# House of Commons Justice Committee inquiry into the effectiveness of spending on the criminal justice system in the UK

## Evidence from the Sainsbury Centre for Mental Health

### Executive summary


- The effectiveness of prison should be judged not only in terms of reoffending but through outcomes such as improved health, housing and employment.

- Prison mental health care needs to be improved, especially for those with complex problems, depression and anxiety.

- Rehabilitation needs to focus on what offenders want for their lives, not merely on their offending behaviour.

- The arrival of IPP and increasing numbers of hospital transfers are increasing the time prisoners spend in custody: this is both costly and delays their resettlement.

- Diversion from custody, within or outside the criminal justice system, can be cost-effective. Community-based alternatives that command the confidence of sentencers need to be developed.

- Women, children and young people are especially damaged by the use of custody. Investment in improved support in the community is vital for these groups.

- Anti-social behaviour orders are being used too commonly with people with mental health problems and are at risk of escalating their progress into the criminal justice system.

- Early years work with young children at risk of conduct disorder and emotional or behavioural problems is highly cost-effective in reducing offending later in life.


### 1. Introduction

1.1 The Sainsbury Centre for Mental Health works to improve the quality of life for people with mental health problems by influencing policy and practice. We focus on criminal justice and employment. The evidence we have provided focuses on the experience of people with mental health problems in the criminal justice system and how that system could provide better value through more effective approaches to mental ill health and offending.

1.2 The effectiveness of criminal justice services are usually defined in terms of offending and reoffending. While this is an important measure of success or failure, it should not be the sole determinant of achievement. Effectiveness should also be judged through other outcomes: in finding employment, in having a stable home and in

maintaining good health. This is crucial to understanding what value services add to people's live and to the communities they live in.

## 2. Mental health care in prison

2.1 Levels of mental ill health in prison are very high. It is vital that prisoners are offered support for mental health problems. Gaps in provision cause unnecessary distress but also exacerbate the exclusion individuals face and reduce their prospects of recovery before and after release.

2.2 Most English prisons now have mental health inreach teams. These work with people with severe and enduring mental health problems. Many have begun to improve the quality of care prisoners receive but they face major barriers:

- Staffing levels are less than one-third of those found in community mental health teams compared with the level of need in prison (Sainsbury Centre, 2007b).
- Hurried receptions make screening for mental distress difficult.
- Frequent movement of prisoners between establishments damages continuity of care
- A lack of follow-up by community teams of released prisoners.

2.3 While inreach teams are beginning to make a difference to those with more severe conditions, the larger number of prisoners with depression, anxiety and other common mental health problems receive little or no health care (Sainsbury Centre, 2007b). There are also major gaps in provision for prisoners with personality disorders and those with complex problems, eg a 'dual diagnosis' of substance use and mental health problems.

2.4 Psychological therapies may help offenders with a range of mental health problems, particularly depression and anxiety. The Improving Access to Psychological Therapies (IAPT) programme aims to provide better access to talking therapies for people who require support from mental health services. There has as yet been little discussion as to how IAPT could be made available to offenders with mental health problems, particularly those in prison.

## 3. Rehabilitation

3.1 The Sainsbury Centre has carried out a review of Offending Behaviour Programmes (OBPs) in the UK. These are delivered by psychologists and aim to change the way offenders think in order to change their offending behaviour. We found a mixed picture of effectiveness (Sainsbury Centre, forthcoming).

3.2 The major limitation of offender rehabilitation is its focus on reducing maladaptive behaviours, eliminating distorted beliefs, removing problematic desires and modifying emotions and attitudes that promote offending behaviour. These are predominantly negative goals; they ignore many other factors in the process of rehabilitation such as a person's need for somewhere to live, a job, family relationships that are pivotal in helping offenders to pursue more socially acceptable goals and to seek alternative ways of living that are meaningful and valuable.

3.3 Employment is widely considered to play an important role in the rehabilitation of offenders. An overview of 400 research studies concluded that employment-related prison programmes were the single most effective intervention for juveniles (Lipsey, 1995). However, even the best employment schemes in prison may not help prisoners to find and maintain employment unless they are supported by good aftercare services (Gillis, 2000).

3.4 Accommodation is also crucial: a resettlement survey in 2001 found that 31% of prisoners with an address on release got into paid work, compared to 9% of those who did not have housing on release (Niven and Olagundoye, 2002).

3.5 Education programmes to address low literacy and lack of other basic skills are also thought to improve offenders' employability and reduce re-offending. Porporino and Robinson (1992) found lower re-imprisonment rates for offenders who had completed an adult basic education programme while in prison.

## 4. The role of secure hospitals

4.1 The population of secure hospitals in England is rising. While numbers in high secure hospitals such as Broadmoor are falling, medium secure units are growing. In July 2007, a record 3,723 people were being detained in 'forensic' mental health services (Rutherford and Duggan 2007).

4.2 An increasing proportion of people admitted to forensic hospitals are transferred from prison. In 2006, 961 people were transferred to hospital directly from prison while 293 were admitted after being given hospital orders (Rutherford and Duggan 2007).

4.3 Transfer times from prison to hospital remain problematic. An average of 42 prisoners every quarter have to wait for more than three months for transfer. While waiting times have fallen in many parts of the country (to a government guideline of 14 days), average waiting times in London remain far higher (Rutherford and Duggan 2007).

4.4 Nine in ten people transferred to medium-secure services stay longer in detention than they would have done under the terms of their original custodial sentence. This is because there are inadequate step-down options available, and because forensic mental health services are becoming increasingly risk-averse and reluctant to discharge patients.

4.5 The cost of medium secure services is £165,000 a year, compared with £40,000 for a year in prison, but reoffending rates are (for a variety of reasons) far lower. Decisions about the relative merits of prisons and secure hospitals therefore need to take into account the needs and prospects of the individual. Alternative forms of provision could also be examined.

## 5. Imprisonment for Public Protection (IPP)

5.1 IPP is a sentence for offenders who are deemed to be 'dangerous'. They are placed on sentences with a minimum term, but of potentially indeterminate length. Release

is determined by the Parole Board, who assess risk reduction following course completion and risk management planning.

5.2 Currently there are more than 4,000 IPP prisoners in England and Wales. Only about 15 IPP prisoners have been released to date, in part due to the shortage of treatment and behaviour programmes available.

5.3 Mental illness is thought to be more common among people on IPP than any other sentence type in prison. This is thought to be in part because IPP is at times used instead of mental health options such as hospital orders. There are also concerns that the indeterminate nature of IPP, and the uncertainly felt by prisoners about their sentence, has a negative impact on their emotional health.

5.4 The number of IPP sentences has increased while the number of hospital orders has fallen. It is possible that the courts are identifying 'dangerousness' (a prerequisite of IPP) rather than obtaining a diagnosis for a mental illness or personality disorder. As a consequence, many IPP prisoners may require transfer to medium secure hospitals, putting pressure on existing places.

## 6. Diversion

6.1 A major gap in provision for people with mental health problems in the criminal justice system is of criminal justice liaison and diversion (CJLD). This aims to identify people in police stations and courts and to divert them within or away from the criminal justice system to appropriate health and social care. The absence of effective CJLD (NACRO, 2005) leads many people with severe mental health problems to be imprisoned.

6.2 One of the key barriers to building better systems of diversion is the fear that sanctioning alternatives to imprisonment will put public safety in jeopardy. Research however suggests that there is no added public safety risk from diversion (Sainsbury Centre, 2008).

6.3 Research is beginning to show that diversion is also cost-effective. In their first year schemes should expect to spend more money than they save, but savings begin in years two and three, where navigating people away from the revolving criminal justice system door pays dividends.

6.4 Diversion will only work if a range of different agencies work well together. This can be achieved partly through creating protocols and service level agreements, but it is also essential to ensure service users are equipped to take advantage of the treatment and service packages that multi-agency working allows.

6.5 'Diversion to what?' is the stumbling block of CJLD across the world. Access to alternatives, rather than legislation or political momentum, is the single most important factor dictating the success or failure of diversion. Investment is needed to create viable alternatives and prevent the criminal justice system becoming the resting place for those who have been forgotten elsewhere.

## 7. Community orders

7.1 Recent studies have indicated that about one half of community-sentenced offenders have an emotional or wellbeing problem that is directly related to their offending behaviour (Seymour and Rutherford, 2008).

7.2 The Community Order is composed of a choice of twelve different requirements. One of these is a Mental Health Treatment Requirement (MHTR), available for offenders who have an identified mental health problem that is not serious enough to require the use of the Mental Health Act, where treatment is readily available, and where the offender has given their consent.

7.3 While the MHTR could be a useful alternative to custody for some offenders, less than 1% of Community Orders include a MHTR. There has been a lack of awareness of, and confidence in, the MHTR among sentencers. There is also a lack of availability of treatment, and courts have found it difficult to obtain timely psychiatric reports (Seymour and Rutherford, 2008).

## 8. Women

8.1 Last year's Corston Report (Home Office, 2007) made a cogent case for radical changes to the women's prison estate. It recommended greater use of community sentences for women; reduced use of custody for remand; and the creation of smaller, urban units for women to replace the current stock of 17 women's prisons.

8.2 The vast majority of the 4,400 women prisoners in England have a range of mental health problems. The Corston Report's recommendations are supported by evidence gathered by Sainsbury Centre (Rutherford, 2008) and others from women prisoners with mental health problems:

- A short spell in prison can be sufficient for a woman to lose her children and her home, especially if she is imprisoned far from home.
- Screening remand prisoners for mental health problems is unreliable.
- Many women prisoners have drug and alcohol problems that cannot be properly addressed during their imprisonment.

8.3 Instead of a short custodial sentence, for many women a community order would be more beneficial, both to the public and to them. Community sentences allow for a creative package of requirements, including unpaid work in the community, electronic curfews, drugs, alcohol and mental health treatment and supervision by probation.

## 9. Young people

9.1 For most young people, incarceration neither offers the best chance of reducing reconviction nor of addressing mental health needs. Keeping young people with mental health difficulties in custody is also expensive (costs range from £50,800 to £164,750 per year per child) yet nearly 70% of young people are reconvicted on release.

9.2 The wish to avoid premature labelling, coupled with the greater number of adolescents likely to have emerging or unclear mental health difficulties, have made it easier for early signs to be construed simply as bad behaviour requiring punishment. From schools to police stations, there remains extremely limited systematic and proactive activity to identify and divert young people with mental health difficulties into more appropriate packages of care (Khan, 2008).

9.3 Local systems should be developed to identify young people with mental health vulnerabilities effectively at the police custody stage, and to take necessary action to divert them away from the youth justice system or to feed information into the court process with the aim of diverting them into more appropriate packages of care.

9.4 In Northamptonshire and Hereford, Youth Offending Team (Yot) health practitioners work closely with community psychiatric teams to identify young people with mental health difficulties in police custody. The Yot practitioner assesses the young person, liaises with the court to offer advice where necessary and negotiates with local mental health providers to facilitate a residential placement or the provision of a package of mental health care (Khan, 2008).

## 10. Anti-social behaviour orders (ASBOs)

10.1 Despite government guidance that mental health problems should be taken into consideration before an ASBO is issued, one-third of ASBO recipients have mental health problems and/or learning disabilities (BIBIC, 2007). Many do not get support to help them keep to the conditions of their ASBO. This puts them at risk, ultimately, of imprisonment if they breach their order.

10.2 We are concerned that the use of ASBOs among people with mental health problems risks speeding up their journey into the criminal justice system.

10.3 We believe that anyone being considered for an ASBO should be screened for mental health problems and for learning disabilities. Where possible those people should be given appropriate alternatives, such as referral to community mental health services (CAMHS for under-18s), specialist voluntary sector agencies or Acceptable Behaviour Contracts (Sainsbury Centre, 2007a). Mental health problems, substance use and learning disabilities should also be taken into account when a person breaches an ASBO.

## 11. Early years work

11.1 Longitudinal studies in the UK and abroad indicate a high degree of persistence between adverse mental states in childhood and those in adult life (Kim-Cohen et al 2003). The most common mental health problem in childhood is conduct disorder, affecting nearly 6% of all children between the ages of 5 and 16 in Great Britain (Green et al 2005). Conduct disorder persists into adulthood in about 40% of cases. It is also strongly predictive of a range of poor outcomes in adult life, including criminal behaviour (Stewart-Brown 2004).

11.2 The social and economic costs of conduct disorder are high. By age 28, the costs incurred by the public sector for individuals with conduct disorder are about 10 times

higher than for those with no problems (Scott et al 2001). Nearly two thirds of this cost is borne by the criminal justice system. The lifetime costs of childhood conduct disorder (relative to individuals with no conduct problems) may be in the order of £250,000 per person, taking into account crime-related costs, reduced earnings and poorer health (Friedli and Parsonage 2007).

11.3 Pre-school parenting programmes are the main form of intervention aimed at addressing conduct disorder and related emotional and behavioural problems in early childhood. A recent review (Dretzke et al 2005) found that the costs of intervention are relatively low, at around £6,000 per child for a home-based individual programme and £1,350 per child for a community-based group programme. Given the estimated lifetime costs of conduct disorder, the effectiveness of a programme in preventing or reducing the severity of childhood problems does not need to be particularly high in order to make it worthwhile economically.

11.4 The effectiveness of pre-school programmes justifies investment on a significant scale. One US study found that by age 27 the number of arrests among those who had participated in a childhood programme were 50% lower than among a matched control group. A study in Chicago found that every $1 invested in the programme yielded cumulative benefits to society of $17 by the time the participants reached 40 (Schweinhart et al, 2005).

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