are the providers, with referral to tertiary services where appropriate. In 2007 Avon and Wiltshire Partnership changed the name of the in-reach team to criminal justice liaison services. The service works across the offender mental healthcare pathway providing mental health services to criminal justice agencies including prisons.

The PCT, through its service level agreement, has clearly articulated the principles on which prison mental health services to HMP Bristol commissioning takes place. The principle of equivalence is top of the list.

The service must:

- provide access to mental health services comparable in quality to that available within the NHS, within the constraints of custody;
 - be in accordance with statutory rules and standing orders laid down by the prison service or NHS with regard to healthcare for prisoners;
 - recognise that high quality healthcare is multidisciplinary and can only be delivered through good working relationships with other prison health staff, prison officers and management, probation services and NHS colleagues;
 - secure improvements in the health status and prevent or decrease morbidity and disability associated with mental ill-health;
 - ensure equitable access to, and delivery of, appropriate services which are acceptable to all members of the population and that no service user receives less favourable treatment on the grounds of age, colour, disability, ethnicity, religion, sex or sexuality;
- take all reasonable steps to ensure patients are re-integrated with and supported by mainstream NHS services during the period leading up to and following release from custody, including effective joint working and liaison with other organisations both statutory and voluntary.

The PCT sees the prison-based mental health service as consisting of a number of different but integrated elements:

- *The Primary Care Mental Health Service* – providing assessment, treatment and care to adults with common mental health disorders such as depression, anxiety disorders while they are in HMP Bristol.
- *Secondary Mental Health Services* – providing a multidisciplinary specialist assessment and treatment service similar to the community mental health team. The provider will develop protocols for referral from primary to secondary mental healthcare.

The PCT is also clear that the mental health service within the prison does not stand alone. The service level agreement points to the importance of pre-prison teams such as the local court assessment and referral service and there is a strong emphasis in the agreement on through care and release, the following aspects of which must be addressed:

- provide support to the prisoner and their family/carers in helping them achieve better social functioning and prepare for release;
- provide effective through care that responds quickly and seamlessly to changing needs;
- ensure prisoner mental health and/or drug treatment needs, prognosis and likely pattern of relapse is fully incorporated into sentence planning process

- ensure appropriate arrangements are in place for on-going aftercare of prisoners with mental health, substance misuse or co-morbidity problems in the community prior to prisoner's release;
- participate in discharge planning meetings;
- provide seamless continuity of care as part of the pre-release process;
- liaise with community mental health teams to ensure seamless transfer from prison back into the community;
- forge strong links with other mental health services within the community (both statutory and voluntary);
- participate in multidisciplinary assessment of need, including sentence planning;
- participate in multidisciplinary care plan review meetings.

Transfer to Hospital

One important aspect in the appropriate use of mainstream NHS resources is to ensure that all those prisoners requiring transfer to the NHS for acute mental health in-patient care are transferred promptly. Between January and November 2007, 22 prisoners were transferred to the NHS, 59% of who were transferred within 14 days. There is a local protocol in place to manage the transfer process. There has been a significant shift in transferring prisoners where appropriate to psychiatric intensive care units, reducing the need for lengthy waits for beds in medium secure units.

Agreed Mental Health Service Developments

Currently the in-reach team consists of four practitioners; however, negotiations with the PCT have led to a significant increase in resources through the redesignation of existing prison primary care resources for mental health. The new resources will mean that interventions for prisoners move beyond triage and assessment to cognitive and dialectical behav-

oural therapy and group work – a large increase in face-to-face interventions. In addition to the increase in the size of the team from four staff to 15.5 whole-time equivalent staff, there has also been an agreed increase in counselling sessions, including specialist sessions for victims of sexual abuse.

HMP Nottingham

The mental health service at HMP Nottingham has one of the longest histories of service provision in England. It has a pathway within the prison itself, with clear referral criteria, and mental health expertise is apparent not just within the specialist service but within primary care too. It is highly unusual in that an audit is regularly undertaken including a recent PCT-driven review of service-user satisfaction. Investment has improved and there are plans to increase it yet further. Very few in-reach services have such clearly delineated resources for diagnosis of personality disorder and it is clearly an example of good practice. One reason for this is the strong clinical leadership it receives. The psychiatrist who leads this team commented:

“Basically it has been a combination of fighting many battles, being able to get resources from commissioners by demonstrating a track record of delivering in the prison, building relationships at all levels, providing direction, thinking outside the box, thinking and planning the next development even before the previous one has been fully implemented, by making all connected with it proud of what they are doing because it is better than what others do and influencing a change in attitude of colleagues about prison mental healthcare.”

HMP Nottingham aims to provide mental healthcare that is at least equal to the services available in the community. Although this may well contribute to a reduction in reoffending it is not its primary objective.

Background and introduction to the service

A mental health service has existed at HMP Nottingham for nearly 15 years; it originally consisted of a psychiatric clinics provided by the local trust. In 2003 a multidisciplinary team with appropriate management and leadership was established, with in-reach nurses; psychiatrists were included in 2006.

The prison takes 550 inmates and serves as a remand and local prison. Judged on prison service key performance indicators it fell midway, coming 46th out of 121 prisons (and 5th out of 16 comparable old Victorian prisons). HMP Nottingham does not experience problems in recruiting staff and there is no significant overcrowding.

Prison Mental Healthcare

Organisation of the service

Screening for mental health at reception is undertaken by nurses working for the primary care trust who have special training in mental health and learning disabilities. They use the national prison screening tool – the Grubin screen – at the daily assessment clinics. During the three-month period August to October 2008, 340 prisoners screened positive and were referred to primary care or in-reach services. A pathway has been set out with explicit criteria for referral to primary, secondary and acute admission mental healthcare.

All referrals for primary mental healthcare from reception, wing staff or self-referrals are sent directly to the assessment clinic without any further scrutiny. Those under the care of mental health services in the community and with significant psychiatric contact are sent directly to the in-reach service. The criteria for allocation to primary or secondary care is based on the following classification with cluster 1 being dealt with by primary care and clusters 2, 3, and 4 being allocated to the in-reach service. When it is not clear if the referral is for primary mental healthcare or for in-

reach services then the decision is made at a weekly joint meeting. The prison also has an enhanced care wing, with 24-hour nursing staff, which is for those with physical and mental disorders that require higher level of supervision.

Primary mental healthcare is provided and managed by the PCT and the in-reach service is provided and managed by Nottinghamshire Healthcare NHS Trust. However, arrangements such as the attendance of primary care managers at the in-reach allocation as well as business meetings, regular dialogue and discussion provide for a close working relationship. The substance misuse service is also well integrated with the prison based drug workers, the counselling assessment, referral advice and throughcare services (CARAT), the alcohol problems advisory service (APAS) and the primary as well as in-reach mental health services.

There is also integrated care for prisoners with drug problems especially those with a dual diagnosis. The nurses work within the substance misuse team and link in with primary care as well as in-reach services. Those with a drug habit as well as a serious mental disorder are often jointly cared for by the in-reach service and a combination of the integrated drug treatment system for prisons, CARAT and APAS.

The 2008 Chief Inspector of Prison's report on HMP Nottingham commented:

“Mental health in-reach services were working well, with good relationships between the primary care team. Waiting times were short and there was prompt access to psychiatrists. Over the previous six months, eight prisoners had waited less than six weeks between referral and transfer to outside hospital. The exception to this was a prisoner on the segregation unit waiting for a place on a personality disorder unit. There were good links with the community mental health services.”

Table 2: Examples of ratings of service user satisfaction: In-reach team at HMP Nottingham (2008)¹⁰²

Number	Statement	Mean score
1	The healthcare centre is clean and comfortable	4.54
2	Staff from the in-reach team listen carefully to me	4.50
3	I have trust and confidence in the staff from the In-Reach Team	4.38
4	Staff from the in-reach team treat me with dignity and respect	4.50
5	I am given enough time to discuss my problems	3.91

Outreach/External Liaison

All prisoners in receipt of the prison mental health in-reach service receive the care programme approach (CPA). Systematic attempts are made to connect prisoners with external mental health services on release. All prisoners requiring primary care on release are referred to GPs. All those requiring secondary care are referred to appropriate mental health services depending on the area they go to. However, it is recognised that this is not as effective as it needs to be because of the precipitate release of remand prisoners and the timelag between release and service provision in community. Commissioners have been asked to create an outreach post, whose job would be to function as the care co-ordinator until this is taken up by community services.

Resourcing of the service

In primary care, there are 18 mental health nurses. The mental health in-reach team has two nurses and a good multidisciplinary mix: it is rare to have a full-time post made up of a psychiatrist and a psychologist. The new resources for in-reach have come partly from internal reorganisation, but also from the new integrated drug treatment service.

User Involvement with service delivery

- Prison service users are involved in providing feedback on mental health service delivery in a variety of ways:

- Care plans discussed with prisoners.
- The prison is currently in the process of setting up prisoner forums (primary care);
- A prison in-reach user satisfaction survey carried out in 2008.

The service user survey is unique and is worthy of greater attention. It was reported earlier this year and was undertaken as part of Nottingham City PCT's commissioning requirements. The entire caseload of the in-reach team was targeted with a postal questionnaire and a response of 53% was achieved. The satisfaction schedule was rated in a uniformly high manner with no mean rating falling below 3.22/5.

Case Study Set 5: Offender health-care plan (including mental health) – Derbyshire PCT

According to the DH the core task of primary care trusts is to 'invest locally to achieve the greatest gains and reductions in health inequalities at best value for current and future service users'.¹⁰³ The offender population is known to experience significant health inequalities and have needs that exceed those of the general population. Much of the evidence for this level of health need has been drawn from prisoners.¹⁰⁴ But the few studies to examine the health of offenders within community settings have indicated that this group also

¹⁰² Full results in Appendix 1

¹⁰³ World-Class Commissioning: Competencies, Department of Health, 2008 .

¹⁰⁴ Improving Health, Supporting Justice – A Consultation Document. A strategy for improving health and social care services for people subject to the criminal justice system, Department of Health, 2007

experience significant health inequalities when compared with the general population. To address this, Derbyshire County PCT and the National Probation Service in Derbyshire conducted a health needs assessment of community offenders in both Nottinghamshire and Derbyshire and developed an offender healthcare plan to provide for the mental health needs (as well as physical, housing and education needs) of offenders in the community.

Lesson: Health needs assessments usually focus their attention on offenders in prison

and yet research shows that offenders in the community also have significant health problems. Conducting a health needs assessment for offenders in the community and on probation can inform the development of a commissioning strategy for that neglected population.

Derbyshire Community Offenders

In 2007 Derbyshire Probation Service managed 2,764 offenders in the community.¹⁰⁵ In order to improve the commissioning for community offenders, Derbyshire County PCT and the National Probation

Box 3: Examples of planned services in the Derbyshire offender healthcare strategy

Mental Health Services

- Commission psychological interventions for mild to moderate mental health disorders in primary care or community settings with equitable access for community offenders across the county. A high proportion of offenders have mild to moderate mental health disorders and poor access to services, which may contribute to reoffending.
- Cognitive behavioural therapy (CBT) in primary care to be provided by primary care mental health workers, further availability to be provided by the initiative to improve access to psychological therapies. A £5 million investment package will target most deprived communities, such as Bolsover, first. Providers are required to collect data demonstrating equitable access, including for offenders. Self-referrals and referrals from offender managers will be encouraged.
- Review options for the provision of evidence-based interventions to promote improved self-esteem, interpersonal relationships and parenting skills in community offenders. Identified by offender managers as a key area of need and may prevent re-offending. Community initiatives, such as improving parenting skills, community payback, social inclusion and Sure Start, to be mapped. Probation to develop multi-agency links for appropriate referral, access and for offenders and their families in the community.

Drug and Alcohol Services

- Ensure that offenders wishing to access drug and alcohol team services are able to do so without delay. Offenders who have not been directed through a community order to attend report delays in accessing these services.

Housing Support Services

- Review housing support services; both statutory and voluntary agencies to ensure they are adequate and equitable. Offender managers identify access to appropriate housing as major issue and one which may contribute to reoffending. Probation services working in partnership with city and county providers to promote and improve housing for offenders using Supporting People funds; review the remit of the housing and health strategy manager.

105 Probation Statistics Quarterly Brief, July-September, England and Wales, Ministry of Justice, 2007; www.justice.gov.uk/docs/q3brief-probation-2007.pdf

Service Derbyshire participated in a project to find out more about the health needs of community offenders in both Nottinghamshire and Derbyshire. The project was led by the Centre for Criminal Justice and Mental Health at Lincoln University and funded by the East Midlands care service improvement partnership.

The study, published in 2008, provided detailed information on the mental health needs of the Derbyshire probation population.¹⁰⁶ It showed that the mental health of this group was significantly worse than that of the general population and furthermore that a significant proportion were at risk of being dependent on alcohol (49%) or of abusing drugs (35%). Nearly a third (32%) had been seen formally by a mental health

service at some point. Importantly, the general physical health of those who had contact with mental health services was also significantly worse than the rest of the probation sample. This group were likely to visit both their GP and accident and emergency department more often than others.

A plan was developed to address the health needs of this probationer group. It will be implemented by the lead commissioner for offender health in partnership with public health and Derbyshire Probation Service (through the joint prison health commissioning group and Derbyshire prisons partnership board). Other programme boards, such as the mental health strategic commissioning board, may also be engaged.

106 Brooker C, Syson-Nibbs L, Barrett P, and Fox C, "Community Managed Offenders' Access to Healthcare Services: report of a pilot study", accepted for publication *Probation Journal*, 2008

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Conclusion and recommendations

Mental health service provision is absent from much of the criminal justice system; where it does exist it is fragmented, uncoordinated and unaligned to mainstream developments in generic mental health service provision. There are a number of improvement arguments in services for mentally ill offenders: that it is the “right” thing to do in terms of reducing health inequalities, that it is an effective thing to do in terms of crime reduction and that it is a course of action supported by the public. The follow conclusions and recommendations were prompted by our research and discussed at a roundtable with a panel of experts and practitioners from offender mental health. They argued that lack of clear accountability and weak financial incentives are obstacles to improvement.

Recommendations

To address the obstacles for mental health-care in the criminal justice system, and drawing on the lessons learn from the case studies, the authors propose the following recommendations. The recommendations were tested with a group of experts and practitioners in the fields of mental health and criminal justice. The recommendations cover five areas: police and early diversion, prison and commissioning, probation, courts and structural reform. Much of the onus for change is on the DH and PCTs. Across the pathway there are differing but crucial roles for the health service in changing the way the criminal justice system deals with offenders with mental illness.

1. Police and early diversion

Investment in offender mental health should allow earlier intervention at every stage of the pathway through the criminal justice system. It could significantly reduce the costs of acute admissions to either medium or high-secure NHS forensic services. The balance between community and custodial sentencing needs to be dramatically altered in favour of increased use of mental health treatment orders with the accompanying benefits of reducing the prison population and providing more cost-effective services. For example, the average cost of a custodial sentence is £13,125 per head while a community order costs £1,500-£4,000. Even with mental health treatment included the community order option remains cheaper.¹⁰⁷ Further savings are likely as such a model is also likely to reduce re-offending rates in some (but not all) cases.

Recommendation 1: PCTs should commission police custody diversion schemes

Offenders with a mental illness should be assessed routinely in police stations and courts and, where appropriate, taken into the NHS for care and treatment. Community mental health teams or assertive outreach teams could be re-directed to staff custody diversion schemes, both to assess and to provide assertive community-based intervention packages.

Recommendation 2: Give PCTs an incentive to transfer offenders with mental illness into treatment

PCTs should be given financial incentives to take offenders with mental illness out of the

¹⁰⁷ Final report of the Strategic Policy Team project on mentally disordered offenders, Home Office, Unpublished

system at the earliest possible stage (police stations and courts) and into the NHS. In addition, PCTs should ensure that mainstream mental health services are supporting probation services by identifying those with mental health disorders and enabling their access to appropriate services.

Recommendation 3: Pilot Mental Health Crisis Resolution Teams

A number of organisations have proposed the creation and development of “assessment suites” or “places of safety” separate from police custody suites.^{108, 109} A report from South Wales proposes that staff at these suites should have training in control and restraint, de-escalation and assessment. Their primary functions would be to prevent self-harm and suicides in custody, and to provide multi-agency assessment, detoxification facilities and liaison with non-healthcare services such as housing.¹¹⁰

2. Courts

Our expert panel noted that courts had little accountability in relation to the sentencing of offenders with mental health needs. Judges have a number of options in relation to offenders with mental illness – court diversion, court assessment and referral, mental health courts, mental health liaison schemes – but no incentive to use one rather than another. Evidence about the effectiveness of these different options or models is sparse.¹¹¹ Courts require dedicated mental health staff to work with them, so that offenders can either be placed in forensic secure accommodation or, where the mental disorder is less serious, be referred to an appropriate mainstream mental health/ drug service with appropriate monitoring. Brooklyn Mental Health Court, which requires people on treatment orders to return to court every week, provides an example of such arrangements.

Recommendation 4: Expand mental health court pilots

Mental health courts have the potential to reduce reoffending by those with severe mental illness. San Francisco Mental Health Court demonstrates that not only are there potential savings in acute care, but also that reoffending for all crimes – especially those involving violence – is significantly reduced.

The relationship between offending and mental health status is not necessarily straightforward. Improved mental health-care will not automatically reduce reoffending, nonetheless when offending is not “goal-directed” and clearly results from the impact of a mental health disorder, such an outcome is likely.

The reduction in reoffending among clients of the San Francisco Mental Health Court was between 25% and 39% after 18 months. If a similar reduction in reoffending were seen among offenders with severe mental illness the number of recidivists would fall by more than 7,000 each year. The authors recognise that mental health courts are not appropriate for all mentally ill offenders and that they are not without costs. But evidence reviewed in this report suggests that the Department of Health and Ministry of Justice should radically expand the very small-scale pilots planned for later in 2009.

3. Prison and Commissioning

Prison mental health services are still underfunded and they have little national guidance on how they should operate. Most in-reach teams are provided solely by nurses, however we have shown how sound clinical leadership within a multidisciplinary team, as in Nottingham, can be highly effective. That strong clinical leadership is urgently required is underlined by the fact that not one mental health nurse consultant works as a specialist in prison mental health. This report also shows that a sound commissioning provider partnership and an integrated use of resources, as in Bristol, can lead to a well-funded service.

108 South Wales police model

109 Bather P, Fitzpatrick R, Rutherford M, *Briefing 36: Police and Mental Health*, Sainsbury Centre for Mental Health, 2008

110 South Wales police model

111 Scott D, et al. *The Effectiveness of Criminal Justice Liaison and Diversion Services for Mentally Disordered Offenders: A Systematic Review of the Evidence*, Unpublished 2008

Even if prison mental health were adequately funded, the commissioning of such services would still be taking place in an environment that is too complex. Drug treatment services in prison, for example, are currently commissioned through both the health service and the prison service. We understand that Lord Patel is currently reviewing the way that funding is allocated to drug treatment services in prison; we hope that he recommends clearer commissioning pathways.

Recommendation 5: Integrate mental health services in PCT commissioning

Services for prisoners with mental health disorders are delivered by numerous teams some commissioned by the NHS (such as in-reach teams), others are commissioned by the Prison Service, part of the Ministry of Justice. This disjointed commissioning leads to poorly coordinated, ineffective services. Where possible all mental health services and resources should be delivered by one team, commissioned by the NHS.

Since taking over the commissioning role for offender health in 2006, PCTs have had much to do. Not only have they received little incentive to invest in offender mental health, but also very little support to undertake this function in what is a specialised area of health-care that is new for many of them. Yet PCTs should be commissioning services for offender mental health across the whole criminal justice pathway and not focusing resources solely on the prison population. Commissioners struggle with implementation of an outcomes framework for offender mental healthcare services. One reason for this is the lack of guidance on the function of prison mental health in-reach services and court diversion schemes. Such guidance is urgently required from the Department of Health.

4. Probation

Very little is known formally about the prevalence of mental health disorders among offenders who are being managed in the community, the general health inequalities that

they experience are among the highest of any group. The assessment of health needs in Derbyshire suggests that up to 30% of probation caseloads are people who, in the past, have had formal contact with mental health services. The prevalence of both alcohol and drug problems is higher than this. There have been no formal estimates of personality disorder in this group. A further difficulty, restricting even those known by probation services to have a mental health disorder, is their lack of access to services, especially psychological therapies.

Recommendation 6: The Department of Health should instruct PCTs to provide full health needs assessments for offenders

Resources for offender with mental health disorders are focused myopically on the prison population. The prevalence of mental illness for offenders on probation is also high and if health is to be improved (and costs reduced) resources must be spread along the whole pathway. The offender health directorate of the Department of Health should instruct PCTs to conduct health needs assessment for offenders on probation in order to include them in PCT's offender mental health strategy.

Recommendation 7: Department of Health should provide policy implementation guidance

In order to improve outcomes for mentally disordered offenders, PCTs need clear guidance on the role and functions of prison mental health services. NHS policy implementation guidance must be developed so that the impact and outcomes of commissioned prison mental health services can be evaluated.

5. Structural reform

Responsibility for policy relating to the mental health of offenders rests with the Department of Health and specifically its offender health directorate. The fact that offender health is a separate directorate makes it difficult to integrate mainstream health developments in prisons, such as increasing "access to psycholog-

ical therapies” and “reducing health inequalities”. For example there is scant reference to offenders in the DH’s review of progress in reducing health inequalities.

Recommendation 8: Amalgamate offender health into the Department of Health

As long as offender health remains a separate unit, offenders with mental health needs will not receive equivalent services to those available in the community. We recommend that offender health should be integrated into the department as a whole and its resources reassigned to major policy programmes, such as mental health and public health. If such a change were made, it is likely that wide-ranging offender health plans, such as the

one in Derbyshire, would spread across the country more quickly than at present.

Recommendation 9: Include offender health in regulatory review

The NHS performance management framework for PCTs provides no incentive for investment in offender mental health services. Such a direction should be included in the annual health check of the Healthcare Commission, or its successor.

This report is a call to action on behalf of a forgotten minority, not simply because it is right to promote equality of care for the individuals concerned, but also because it would reduce the cost of offenders with mental illness to their victims and to taxpayers as well.

Appendix 1

Estimated reduction in re-offending rates and costs from implementing mental health courts in England & Wales

LOW ESTIMATE

Figure	Statement	Source
83,815	Number in Jail in England and Wales	Population in custody, Ministry of Justice, November 2008
7%	% of the prison population with a serve mental illness	Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H, "Psychiatric morbidity among adults living in private households, 2000", <i>International Review of Psychiatry</i> , 15 (1), 65-73, 2003
5,867	Total in jail with SMI	
65%	National reoffending rate	Re-Offending by Adults: Results from the 2004 cohort, Home Office, 2007/8 Performance
3,814	Number with SMI who reoffend	
39%	Reduction in reoffending rate from San Fran	McNeil D E, Binder R E, Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence, <i>Am J Psychiatry</i> , Sep 2007; 164: 1395 - 1403
25%	Reduction in court reoffending rate	
40%	Potential mental health court reoffending rate	
2,326	Number with SMI who reoffend if MH courts widely used	
1487	Reduction in number of recidivists	
£65,000	Cost of one recidivist	Reducing re-offending by ex-prisoners, Summary of the Social Exclusion Unit report, Cabinet Office, 2002
£96,674,316	Benefit before cost of MH courts	

HIGH ESTIMATE

Figure	Statement	Source
83,815	Number in Jail in England and Wales	Population in custody, Ministry of Justice, November 2008
13%	% of the prison population with a serve mental illness	Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H, "Psychiatric morbidity among adults living in private households, 2000", <i>International Review of Psychiatry</i> , 15 (1), 65-73, 2003
10,896	Total in jail with SMI	
65%	National reoffending rate	Re-Offending by Adults: Results from the 2004 cohort, Home Office, 2007/8 Performance
7,082	Number with SMI who reoffend	

Figure	Statement	Source
39%	Reduction in reoffending rate from San Fran	McNeil D E, Binder R E, Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence, <i>Am J Psychiatry</i> , Sep 2007; 164: 1395 - 1403
25%	Reduction in court reoffending rate	
40%	Potential mental health court reoffending rate	
4,320	Number with SMI who reoffend if MH courts widely used	
2,762	Reduction in number of recidivists	
£65,000	Cost of one recidivist	Reducing re-offending by ex-prisoners, Summary of the Social Exclusion Unit report, Cabinet Office, 2002
£179,538,016	Benefit before cost of MH courts	

Appendix 2

Ratings of service user satisfaction: In-reach team at HMP Nottingham (2008)

Item Number	Statement	Mean	Standard Deviation
1	The Healthcare Centre is clean and comfortable	4.54	.588
2	Staff from the In-Reach Team listen carefully to me	4.50	.659
3	I have trust and confidence in the staff from the In-Reach Team	4.38	.647
4	Staff from the In-Reach Team treat me with dignity and respect	4.50	.590
5	I am given enough time to discuss my problems	3.91	1.203
6	I am given information in a way that is easy to understand (verbal, written, translated or accessible)	4.38	.647
7	Staff keep appointments and are on time	3.79	1.179
8	The input from the In-Reach Team is sufficient for my needs	4.17	.917
9	I have had the chance to discuss the medication I am taking, including its purpose and side effects	4.13	1.140
10	I have had the opportunity for psychological (talking) therapy or counselling from the In-Reach Team if I wanted	4.25	.944
11	I have found the psychological (talking) therapy or counselling helpful	4.14	1.082
13	I was involved in deciding what was in my care plan	3.42	1.248
14	At my care review meeting (CPA) I have had the chance to express my views	3.33	1.495
15	The care I receive meets my needs related to my ethnic origin and cultural background	4.21	.884
16	The In-Reach Team have involved my carers / relatives if I wanted them to	3.22	1.204
17	Overall, I am satisfied with my care from the In-Reach Team at this prison	4.39	.722