



38: The Bradley Report and the Government's Response:

The implications for mental health services for offenders

Summary

The Bradley Report was the result of an independent review of the experience of people with mental health problems and people with learning disabilities in the criminal justice system. Commissioned by the Ministry of Justice and published in April 2009, it made some 82 recommendations for change. Among those recommendations were important new proposals to tackle the over-representation of people with mental health problems in prisons in England. They include the proposed creation of a national network of Criminal Justice Mental Health teams to divert people towards support services from police stations, from courts

and following release from prison. The report also called for a 14-day maximum wait for people who need to be transferred from prison to hospital for urgent mental health treatment and for the NHS to take on responsibility for providing health services in police stations. The Bradley Report can and should lead to major changes in the way offenders with mental health problems are supported and treated in this country. If implemented, it can not only improve the mental health of offenders but make communities safer and ultimately reduce the costs to the taxpayer of criminal justice.



Introduction

On 30 April 2009, the former Home Office minister Lord Bradley published his report on 'People with mental health problems or learning disabilities in the criminal justice system'. The government's response was published the same day.

The report was commissioned by the Secretary of State for Justice, Jack Straw, on 5 December 2007, as part of the government's response to Lord Carter's review of Prisons (Carter 2007):

"Today I asked my noble friend Lord Bradley to carry out a review, reporting jointly to the Department of Health and my Department, on diverting more offenders with severe mental health problems away from prison and into more appropriate facilities"

(House of Commons 2007).

The Carter Review had recommended an increase to prison estate capacity through the building of three 'Titan' prisons, each holding 2,500 prisoners. (The government later revised this proposal and now plans to build five prisons, each holding 1,500 people, by 2014.) The Carter Review also made clear that there were some groups who could be moved away from prison in the future to community alternatives (in particular women, those on short sentences, and people with mental health problems).

Lord Bradley was initially given a six-month time frame to complete his review, and the *"initial focus of the review was the organisation and effectiveness of current court liaison and diversion schemes"*. However, the review was quickly extended to a year when *"it was very soon apparent that merely analysing such schemes would be a missed opportunity and a more comprehensive consideration of the 'offender pathway' and the associated mental health services would be more productive"* (Bradley 2009, p. 4).

Bradley wanted to understand *"the real practical barriers to effective diversion"*, which he defined as:

"A process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and

early intervention), this informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence"

(Bradley 2009, p. 16).

Lord Bradley's evidence base for his review and its recommendations were formed through 26 visits (to courts, probation sites and prisons), 16 regional stakeholder and service user interest group events, more than 80 meetings with experts (including judges, clinicians, civil servants, academics, and third sector chief executives), and nearly 200 written consultation responses from interested parties (see annexes to Bradley 2009, pp. 153-165).

The primary problem, Bradley identified, was that:

"While public protection remains the priority, there is a growing consensus that prison may not always be an appropriate environment for those with severe mental illness and that custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide. In addition, recent studies of mental health services for prisoners suggest that there is still some way to go in achieving equivalence with mental health services in the community"

(Bradley 2009, p. 7).

This briefing paper examines the Bradley Report and the Government's response in terms of mental health. It does not address the needs of offenders with learning disabilities, whose needs may be quite different.

Background

A significant proportion of those who end up in the criminal justice system have a mental health problem. Responsibility for prison health care lies with the NHS, which aims to give prisoners access to the same quality and range of health services as the general public receives in the community, known as 'equivalence'.

Delivering 'equivalence' to offenders is an enormous challenge. Many offenders and prisoners have a combination of mental ill health, substance misuse and personality

disorder, as well as a range of other issues to deal with.

Overcrowding in prisons and a lack of staff skilled in identifying and managing mental health problems are major problems that need to be addressed. There is growing evidence that prisons are not effective at reducing offending, and the resettlement experience of most prisoners is poor (e.g. Durcan 2008; Sainsbury Centre 2008a).

England and Wales together have one of the highest imprisonment rates in Europe. In May 2009, 82,900 people were in prison (MoJ 2009a).

Up to 90% of prisoners have some form of mental health problem (Singleton *et al.* 1998). Most adult prisoners with mental health problems have common conditions, such as depression or anxiety. About one in ten has a more severe condition, such as psychosis, and about two-thirds have a personality disorder.

Rates of self harm and attempted suicide in prison are high. A total of 61 prison suicides (MoJ 2009c) and 23,026 self-harm incidents (House of Commons 2009a) were recorded in 2008.

Not everyone enters prison with a mental health problem – for some, being in prison will lead them to develop depression or anxiety (JCHR 2004).

Ethnicity

People from Black and minority ethnic (BME) communities represent about 10% of the UK population (ONS 2001) but in prison this rises to 26%, a significant proportion of whom are foreign nationals (MoJ 2008). While the rate of diagnosed mental health problems in prison is lower in BME people than among the white population, this may reflect lower levels of identification and referral (Durcan & Knowles 2006).

Women

At the end of May 2009, there were 4,300 women in prison (MoJ 2009a). A study of 500 women prisoners found that “*women in custody are five times more likely to have a mental health concern than women in the general population*” (University of Oxford, cited in Prison

Reform Trust 2008). While women represent just 5% of the prison population, they account for over half of all reported self-harm incidents (HMIP 2009).

Young people

At the end of May 2009, there were 2,100 young people aged 15-17 years and 9,600 aged 18-21 years in custody (MoJ 2009a). The majority are held in Young Offender Institutions.

Young people in custody have an even greater prevalence of poor mental health, with 95% of 16 to 20 year olds having at least one mental health problem and 80% having more than one (Lader *et al.* 2000).

Imprisonment for Public Protection (IPP)

On 30 April 2009, 5,246 prisoners were subject to the indeterminate sentence of Imprisonment for Public Protection (IPP). Of these, 104 were being detained in secure psychiatric hospitals (House of Commons 2009b).

Levels of mental illness are far higher among IPP prisoners than among the general prison population. Nearly one in five IPP prisoners has previously received mental health treatment, while one in ten is receiving mental health treatment in prison and one in five is on mental health medication (Sainsbury Centre 2008b).

Bradley's key recommendations and the Government's response

The report was structured around the ‘offender pathway’:

- Early intervention, arrest and prosecution;
- The court process;
- Prison, community sentences and resettlement; and
- Delivering change through partnership.

It made 82 recommendations, and the Government accepted nearly all of them either in full or in principle. Only four recommendations were not accepted, but are ‘under review’.

The government divided its responses to Bradley's recommendations into seven headings:

1. Governance arrangements

2. Children and young people
3. Police
4. Courts
5. National Offender Management Service
6. Criminal justice mental health teams
7. Overarching systems

This briefing summarises some of the key recommendations and the Government's responses, and offers short assessments about their potential significance.

1. Governance arrangements

One key recommendation was accepted immediately – the establishment by the end of May 2009 of a Health and Criminal Justice National Programme Board (Bradley 2009, p. 9), which would:

“Bring together the relevant departments covering health, social care and criminal justice for children and adults. The first priority for the board will be to consider Lord Bradley’s recommendations and develop a national delivery plan by October 2009. A National Advisory Board will also be established to ensure wider involvement from interested organisations”
(MoJ 2009b).

In addition, Bradley recommended that: *“a National Advisory Group should be set up to support Ministers and the Programme Board”* (Bradley 2009, p. 125).

The National Advisory Group (NAG) would provide independent evidence-based advice, independent challenge, and highlight good practice, to the Programme Board. The NAG would have an independent chair, and incorporate service user and carer experience. The government accepted the need for the NAG, and promised to make arrangements to establish it by 31 July 2009 (MoJ 2009b, p. 9).

Assessment

Sainsbury Centre agrees that the strategic overview provided by a Programme Board and Advisory Group is much needed. Sustained political leadership will be essential to drive through this agenda and champion it with the public. It is also essential that the NAG begins

and remains ‘independent’ but influential, and it will be vital that the chair is regarded publicly as robustly separate to government.

2. Children and Young People

Lord Bradley made a significant decision not to examine in detail the area of youth justice, stating: *“This is clearly a complex area that I am not able to do full justice to within the confines of this review”* (Bradley 2009, p. 19).

He did, however, make a number of recommendations, including advocating the need for: *“dedicated scrutiny in a separately commissioned piece of work”* (Bradley 2009, p. 33).

The Government accepted this recommendation in principle:

“... pending further assessment to judge whether there is a case for a further review. Significant relevant review work has recently taken place, for example the major independent review of children and adolescent mental health services ‘Children and Young People in Mind’. We are already supporting a pilot programme of effective liaison and diversion. The aims of this are to enable young people to access a holistic assessment of need and integrated support”
(MoJ 2009b, p. 12).

The report also recommended (Bradley 2009, pp 32-33):

- **Mental health and learning disability awareness training for all staff in schools and primary care services.** The Government responded that it would consider this further with the appropriate professional and training bodies for these sectors (MoJ 2009b, p. 11).
- **A mental health worker in all Youth Offending Teams.** The Government accepted this pending further assessment, and stated that an explicit decision would be made in the forthcoming health strategy for children and young people in contact with the criminal justice system (MoJ 2009b, p. 12).

Assessment

Sainsbury Centre would support Bradley's recommendations, but the proposed review should not stand in the way of action being

taken immediately. As well as ensuring that age-appropriate diversion arrangements are put in place for children and young people, we need to invest now in evidence-based early intervention activities in schools and children's services. Diversion will only be effective for under-18s if it forms the gateway to services that accept and support vulnerable young people and their families and that work holistically with them.

3. Police

The critical recommendation in this section was that *"the NHS and the Police should explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS at the earliest opportunity"* (Bradley 2009, p. 48)

The Government accepted this recommendation, but replied that a decision would take some time: *"The Programme Board will examine the potential benefits of transferring commissioning to the NHS and report to Ministers on the options and their merits by April 2010"* (MoJ 2009b, p. 13).

Two recommendations related to the *"appropriate use of sections 135 and 136 of the Mental Health Act, and that police stations should no longer be used as places of safety"* (see Bradley 2009, pp 45, 47). The government stated that *"this issue is addressed in the Code of Practice for the Mental Health Act (2007)"* (MoJ 2009b, p. 13).

Other recommendations related to the roles of *"appropriate adults"* in police stations (Bradley 2009, p. 43) and of *"Local Safer Neighbourhood Teams ... in identifying and supporting people in the community with mental health problems or learning disabilities who may be involved in low level offending"* (Bradley 2009, p. 36; MoJ 2009b, pp 12-13). Both were accepted in principle, but referred to the Programme Board.

Recommendations that *"mental health awareness training should become a key component of the police training programme"* and *"Community Support Officers and Police Officers should develop training programmes with local mental health services"* (Bradley 2009, p. 36, 53) were accepted in principle. The Government noted that the National Police Improvement Agency are currently developing guidance on mental health awareness training, and further consideration is required of the

Places of safety

Under sections 135 and 136 of the 1983 Mental Health Act, the police can take a person to a place of safety for an assessment, usually by an approved clinician or a mental health practitioner. An estimated 11,000 people are detained in police stations as places of safety each year. Guidance states that police stations should only be used as 'places of safety' in 'exceptional circumstances'. Ideally, a 'place of safety' should be a hospital rather than a police station yet just 6,400 people are detained in this way in hospitals annually. Hospitals often feel that they are ill-equipped to cope with mentally unstable people who need to be held securely for assessment at the request of the police.

cost and timeframe for delivering such training packages (MoJ 2009b, p. 14).

Assessment

We support the notion of a transfer of police custody health care to the NHS, following on from the significant progress made in prisons since the completion of such a transfer in 2006.

For this to be successful, the NHS should provide the police with screening services to identify early signs of mental health difficulties and the risk factors for mental health problems in children and young people. The presence of workers who are expert in identifying mental health problems or learning disabilities in police stations is crucial. Primary care trusts will need guidance on the competencies and functions of these staff, while guidance is needed for the police on how liaison with local mental health and drug/alcohol services should take place to ensure rapid response assessment and assessment of 'mental capacity' issues.

However, bringing the NHS into police stations should not become an excuse to utilise a police cell as a place of safety for section 136. This must be avoided through clear protocols and arrangements between the police and hospitals or health care centres.

We are pleased that the role of Local Safer Neighbourhood Teams is highlighted, particularly in establishing links with community resources to be able to signpost individuals to appropriate care and support. For this to work, mainstream mental health services, such as community mental health teams, need to be better prepared to share information and work closely with Safer Neighbourhood Teams when appropriate. This would ensure that individuals presenting in crisis in the community were directed into health care facilities rather than towards police custody and the criminal justice system.

4. Courts

Much of the Bradley report was focused on the role of the courts. Bradley identified many of the current problems related to mental health in the court and sentencing process with the availability of good mental health assessment and the long delays that occurred when waiting for a formal psychiatric report when required.

Bradley recommended (Bradley 2009, p. 73) that *“Service Level Agreements should be developed between the courts, health services, probation and the Crown Prosecution Service to provide psychiatric reports and advice to the courts”*. The government accepted this recommendation, pending the independent evaluations of results from two current court pilots in the South West and London regions, which are expected to be completed by the end of 2009. The Government stated that *“a core SLA will be agreed and implemented by April 2011”* (MoJ 2009b, p. 14).

A recommendation for *“mental health awareness training for the judiciary”* (Bradley 2009, p. 74) was accepted but referred to Her Majesty's Court Service (HMCS) and the Judicial Studies Board (MoJ 2009b, p. 15).

Bradley recognised that dual diagnosis is the norm among most offenders (Bradley 2009, p. 21) and recommended *“an examination of the treatment of offenders with dual diagnosis and an assessment of the service provided to offenders with mental health problems in Community Justice Centres”* (Bradley 2009, pp. 76, 80). These recommendations were accepted in principle and have been referred for consideration by the Programme Board (MoJ 2009b, p. 15).

Three recommendations related to the much underused Mental Health Treatment Requirement (an option available to sentencers when constructing a community sentence) (Bradley 2009, p. 96). All three were accepted by the Government (MoJ 2009b, pp 15-16).

Bradley asks for *“further research into the use of MHTRs”* (accepted by the Government pending results from research by Sainsbury Centre and the Offender Health Research Network), *“a SLA to ensure that MHTRs can be provided to offenders when requested by courts”* (a model will be developed by December 2009, pilots completed by September 2010, and national roll-out by April 2011) and *“the development of clear guidance regarding the use of MHTRs”* (referred to the Sentencing Guidelines Council for time framing and issuing).

Assessment

Sainsbury Centre welcomes the recognition that ‘dual diagnosis’ should be regarded as the norm among offenders and prisoners with the full range of mental health problems. We strongly endorse the recommendation that improved services should be urgently developed for this group.

We note that the Government has accepted all these recommendations in principle, but will consider the practical and resource implications. As Bradley acknowledges, a diversion strategy for offenders with mental health problems will have only limited impact if it does not address substance misuse. The available evidence strongly suggests that investment in evidence-based approaches to dual diagnosis among the offender population will bring substantial benefits to individuals, families, communities and society, and will be cost-effective too. To achieve this, mental health and substance use services need to be joined up at all levels. Yet the commissioning of each too often works in different directions with different targets.

We would like to see the availability of community sentences that can work with people with both mental health and drug/alcohol problems. This should be considered, for example, in future research on and review of the use of the drug rehabilitation requirement, the alcohol treatment requirement, and the mental health treatment requirement.

The Mental Health Treatment Requirement is rightly identified as currently being under-used and we endorse the recommendation that significant joint-working is needed to enable greater use of this provision.

Voluntary sector organisations can also play a useful part, and should be included in any SLAs between agencies in terms of providing mental health provision to offenders on the MHTR. Voluntary sector agencies already work with statutory agencies to be a formal part of an offender's community sentence, for both treatment requirements and others, such as the 'specified activity' requirement. This relationship should continue and should be considered in the design of the SLA modelling process.

The Criminal Justice Act 2003 allows sentencers considerable creativity when making a community sentence. Offenders with mental health problems might not always need the level of treatment that can be provided by a MHTR, and guidance should be given on using the supervision requirement or specified activity requirement in a way that can support the engagement of offenders with lower level mental health needs with mainstream services.

5. National Offender Management Service

NOMS is responsible for prisons and probation services both inside and outside prison, and manages much of the criminal justice process, from the court stage through to resettlement and risk management of offenders and released prisoners.

The most important recommendations in this section relate to primary care services, personality disorder, resettlement, and transfers to hospital from prison.

Relating to primary care services, Bradley recommended (Bradley 2009, pp. 103-4) that: *"Robust models of primary mental health services should be developed, ensuring an appropriately skilled workforce to assess and treat those with mild to moderate conditions"*, that *"primary mental health care must include a range of non-health activities to support wellbeing in prison"*, and that *"NHS commissioners should seek to improve the provision of mental health primary care services in prison"*.

These were accepted by the Government, which stated that this work would be taken forward *"with regional offender health commissioning groups and part of the specified regional development activity during 2009/2010"* (MoJ 2009b, p. 17).

On personality disorder, Bradley recommended (Bradley 2009, p. 109) further work to: *"evaluate treatment options for prisoners with PD, an evaluation of the Dangerous and Severe Personality Disorder programme to ensure it is able to address the level of need, and to develop an interdepartmental strategy for the management of all levels of PD in both the health and criminal justice systems"*.

The Government accepted these recommendations, and stated that a personality disorder strategy will be developed by February 2010 to address these recommendations (MoJ 2009b, p. 19).

Bradley recognised that the Care Programme Approach (CPA), a resettlement and mental health service provision package widely used in mainstream mental health services, should be utilised far more widely in prisons.

He recommended that *"offender managers should be aware of their role in the CPA process and the new DH guidance 'Refocusing the Care Programme Approach' should be fully implemented in prisons as a matter of urgency"* (Bradley 2009, p. 110). The Government accepted this, and stated that CPA would be part of the roll out programme for its offender manager training strategy (MoJ 2009b, p. 19b).

Bradley went further to recommend that *"improved continuity of care for prisoners subject to CPA should be a mandatory item in the standard NHS contract for mental health"* (Bradley 2009, p. 110). The Government accepted this in principle, but said that *"further assessment is required by DH to determine the impact on local NHS organisations"* (MoJ 2009b, p. 19). A recommendation (Bradley 2009, p. 116) that *"further work should be undertaken to ensure better implementation of CPA in prisons"* was accepted, with the government referring to the Programme Board for further consideration (MoJ 2009b, p. 20).

A significant recommendation related to transfer times for prisoners with acute mental health problems who required treatment in a secure hospital.

Bradley called on the Department of Health to “develop a new minimum target for the NHS of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting”, and that “this new target should be included as a mandated item in the Central Mental Health contract and included in the next edition of the Operating Framework” (Bradley 2009, p. 106).

The Government did not accept these recommendations, but placed them ‘under review’ stating that:

“The Government agrees with the goal behind this recommendation and considers that the time to transfer those with acute severe mental ill health from prison should be reduced to a minimum. The Board will consider what further guidance should be issued to the NHS and criminal justice agencies along with improved commissioning of services to achieve this. The priority level will be considered against the principles for developing the NHS Operating Framework”

(MoJ 2009b, p. 17).

Bradley also made calls for “mental health awareness training for all probation staff” (accepted, with a rolling programme to begin in 2010 and completed in five years, MoJ 2009b, p. 16) “and prison officers” (accepted, being delivered by current offender health regional teams, MoJ 2009b, p. 19) (Bradley 2009, pp 69, 111).

Bradley made a number of other recommendations for NOMS, all of which the government referred to the Programme Board for further consideration (MoJ 2009b, pp 16-20). These included:

- An evaluation of approved premises with enhanced mental health services (Bradley 2009, p. 67);
- A study of the relationship between IPP sentences and mental health problems (Bradley 2009, p. 100);
- An evaluation of the current health screen to improve identification of mental health needs on reception into prison (Bradley 2009, p. 102);
- An assessment of the quality of low and medium secure services (Bradley 2009, p. 106);

- The development of improved dual diagnosis services (Bradley 2009, p. 107);
- The creation of a resettlement strategy for prisoners with mental health problems on short sentences who would not get probation supervision (Bradley 2009, p. 113);
- The establishment of a community mentorship programme for people with mental health problems leaving custody (Bradley 2009, p. 119).

Assessment

Sainsbury Centre is pleased that Lord Bradley drew attention to primary mental health care within prisons, given the well documented high levels of need. We strongly support the need for robust and holistic models of primary mental health care which support wellbeing in prison.

We strongly endorse the recommendation that the Department of Health should develop a mandated minimum transfer target of 14 days for those with acute severe mental illness to be transferred to a health care setting. Two recent government pilots to deliver a 14-day maximum transfer waiting time were very challenging and ultimately unsuccessful, particularly in London. A mandated target would ensure that prison and health services had to work together effectively and swiftly, and would increase the likelihood of cooperation. The government has approached this recommendation with caution, but it is positive that it has not been rejected at this stage and will be considered further.

We are encouraged that Lord Bradley highlights the need for a robust inter-departmental strategy for the management of all individuals with a personality disorder. We particularly welcome his recommendation that this should address the needs of those with all levels of personality disorders and should not be exclusively focused on those said to have ‘dangerous and severe’ personality disorder, a group for whom the evidence base for specialist treatment and services is weak, and the costs very high. A far greater number of prisoners, including many who reoffend frequently, have Antisocial and Borderline personality disorders and it is vital that their needs are much better addressed than they are now.

We are also pleased that Lord Bradley raises concerns about the impact of the new indeterminate sentences. There have been

many more people subject to Imprisonment for Public Protection (IPP) than anticipated, causing major resourcing problems, and this group has particularly high levels of mental health problems and complex needs (Sainsbury Centre 2008b).

As Lord Bradley notes, the majority of those discharged from prison are not subject to probation supervision because they have served a sentence of less than 12 months. We strongly endorse Lord Bradley's recommendation for the need to develop a national strategy for those who leave prison who are not subject to probation supervision. We agree that CPA can be a very useful mechanism to ensure better continuity of care for those leaving prison who have a severe mental illness, and that an equivalent system should be investigated for the many who do not qualify for CPA. An automatic referral system from prison inreach to community mental health teams or community GPs as part of a resettlement package would be a very positive starting point.

6. Criminal Justice Mental Health Teams

Perhaps Lord Bradley's most significant recommendation (Bradley 2009, p. 130) is that:

"The National Programme Board will oversee the development of a national model of Criminal Justice Mental Health Teams with agreed common elements and its roll-out across the country."

The report recommended the creation of these new teams to play a pivotal role in diverting people with mental health problems to treatment and support at all stages of the criminal justice system. In place of the piecemeal arrangements currently in place for diversion, the proposed new teams would work not just in the courts but in police custody suites and with released prisoners.

The report called for all police custody suites to have access to Criminal Justice Mental Health (CJMH) teams, to enable improved screening and identification of individuals with mental health problems, *"providing information to police and prosecutors to facilitate the earliest possible diversion of offenders with mental disorders from the criminal justice system, and signposting to local health and social care services as appropriate"* (Bradley 2009, p. 53).

The Government accepted this only in principle, stating that it: *"agrees with the goal behind this recommendation, and as a medium term goal that every police custody suite and every court should have access to mental health liaison and diversion services, able to carry out timely assessments, and where appropriate refer offenders to treatment. The Programme Board will consider, as part of the delivery plan, what further advice needs to be given to PCT commissioners and the CJS to help achieve this goal"* (MoJ 2009b, p. 21).

A recommendation (Bradley 2009, p. 74) that CJMH teams *"should form close links with the judiciary to ensure that they have adequate information about the mental health and learning disability of defendants, and information concerning local health and learning disability services"* was accepted in principle and referred to the Programme Board pending the findings of the ongoing mental health court pilots (MoJ 2009b, p. 21).

Bradley also recommended (Bradley 2009, p. 80) that *"All courts, including current specialist courts, should have access to liaison and diversion services in order that specialist courts are seen as an addition to a comprehensive liaison and diversion service"*, a recommendation that seems derived from Bradley's lukewarm response to standalone mental health courts. This was accepted in principle, with the Programme Board and Department of Health to consider further the implications for PCTs and local NHS organisations (MoJ 2009b, p. 22).

Three recommendations related to the involvement of, and linking between, prison inreach services and CJMH teams.

First, that *"prison inreach should develop a liaison and diversion role to enable some of their capacity to be freed for more clinical practice"* (Bradley 2009, p. 104). This was accepted by the Government and referred to the Programme Board in light of a recent Offender Health evaluation of inreach services (MoJ 2009b, p. 22).

Second, that *"prison inreach and CJMH teams can ensure better continuity of care by working together through use of the Care Programme Approach"* (Bradley 2009, p. 110). This was also accepted (MoJ 2009, p. 22).

Third, that CJMH can act as a link between a released prisoner and ongoing probation supervision, “to act as a point of information and support for probation and third sector staff, and other organisations involved in resettlement” (Bradley 2009, p. 116). This was accepted in principle, with the Programme Board to consider the practicalities of a CJMH team following an offender throughout the pathway (MoJ 2009b, p. 23).

Recommendations accepted in principle and referred to the Programme Board for further consideration (MoJ 2009b, p. 24-25) included calls for CJMH teams to:

- Be responsible for ensuring continuity of mental health care (Bradley 2009, p. 135);
- Ensure that appropriate information is shared between all agencies responsible for caring for an offender with mental health problems (Bradley 2009, p. 137);
- Have direct involvement and input to local multi-agency public protection arrangements (Bradley 2009, p. 137);
- Have a minimum dataset...developed for collection by teams (Bradley 2009, p. 139).

To ensure CJMH teams are established across the country to consistent standards, Bradley stated that implementation would require attention to:

- Core minimum standards for each team
- National network
- Reporting structure
- National minimum dataset
- Performance monitoring
- Local development plans
- Key personnel.

A critical recommendation was to make CJMH teams a mandatory requirement for the NHS: “The requirement for Criminal Justice Mental Health Teams is currently included in the Standard NHS contract for mental health and learning disabilities on a non-mandated basis. This should be included in the contract as a mandated item and reflected in the next edition of the NHS Operating Framework” (Bradley 2009, p. 131).

This was put ‘under review’ by the Government, which stated that:

“The Government agrees with the goal behind this recommendation and the Board will consider what further guidance should be

issued to the NHS and criminal justice agencies along with improved commissioning of services to achieve this. The priority level will be considered against the principles for developing the NHS Operating Framework and fed into the development of the NHS Contract”

(MoJ 2009b, p. 24).

However, more encouragingly it stated that:

“The Government considers that, as a medium term goal, every police custody suite and every court will have access to mental health liaison and diversion services able to carry out timely assessments and, where appropriate, refer offenders to treatment”

(MoJ 2009b, p. 24).

Assessment

Sainsbury Centre strongly supports the development of a national system of Criminal Justice Mental Health teams. The call that these teams extend their roles, for example into police custody suites, is highly commendable.

With sufficient resource and mainstream engagement, CJMH teams could act as a gateway to mainstream mental health care for a group of people who frequently get excluded from these services. There is, however, a risk that CJMH teams would become ‘silted up’ with caseloads of released prisoners, and would not be able to deliver on their crucial front-end service in police custody and courts. This is likely to happen if mainstream services do not sufficiently engage with offenders, and instead abdicate responsibility for offenders to CJMH teams.

The funding of these new teams also needs to be thought through with care. We would recommend joint funding between health and criminal justice commissioning agencies. It is vital that the size and funding required of such teams, who would be responsible for all offenders with mental health needs, is sufficient for them to maintain contact with offenders throughout the criminal justice system.

It is also unclear how voluntary sector organisations would be included in the development and operation of CJMH teams as part of a standard NHS contract. We are also concerned that allowing scope for ‘local development plans’ could create national

disparity in standards and services. This has been a major weakness of liaison and diversion arrangements and should not be repeated for CJMH teams.

The report rightly draws attention to the relationship between inreach and CJMH teams. Many inreach teams, however, already take on a diversion role, finding hospital beds for prisoners who need them and liaising with community mental health teams ahead of release. Most are also overwhelmed with their existing workload.

The important task here is to unlock mainstream and forensic mental health services to reduce pressure on inreach teams. Community mental health teams too often do not accept referrals for prisoners who have been seeing inreach teams because they operate a higher threshold for access to their services. Unless this is tackled, people will continue to see their care stopped when they leave prison.

7. Overarching systems

The final section of government responses is a broad category, comprising of thirteen recommendations. Some refer to specific policies such as a recommendation on Anti-Social Behaviour Orders (ASBOs) and Penalty Notices for Disorder (PNDs). It emphasises the *“need to provide mental health information before these Orders and Notices are given or breached”* (Bradley 2009, p. 37). This was accepted in principle by the Government, with the Programme Board to review policies and the implications for police work (MoJ 2009b, p. 25).

Lord Bradley also recommended that *“the Offender Assessment System (OASys) should be replaced”* (Bradley 2009, p. 137). This was accepted by the Government: NOMS will work with mental health professionals to develop the mental health related questions in the next version of OASys (MoJ 2009b, p. 26).

Bradley recommended that *“a new study should be commissioned which repeats the 1997 ONS survey of the psychiatric morbidity of prisoners to provide new baseline data. In addition, the government should explore the feasibility of adding to the study the psychiatric morbidity of offenders at other stages of the criminal justice system”, and that ‘a similar study should be undertaken to establish the prevalence of*

people with learning disabilities in the criminal justice system” (Bradley 2009, p. 138). This was accepted in principle, for the Programme Board to consider further (MoJ 2009b, p. 27).

Two recommendations related to training for staff, including that *“where appropriate, training should be undertaken jointly with other services to encourage shared understanding and partnership working. Development of training should take place in conjunction with local liaison and diversion services”* and that *“the training programme must be developed in conjunction with service users”* (Bradley 2009, p. 111).

These were accepted by the Government, which stated that: *“During 2009/2010 each regional delivery plan contains a multi agency training plan and will be reported against as part of the regular reporting schedule during this period. Any additional advice taken from national user group will influence the continuing development of the training programmes during this time”* (MoJ 2009b, p. 26).

Many recommendations related to better ways of working. Bradley recommended that:

- PCTs and partners should jointly plan services for offenders to ensure effective commissioning and delivery of services;
- Consideration should be given to a lead PCT commissioning offender mental health and learning disability services on behalf of a cluster of local PCTs in each area;
- Connecting for Health, PCTs and SHAs should work together to roll out integrated information systems to health services provided in all Criminal Justice Settings (Bradley 2009, pp 146, 148).

The Government accepted the first two of these recommendations, stating that commissioning is developing and improving, particularly with the introduction of World Class Commissioning. The Government also noted that *“Offender Health has a current programme of activity to ensure robust models are developed, working with regional offender health commissioning groups and part of the specified regional development activity during 2009/2010”* (MoJ 2009b, p. 27).

The third recommendation was accepted in principle, to be considered further by Department of Health and the Prison Health IT Board, reporting by April 2010 (MoJ 2009b, p. 28).

A significant recommendation (Bradley 2009, p. 146) that “*The Department of Health should include explicit reference to the needs of offenders with mental health problems or learning disabilities into future NHS Operating Framework documents*” was put ‘under review’ by the Government. Its response stated that:

“The Department of Health agrees that the needs of offenders with mental health and learning disabilities should be considered by the NHS and the Programme Board will establish the best way to communicate this to the NHS, which could include through the Operating Framework however there maybe other appropriate mechanisms”

(MoJ 2009b, p. 28).

Assessment

Sainsbury Centre agrees that commissioning and training are two fundamental drivers for change and improvement. Joint working, pooled budgets, shared understanding and agreed protocols will all be essential in the delivery of Lord Bradley’s Report, and it will be a major challenge. Central support for locally delivered services is critical, and it is therefore significant that these recommendations will be taken forward by the Programme Board and government.

Lord Bradley’s recommendations calling for more training for those working in and around the criminal justice system, as well as more mental health awareness generally (e.g. GPs and in schools), are very important. This training might additionally target those working in the CPS and court officials (such as solicitors, prosecutors and duty officers) who all play a crucial role. It seems logical that this training should cover awareness about drug and alcohol issues and learning disabilities and their links with mental health. Potentially, this training can complement and enhance work to get across public health messages on drug and alcohol use (e.g. on links between cannabis and mental health).

It is also important to understand the distinct training needs of the different agencies involved. Training should be in the form of an ongoing programme, with refresher training built in, not just a one-off course. Criminal justice awareness training, meanwhile, should be offered to health and social care agencies to understand the legal responsibilities and context for criminal justice agencies. This would

address some of the barriers to information sharing and communication between agencies across sectors.

While there will be a requirement for some practitioners to receive separate training to meet the specific needs of their role, we would like to see this, in the main, organised and delivered through a multi-agency approach to a multi-agency audience. We also support the need for service user involvement in all aspects of this training, including from a range of Black and minority ethnic communities.

Practitioners and commissioners from a variety of agencies would benefit from guidance on the roles and responsibilities of different agencies and which addresses how local services for offenders might be delivered in partnership. This guidance should also cover the roles and responsibilities of mental health and other services in terms of working with sentencers, such as their role as expert witness and in providing psychiatric reports. The role of inreach teams with courts also needs to be considered, especially given the detailed knowledge they will have of some defendants, but also given the limited resource such teams have to deliver within their existing role.

The structures for governance, commissioning and delivery are important, and at all levels. Nationally, it is essential that the National Programme Board is linked up with other cross-government initiatives, such as the Youth Crime Action Plan and the New Horizons strategy, to avoid both duplication and contradiction between them.

Careful thought also needs to be given to these structures at the regional and local levels. Successful implementation of Lord Bradley’s recommendations is particularly dependent on the local level, particularly among primary care trusts (PCTs). The Offender Health and Social Care Strategy, set to be published in October 2009, needs to address how locally effective commissioning, delivery and partnership working might be realised. The strategy could consider a variety of mechanisms. For example, in some areas it may be appropriate for a particular PCT to take the lead in commissioning for offenders.

A new ONS study would help bolster what is already known about mental health problems in prisons, but would also give much needed

information on the needs of offenders in the community or at police stations, about which we know very little on a quantitative level. It should include specific information about under-18s, young adults and about different ethnic groups.

A honing and improving of the OASys system is needed. OASys was never intended to be a diagnostic tool, but has increasingly been used in this way. A refined mental health section could help to enable better identification of mental health problems, but it should not replace the need for a clinical assessment.

Service user and carer engagement

We are pleased that in various ways the views of service users and carers have been included in the review. We strongly urge that service user and carer engagement needs to be incorporated meaningfully into the process of implementation. This could take a number of forms, such as the establishment of a national service user and carer reference group; parallel arrangements to support local implementation; involvement of service users and carers in the delivery of mental health awareness training; and the use of service users as 'peer workers', in particular in terms of the provision of befriending services.

Diversity

The Bradley Report says very little about the specific needs or current experiences of Black and minority ethnic (BME) people in the criminal justice system. We know that people from some BME communities are over-represented both in criminal justice and mental health services and that they continue to experience both less positively than white people. Black people are, for example, still much more likely to come to mental health services via the police or the courts and less likely to get referred by their GPs.

We should avoid making the mistake of implementing the Bradley Report in a 'colour-blind' manner that overlooks the specific needs of people from a range of communities. The views of service users and carers from Black and

minority ethnic communities should be sought especially in this process. And we need a robust investigation of what works in terms of early intervention and diversion services for different BME communities

Conclusion

Lord Bradley's report offers a new beginning for the way the criminal justice system deals with people with mental health problems.

Too many people with a wide range of mental health problems are being imprisoned in this country. Lord Bradley has set out a comprehensive and ambitious way of putting that right.

Sainsbury Centre strongly supports Lord Bradley's plan for a Criminal Justice Mental Health team in every locality in England. Setting these up would be a vast improvement on the patchy provision of diversion schemes we have today. We also call upon the Department of Health to follow Lord Bradley's recommendation and mandate these teams in the next NHS Operating Framework.

We endorse Lord Bradley's call for all prison hospital transfers to be completed within 14 days. It is unacceptable that many prisoners wait for months to go to hospital when they are acutely unwell. But to achieve this change we are going to have to explore better ways of using secure hospital and step-down facilities.

Both prisons and secure hospitals are holding record numbers of people. So more must be done to divert people safely from custody to alternative provision in their own communities. Short prison sentences are especially damaging to people's mental health and they do nothing to reduce further offending.

If Lord Bradley's report were implemented in full, it would make a substantial difference to many thousands of people's lives. It would help offenders with mental health problems to turn their lives around. It would benefit communities and victims by making them safer. And it would reduce the costs of crime to the nation as a whole.

References

- Bradley (2009) *Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*. London: House of Lords.
- Carter (2007) *Securing the Future Proposals for the Efficient and Sustainable Use of Custody in England and Wales*. London: House of Lords.
- Durcan, G. & Knowles, K. (2006) *London's Prison Mental Health Services: A review*. London: Sainsbury Centre for Mental Health
- Durcan, G. (2008) *From the Inside: Experiences of prison mental health care*. London: Sainsbury Centre for Mental Health.
- HMIP (2009) *HM Chief Inspector of Prisons for England and Wales Annual Report 2007-08*. London: The Stationery Office.
- House of Commons (2007) *Jack Straw's Oral Statement to the House of Commons on Lord Carter's Review of Prisons 5 Dec 2007* http://www.justice.gov.uk/news/announcement_051207a.htm
- House of Commons (2009a) *Hansard Written Answers*, 30 Mar 2009: Column 1023-1028W.
- House of Commons (2009b) *Hansard Written Answers*, 16 June 2009: Column 256W.
- Joint Committee on Human Rights (2004) *Deaths in Custody: Third Report of Session 2004-05*. London: House of Lords/House of Commons Joint Committee on Human Rights.
- Lader, D., Singleton, N. & Meltzer, H. (2000) *Psychiatric Morbidity amongst Young Offenders in England and Wales*. London: Office for National Statistics.
- Ministry of Justice (2008) *Statistics on Race and the Criminal Justice System 2006-7*. London: Ministry of Justice.
- Ministry of Justice (2009a) *Population in Custody Monthly Tables May 2009 England and Wales*. <http://www.justice.gov.uk/publications/populationincustody.htm> [Accessed 2 July 2009]
- Ministry of Justice (2009b) *Lord Bradley's Report on People with Mental Health Problems or Learning Disabilities in the Criminal Justice System: The Government's response*. London: Ministry of Justice
- Ministry of Justice (2009c) *Deaths in Prison Custody 2008*. <http://www.justice.gov.uk/news/newsrelease010109.htm> [Accessed 25 March 2009]
- Office for National Statistics (2001) *2001 Census* <http://www.statistics.gov.uk/cci/nugget.asp?id=263> [Accessed 25 March 2009]
- Prison Reform Trust (2008) *Bromley Briefings Prison Factfile December 2008*. London: Prison Reform Trust.
- Sainsbury Centre (2008a) *On the Outside: Continuity of care for people leaving prison*. London: Sainsbury Centre for Mental Health.
- Sainsbury Centre (2008b) *In the Dark: The mental health implications of Imprisonment for Public Protection*. London: Sainsbury Centre for Mental Health.
- Singleton, N., Meltzer, H. & Gatward, R. (1998) *Psychiatric morbidity among prisoners in England and Wales*. London: Office for National Statistics.

More from a **better way**



a better way is our campaign to highlight our concerns and provoke political, media and public debate about the approach we take to mental health in the criminal justice system. We want to change the way people think about mental health and criminal justice and set out **a better way** of working.

Our campaign includes the following publications:

- Commissioning Mental Health Care in the Criminal Justice System: 10 top tips for PCT Boards (June 2009)
- A Missed Opportunity: Community Sentences and the Mental Health Treatment Requirement (March 2009)
- Diversion: A better way for criminal justice and mental health (February 2009)
- On the Outside: Continuity of care for people leaving prison (December 2008)
- The Police and Mental Health: A briefing (September 2008)
- From the Inside: Experiences of prison mental health care (June 2008)
- Short-changed: Spending on prison mental health care (May 2008)

Visit www.scmh.org.uk to find out more about our work and to download copies of these publications.

Briefing 38: The Bradley Report and the Government's Response

The implications for mental health services for offenders

Published July 2009

© Sainsbury Centre for Mental Health, 2009

Recipients (journals excepted) are free to copy or use the material from this paper, provided that the source is appropriately acknowledged.

Register for our monthly email bulletins and copies of new briefing papers at www.scmh.org.uk

BRIEFING

SAINSBURY CENTRE FOR MENTAL HEALTH
removing barriers achieving change

38: The Bradley Report and the Government's Response:
The implications for mental health services for offenders

Summary

The Bradley Report was the result of an independent review of the experience of people with mental health problems and people with learning disabilities in the criminal justice system. Commissioned by the Ministry of Justice and published in April 2009, it made some 80 recommendations for change. Among those recommendations were important new proposals to tackle the over-representation of people with mental health problems in prisons in England. They include the proposed creation of a national network of Criminal Justice Mental Health teams to divert people towards support services from police stations, from courts and following release from prison. The report also called for a 14-day maximum wait for people who need to be transferred from prison to hospital for urgent mental health treatment and for the NHS to take on responsibility for providing health services in police stations. The Bradley Report can and should lead to major changes in the way offenders with mental health problems are supported and treated in this country. If implemented, it can not only improve the mental health of offenders but make communities safer and ultimately reduce the costs to the taxpayer of criminal justice. ▶

SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change



Sainsbury Centre for Mental Health
134-138 Borough High Street, London SE1 1LB

T 020 7827 8300

F 020 7827 8369

www.scmh.org.uk

Charity registration no. 1091156. A Company limited by guarantee registered in England and Wales no. 4373019.