



39: Mental health care and the criminal justice system

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Summary

The population in custody has soared in the last decade and 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. It aims to give prisoners access to the same quality and range of health services as the general public receives in the community. This is an enormous challenge. Many prisoners have a combination of mental health problems, substance misuse and personality disorder, as well as a range of other issues to deal with. But the costs, both financial and social, of containing people in prison without access to appropriate health care are high.

The Government has committed to developing diversion services to identify people with mental health problems in courts and police stations. This is vital to reduce

the number of people with mental health difficulties in custody and to improve community services for offenders of all ages.

Resettlement and rehabilitation are also essential to improve health and reduce further offending. Help with health, housing and employment make a big difference to offenders' lives.

This briefing paper examines the provision of mental health care for adults in the criminal justice system. It looks at what has been achieved to date and identifies priorities for further work. We will be publishing a separate briefing paper which examines the provision of mental health care for children and young people in the youth justice system.



Mental health in prison

England and Wales together have one of the highest rates of imprisonment in Western Europe. The prison population continues to rise, reaching a record high of 86,821 (including 588 in immigration removal centres) in late August 2011 (MoJ, 2011a).

Up to 90% of prisoners have some form of mental health problem (including addictions and personality disorder – Singleton *et al.*, 1998) and 10% of male and 30% of female prisoners have previously experienced a psychiatric acute admission to hospital (DH, 2007). Most prisoners with mental health problems have common conditions, such as depression or anxiety. A smaller number have more severe conditions such as psychosis. Figure 1 shows the prevalence of mental health problems in prisons compared to the general population.

The data on prevalence of mental health problems in prisons is over a decade old and there are now plans to repeat a survey to identify the current level of need. A more recent survey of newly sentenced prisoners indicated that the prevalence of mental health problems among prisoners prior to custody was high. Of the sample, 10% was identified as likely to have a psychotic disorder and 61% a personality disorder. Over a third of prisoners reported significant symptoms of anxiety or depression. The survey also found that levels of psychosis, anxiety and depression, self-harm and suicide attempts were considerably greater among women than men (Stewart, 2008).

Rates of self harm and attempted suicide in prison are high. A total of 58 prison suicides and 26,983 self-harm incidents were recorded in 2010 (MoJ, 2011b). Women represent 5% of the prison population, but account for nearly half of all reported self-harm incidents (MoJ, 2011b).

Not everyone enters prison with a mental health problem: for some, being in prison will lead them to develop depression or anxiety (Joint Committee on Human Rights, 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). Of these, 11% are black British, whereas black Britons represent 2.8% of the general population (Prison Reform Trust, 2011). There are high rates of suicide among foreign nationals: 25% of all prison suicides in 2007/8 (HMIP, 2009). Young black British men are also over represented in ‘stop and search’ incidences and arrests. Some Black communities are also overrepresented in secure mental health hospitals (Rutherford & Duggan, 2007). 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). There is some limited evidence to suggest that black and other BME prisoners are underrepresented in prison mental health team caseloads by comparison with their representation in the

Figure 1: Mental health problems in prisons and the general population

	Prevalence among prisoners (16 years+)	Prevalence in general population (16-64 years)
Psychosis	8%	0.5%
Personality disorder	66%	5.3%
Depression, anxiety etc	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

Source: Singleton *et al.* (1998) Source: Singleton *et al.* (2000)

prison population (Inreach Review Team, 2007; Offender Health South East, 2008; Offender Health South East, 2010).

Women

Of the 86,821 people in prison on 26 August 2011, 4,289 were females (MoJ, 2011a). 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).

Women serve shorter sentences, but during that time their children may be taken into the care of the local authority, and they may lose both their job and their home, increasing the likelihood of re-offending and mental illness. The Corston Review commissioned by the Home Office recommended completely replacing the women’s prison estate and creating better alternatives (Home Office, 2007). This led to the development of the Women’s Diversionary Fund in 2010, with some £2 million jointly provided by the Corston Coalition – a group of charitable funders who pooled their resources to help to implement the review’s recommendations – and the Ministry of Justice to support alternatives to custody for women, particularly the one-stop-shop model. The Corston Coalition and the Ministry of Justice have recently announced a further £3.2 million of funding for 26 organisations to continue this pilot work for a further year.

Imprisonment for Public Protection (IPP)

On 31 March 2011, there were 6,500 IPP prisoners (MoJ, 2011c). Over half of these (3,500) have passed their tariff date. In 2009, 104 IPP prisoners were being detained in secure psychiatric hospitals (House of Commons, 2009).

IPP is an ‘indeterminate’ sentence given to offenders who are identified by the courts as ‘dangerous’ but whose offences do not carry a life sentence. The previous Government forecasted that the number of IPP prisoners will rise to 12,000 by 2014 (MoJ, 2007). The Coalition Government has recognised the need to reform IPP, including restricting it to the most serious cases where the offence would have otherwise merited a determinate sentence of at least 10 years (MoJ, 2010a). In its response to the consultation on sentencing, punishment and

the rehabilitation of offenders, the Government announced that it would be conducting an urgent review of sentencing for serious sexual and violent offenders including IPP sentences (MoJ, 2011d). According to this response, the Government is now considering replacing the IPP regime with a tougher determinate sentencing framework.

Levels of mental illness and complex need 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, 2008a).

IPP prisoners must often complete a number of Offender Behaviour Programmes in order to be considered eligible for release. There is evidence that prisoners whom staff consider to be unsuitable to participate because of mental illness or emotional instability are often excluded from taking part in these programmes (Sainsbury Centre, 2008a).

Unemployment and social exclusion

Prisoners are disadvantaged in many ways before coming into contact with the criminal justice system:

- 67% were unemployed before going to prison (SEU, 2002);
- 58% of newly sentenced prisoners truanted from school regularly and 46% had no qualifications (Stewart, 2008);
- 65% of prisoners have numeracy skills at or below the level of an 11-year-old and 48% have reading skills at or below this level (SEU, 2002);
- 70% will have no employment or placement in training / education on release (Niven & Stewart, 2005);
- 15% of prisoners live in temporary accommodation or are homeless before custody (Stewart, 2008) and 42% of released prisoners have no fixed abode (cited in Williamson, 2006).

It is estimated that being in work reduces the risk of re-offending by between a third and a half (SEU, 2002). But a criminal record, low

educational attainment, health problems and a lack of stable housing can make it very difficult for prisoners to find employment on release.

Centre for Mental Health reviewed the resettlement and employment opportunities for people with mental health problems leaving prison and found that they are particularly disadvantaged as they are often excluded from education, employment and training programmes (Centre for Mental Health, 2010).

Mental health care in prison

Responsibility for prison health care was fully transferred from HM Prison Service to the NHS in April 2006. The Government stated that “prisoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS” (DH & HMPS, 2001). Prison health care is currently commissioned by local primary care trusts and is likely to be the responsibility of the NHS Commissioning Board from 2012.

Prison mental health teams

Specialist mental health ‘inreach’ teams were introduced to work with prisoners with severe and enduring mental illnesses. This has led to an improvement in mental health care in some prisons (Durcan, 2008) but the picture is mixed. Some inreach teams have made a positive contribution – for example a study of five prisons in the West Midlands found that prisoners using inreach services felt better prepared for their release than on previous occasions (Durcan, 2008). However, wide regional variations have been reported in funding for inreach services (Sainsbury Centre, 2008b).

Many prisoners with common mental health problems are also referred to inreach teams. This is because they are given little or no treatment or support from other health services in prison. This puts added pressure on inreach teams and restricts the time they can give to each person.

There has been no implementation guidance for inreach teams or for those commissioning them. Therefore their role and function varies from prison to prison. While inreach teams should include a mixture of staff such as psychiatrists, social workers, mental health nurses and allied

health professionals, most teams are mainly made up of nurses, with varying degrees of medical support.

The role of inreach teams is often restricted by frequent movement within the prison population. On average there were more than 6,000 inter-prison transfers per month between April 2007 and February 2008 (House of Commons, 2008).

The range of interventions offered by inreach teams can often be very limited. There has been a strong tendency for the various teams and agencies in prisons to work separately rather than together. This is a real challenge for a client group who typically have complex and multiple needs of which poor mental health is just one. Siloed working has made it difficult to provide an integrated approach for those who require support across a range of areas. However, there are some prisons that have achieved good practice in this area for example, where inreach teams work with prison primary care teams to help staff develop an understanding of mental health issues (Durcan, 2008).

Identifying mental health problems

Any prisoner thought to be in need of a mental health service will undergo an assessment process. Because agencies in prisons all tend to work independently of each other, prisoners with mental health problems may undergo multiple assessments, with considerable overlap between each.

Most inreach teams are not involved in the medical screening of new arrivals to prison. In some prisons a mental health nurse carries out this screening but in many cases it is done by staff who do not have mental health training (Edgar & Rickford, 2009).

Reception itself can be a chaotic process in which large numbers of people arrive at one time. Records of previous mental health care often do not accompany prisoners when they are transferred from other prisons. As a result, prisoners with mental health problems have often not been identified at this crucial time (Durcan, 2008).

The recent introduction of SystmOne, a prison wide electronic health records database, should bring about improvements in the exchange of information for transferred prisoners.

Additionally most prisons do manage to conduct a secondary screening process, which provides a less rushed screening opportunity. However, there is increasing recognition that the process should screen for considerably more needs than just poor mental health including: learning disability and difficulty, Autistic Spectrum Disorders, speech and communication difficulty, acquired head injury, personality disorder and symptoms of trauma.

Transfer to NHS care

Some prisons have 24-hour health care facilities which include inpatient units. These can be used for any medical need, but their use tends to be dominated by prisoners with mental health problems. There is also evidence that some prisoners with serious mental health problems are placed in segregation units, because 'ordinary location' is considered to be too stressful (Edgar & Rickford, 2009; Durcan, 2008).

For the purposes of compulsory care, prisons are not recognised as hospitals under the Mental Health Act 1983. People must be transferred to an NHS hospital for treatment if compulsion is required.

In 2009, there were 4,258 restricted patients detained in secure hospitals (MoJ, 2010b). During that year, there were 940 transfers of restricted patients from prison to hospital.

Transfer from prison to a secure hospital is often a very slow process, often taking several months. The Department of Health had previously instigated a pilot project to bring waiting times down to 14 days. The Bradley Review (2009), commissioned by the previous Government, called for this waiting time limit to be applied nationally.

Centre for Mental Health conducted a review of secure services in 2009/10 and found that secure mental health provision varies across the country. While some areas were able to manage timely transfers into such provision, the general picture was one of considerable delay both in admitting prisoners to hospital and in discharging patients from secure units to step-down and community services (Centre for Mental Health, 2011).

Primary mental health care

Primary care for prisoners with common mental health problems such as depression, anxiety,

emotional distress and adjustment problems is variable (Prison Health APPG, 2006). Many prisoners have experienced trauma and abuse (Durcan, 2008) and need psychological therapy.

Some prisons are served by prison doctors and others by a local GP practice. While a majority of prison doctors work with prisoners with mental health problems, most do not receive any training in psychiatry (Pearce *et al.*, 2004). Prison nurses provide a significant proportion of the primary care service. Many prison nurses, including those with mental health training, are employed in a generic health role. Those that have tried to provide primary mental health care have often found this difficult due to staff shortages and the broader demands of the generic role.

Some prisons have developed dedicated specialist primary mental health care teams which are able to deliver some crisis intervention and psychological interventions or psychological therapy services.

Centre for Mental Health recommends that each prison be given its own GP practice and a national body be established to monitor standards. Clearer incentives should also be given to practices outside prison to improve care for former prisoners (Sainsbury Centre, 2007).

Dual diagnosis and multiple need

It is estimated that a large proportion of prisoners have both mental health and substance misuse problems (Brooker *et al.*, 2002). However, there is big gap in 'dual diagnosis' services in prisons. Up to 70% of inreach team clients have substance misuse needs, but only around one in ten teams has a specialist dual diagnosis service (HMIP, 2009). This is partly due to differences in priorities between mental health teams and substance misuse teams. The latter have had to prioritise those substance misusers with dependency problems, whereas mental health services have a somewhat broader interest in the impact of substance misuse on wellbeing and treatment care and this may fall below the threshold for substance misuse teams.

Figures suggest that the majority of prisoners (80%) have used illegal drugs in the year before custody (Stewart, 2008). Over half have used cannabis and a third have used heroin and / or crack cocaine.

Nearly one in five of the men entering local prisons admits to having an alcohol problem. During the year before prison, 63% of male sentenced prisoners and 39% of female sentenced prisoners were hazardous drinkers (Singleton *et al.*, 1998). Many more prisoners have had less severe problems with alcohol but would still benefit from treatment.

The provision of alcohol services in adult prisons is variable: some have appointed dedicated alcohol workers, but most prison substance misuse teams do not work with prisoners who have alcohol problems unless they also use street drugs (HMIP, 2009).

A recent report by the Centre found that across the criminal justice pathway, alcohol interventions are under-resourced (Fitzpatrick & Thorne, 2011). There is inadequate support for offenders who misuse alcohol at all levels, from basic screening and advice to specialist counselling and treatment programmes. The poor provision is further exacerbated by misalignment between health and criminal justice agencies and a lack of equivalence between alcohol and drug service commissioning. Substance misuse services run by the National Treatment Agency will be the responsibility of Public Health England from 2012.

In addition to mental health and substance misuse problems, many prisoners also have a range of other interrelated needs including low educational attainment, unemployment, poor housing or homelessness, poverty and difficulties in accessing benefits, poor living skills, and a history of family breakdown, trauma and domestic violence. However, siloed working means that people are often left without the range of support they need to get their lives back on track.

Personality disorders

It is estimated that 66% of prisoners have a personality disorder (Singleton *et al.*, 1998). Personality disorders are not classed as mental illness but are described by psychiatrists as aspects of an individual's personality that make it difficult for them to live with themselves or other people. The majority of prisoners with personality disorders receive little in the way of support targeted to their needs (Durcan, 2008). There is huge geographical variability in practice in the transfer of people with personality

disorders to secure mental health care for treatment (Centre for Mental Health, 2011a).

Under the previous Government, Dangerous and severe personality disorder (DSPD) pilots provided treatment and management for those offenders with severe personality disorders and who posed a high risk of harm. These pilots have been very expensive (costing £69 million per year) and only involved a small number of offenders (DH, 2011). There are now plans to reinvest current funding for the DSPD pilots to increase treatment capacity in prisons and to provide additional psychological support for those successfully completing treatment (DH, 2011). While this is to be welcomed, these plans do not address how interventions for people with severe personality disorders will fit in with other, if any, arrangements for the broader population of offenders with personality disorders.

Alternatives to imprisonment

Police and court liaison and diversion schemes were introduced to ensure that people with mental health problems who come into contact with the police and courts are identified and directed towards more appropriate care. There is evidence that where such services are working well they can be effective (Nacro, 2005; Sainsbury Centre, 2009a), but too often they have been unable to have a major impact on the system. The Government has committed to developing diversion services to identify people with mental health difficulties in police stations and courts and to make treatment-based alternatives to imprisonment available for offenders with mental health and drug problems (MoJ, 2010a).

Diversion

In the absence of a clear national policy framework prior to the Bradley Report, diversion services developed piecemeal. Many schemes have been insecurely funded. Some areas have no diversion arrangements at all. Others have only minimal coverage (Healthcare Commission / HMIP, 2009). It is estimated that just one-fifth of the potential national caseload is seen and even cases of severe mental illness are often missed because many schemes rely on police or court staff to identify individuals who may need

support (Sainsbury Centre, 2009a). The Bradley Report has called for criminal justice mental health teams to be set up across England to divert people from police stations and courts to more appropriate care (Bradley, 2009).

Around 15% of incidents with which the police deal have some kind of mental health dimension. Yet police officers rarely have mental health training and there are few opportunities to divert people from police stations to health and social care services (Bather, Fitzpatrick & Rutherford, 2008).

The Coalition Government has given a commitment to funding and rolling out diversion and liaison services nationally by 2014 so that they are accessible to all courts and police custody centres. The Department of Health has launched a national pathfinder programme with both adult and children and young people's liaison and diversion schemes. Additionally this programme will include piloting on the transfer of police custody healthcare to the NHS across 10 sites. Some of the liaison and diversion schemes will be the subject of more exhaustive evaluation to help make the financial and social business case for further expansion.

Community sentences

For people with mental health problems who cannot be entirely diverted away from a criminal justice sanction, a community sentence with a Mental Health Treatment Requirement (MHTR) can be a viable alternative to a short prison sentence. At present it is little used by the courts because it is poorly understood, subject to lengthy delays and there is no procedure for ensuring that support is available from local community mental health services (Sainsbury Centre, 2009b).

There is a particularly strong financial case for diverting offenders away from short sentences in prison towards effective treatment in the community: estimated savings in crime-related costs of over £20,000 per case (Sainsbury Centre, 2009a).

The Government's recent Green Paper, *Breaking the Cycle* (MoJ, 2010a), highlighted a commitment to reducing the number of short sentences and exploring robust community alternatives, which is maintained in its recent response to the consultation (MoJ, 2011e). Proposals include removing the requirement

for a formal psychiatric report for the purposes of making a MHTR, and ceasing the automatic imposition of stronger penalties on people who breach community orders.

Care after release

The resettlement experience of most prisoners is poor with most receiving little meaningful help on leaving prison. Prisoners with mental health problems are particularly vulnerable. Many have no permanent residence arranged on release which makes it harder for them to keep in touch with services (Sainsbury Centre, 2008c).

Men recently released from prison are eight times more likely than the general population to commit suicide. Women released from prison are 36 times more likely to kill themselves than women in the general community (Pratt *et al.*, 2006). Some individuals may be in distress because they are being released from prison into the same situation that led them to crime in the first place.

The Centre (2008c) has shown that there is poor continuity of care both into and out of prison. The previous Government proposed that all prisoners with severe and enduring mental health problems should be linked into the care programme approach (CPA) system, which is used for planning care in the community, but there are reports that community mental health services are reluctant to accept responsibility for released prisoners (Sainsbury Centre, 2008b; Durcan & Knowles, 2006).

The Coalition Government has recognised that reoffending rates remain unacceptably high. Figures published by the Ministry of Justice show that an estimated 43% of offenders are reconvicted within one year of release from prison; and 74% are reconvicted within nine years (MoJ, 2010c). Reoffending rates are particularly high for those serving a sentence of 12 months or less (MoJ, 2011e).

Breaking the Cycle placed considerable emphasis on the need for more effective rehabilitation (MoJ, 2010a). A key aspect of this needs to be 'through the gate' support for prisoners to ensure access to mental health care on release, as well as support in relation to other needs such as housing and employment (Centre for Mental Health, 2010).

The Government is currently running a payment-by-results pilot at Peterborough prison using a Social impact bond where investors receive a return on their investment based on reductions in reoffending. This pilot focuses on prisoners serving sentences of less than 12 months and provides support in prison and through the gate in order to link prisoners with services in the community.

Conclusion

The introduction of prison mental health teams has led to an improvement in mental health care in some prisons but the picture is mixed. There is still little provision for the vast majority of prisoners who have common mental health problems such as depression and other problems normally supported by primary care outside prison.

Many local diversion schemes have taken the initiative and pioneered promising approaches to identifying and supporting offenders with mental health difficulties. Some prisons, police forces, courts and probation services have also begun work to develop better responses to the needs of offenders with mental health problems.

But opportunities to divert offenders with mental health problems to more appropriate care in the community are still being missed too often. Few released prisoners get adequate help with health, housing and employment. Secure mental health services continue to be subject to long delays, both to admission and discharge.

There is an urgent need to improve mental health care for all offenders. People with mental health problems need to have access to mental health treatment and support at all stages of the criminal justice system. This can be achieved by better services in the community to stop people being imprisoned; investment in improved prison mental health care; and more effective support with rehabilitation and resettlement ‘through the gates’. The Government has set itself an ambitious agenda to make many of these improvements. If diversion is implemented nationally, with good quality community support, it will go a long way to improve the health of a very disadvantaged group of people, to make communities safer and to save significant sums of public money.

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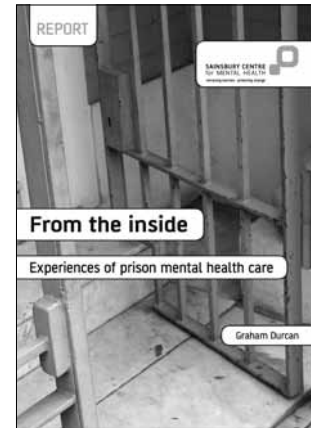
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From the Inside Experiences of prison mental health care

From the Inside is based on interviews with 98 prisoners in five West Midlands prisons. The report finds that mental ill health is not the exception but the rule. The report finds out what prisoners themselves say they need to improve their mental health.

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Diversion A better way for criminal justice and mental health

Diversion finds that many opportunities for diversion are being missed and too little is being done to ensure that offenders with mental health problems make continuing use of community mental health services. The report looks at the evidence on outcomes and the effectiveness of diversion, and includes information from site visits and looks at whether diversion is good value for money.

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Beyond the Gate

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