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Effective mental healthcare for offenders: the need for a fresh approach

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Introduction

This paper sets out Nacro's position on offenders with mental health needs. It explores some of the current problems with the provision of mental health services for offenders at different stages of the criminal justice process and makes practical and clearly targeted recommendations for change.

The Chief Inspector of Prisons, Anne Owers, in her most recent annual report declared 'there are considerable pressures on primary care trusts, and it will be important to ensure that prison healthcare does not once again slip out of sight and down the list of priorities. Mental healthcare, within and outside prisons, remains a major challenge.'[1] Over the last five years, there have been some efforts to improve mental healthcare for offenders. These include the development of mental health in-reach teams, the transfer of responsibility for prison healthcare to the NHS and the issuing of guidance to improve mental health provision along the offender pathway. In addition there are pilot initiatives underway at government level to tackle chronic social exclusion, which can compound the often multiple needs of offenders with mental health problems. There has also been some discussion at government level about the introduction of new approaches to deal with offenders with mental health needs such as mental health courts and hybrid prisons.[2]

While there is undoubtedly more to be done to improve prison mental healthcare – particularly where primary care, mental health awareness training and the recording and sharing of health information are concerned – Nacro believes that the focus of efforts to improve healthcare for offenders with mental health needs should be on the criminal justice process before sentencing. This shift in focus would ensure resources from primary care trusts[3] (PCTs) are not siphoned off to prison healthcare when they could be more advantageously directed towards treating offenders earlier on in the criminal justice system.

Nacro's view is that better systems must be put in place to ensure that offenders with mental health problems are properly identified and assessed as early on as possible. There should also be more consistent provision and effective treatment available at each stage so that this group receives appropriate care and support throughout the criminal justice process from co-ordinated mental health services which are responsive to offenders' needs. A more co-ordinated approach to mental healthcare from agencies, providers and commissioners of services would also result in huge savings across the system: the financial burden of inaction provides a compelling argument for change.

For those who are sentenced, prompt diagnosis and appropriate treatment will not only assist individual recovery but also ensure a more equal outcome for those with mental health problems who enter the criminal justice system. The longer term benefits of effective mental healthcare for both the offender and the system are well documented: the use of custodial sentences is minimised; reoffending levels are reduced;[4] and pressure is eased on health spending in prisons and expensive transfers from prison to hospital.

Background

Mental health needs in the offender population

Those who offend have much greater mental health needs than the general population and at any given time, 5,000 people with a serious mental illness will be in prison.[5] Data from the first full survey of the mental health of prisoners showed higher rates of personality disorder than among the general population: 78% for male remand prisoners, 64% for male sentenced prisoners and 50% for female prisoners[6] compared with approximately 10-13% in the general population.[7] Seven to ten per cent of male prisoners also displayed functional psychosis such as schizophrenia or manic depression[8] (compared with 0.5-0.6% in the general population).[9]

According to an evaluation of the second OASys[10] pilot, 45% of all offenders were identified as having a need in the 'emotional well-being' section of the assessment.[11] Women in particular were more likely to report problems with emotional well-being such as feeling stressed, depressed, anxious or lonely. A third of offenders participating in a self-assessment said they felt depressed and one in ten said this had contributed to their offending behaviour.[12] An analysis carried out by NOMS of OASys data found that 7% of all offenders were at risk of suicide, 7.3% were at risk of self-harm and these risks were higher among offenders convicted of criminal damage and women committing arson and robberies.[13]

Young offenders

Research shows that young offenders have approximately three times higher rates of mental health problems than the general population.[14] An extremely high rate of young offenders in the prison population have personality disorder: 84% of those on remand and 88% of those sentenced[15] with levels of psychosis ranging from 10% (among young sentenced males) to 6% (among young females on remand). Findings from a study on two years of ASSET[16] data show nearly 10% of young people had deliberately self-harmed in the past and 5% had previously attempted suicide.[17] However, in a study carried out on behalf of the Youth Justice Board young offenders expressed doubts about ASSET's ability to pick up mental health concerns.[18] The same study also showed that a fifth of young offenders had problems with depression.

Female offenders

The mental health needs of female offenders are an increasingly pressing concern given that the number of women in prison has trebled over the last decade (while levels of crime committed by women in the same period have not increased). An Office for National Statistics (ONS) survey found psychosis rates among women prisoners of 14%[19] compared with 0.5% in the general population.[20] More than double the proportion of female prisoners (both remand and sentenced) had received help for a mental health issue before being sent to prison compared to men, and they were also more likely to have previously been admitted to a psychiatric hospital at some time in their lives. Interviews carried out with 73 young women in prison by the Youth Justice Board[21] showed that 71% had some level of psychiatric disturbance and they were twice as likely to self-harm as adult female prisoners. It is worth noting though that in a study of 428 women from two remand prisons where 59% showed rates of current mental disorder (rising to 76% when drug or alcohol dependency was included) the prison screening process had only recognised current mental disorders in 19% of the women.[22]

Black and minority ethnic offenders

In general, the incidence of mental health problems is thought to be higher in black and minority ethnic groups than their white counterparts.[23] This is due in part to the fact that police referral rates of individuals from black African and black Caribbean groups to mental health services are almost double the average of referrals from other groups, with courts also making double the average number of referrals for black Caribbeans to mental health services.[24] While people from black and minority ethnic groups are less likely to have their mental health issues detected by a GP, the National Census found there were particularly high rates of detention for black people under section 37/41 of the *Mental Health Act 1983* where a person is sent to hospital from court with a restriction on their discharge in order to protect the public from serious harm.

Mentally disordered offenders

Who are we talking about?

Offenders with mental health needs have usually been referred to by the term 'mentally disordered offender'. However, there is no universally agreed definition of this term and any local definitions

may result in services covering particular groups and excluding others. It is also unclear whether the term 'mentally disordered offender' requires there to be a direct link between the offending behaviour and mental disorder. Legally, the term applies to the small group of offenders subject to Part 3 of the *Mental Health Act 1983*[25] (3,395 in 2005[26] compared with a prison population of over 74,000 at the time) but there are many interpretations of the term in use which are applied to people whose mental health problem does not fit the criteria for admission under the *Mental Health Act 1983*.

This paper – and the proposals outlined in it – will use the term 'offenders with mental health needs'. The term 'mental health need' includes those offenders without a formal mental health diagnosis and covers a wide range of conditions, from those that do not meet the criteria for admission under the *Mental Health Act 1983* to a disorder serious enough to warrant detention under the act. 'Offender' is taken to cover all offenders who commit either minor or serious offences and regardless of whether their offending is related to their mental health need. The inclusion of offenders covered by this last category is important because while, on the one hand, a person with psychosis may commit arson because they are experiencing hallucinations, other offenders may have mental health issues which don't relate to their offending behaviour, but nonetheless may need to be taken into account in decisions about prosecution and sentencing.[27]

Complex needs and the cost of exclusion

This group of service users will often have complex needs and are likely to be affected by a number of the following problems:

- substance use where this is a direct result of the person's mental health problem or gives rise to it
- physical health problems
- homelessness or accommodation difficulties where this is a direct result of the person's mental health problem or gives rise to it
- debts, financial exclusion and poverty
- lack of basic skills, low educational attainment and unemployment
- relationship needs

These difficulties are often compounded by a lack of co-ordination among services. A pilot study found that people with severe mental health problems can end up seeing as many as 23 different professionals from up to seven different agencies between the point of arrest and their return to the community.[28] An ONS survey reported 22% of male remand prisoners and 23% of male remand young offenders had four or five co-existing disorders (eg, personality disorder, psychotic disorder, neuroses, hazardous drinking and drug dependency)[29] and the Revolving Doors Agency was obliged to work across six to ten different sectors for half of its clients within the first three months.[30] There is sometimes uncertainty among agencies about who should take responsibility for dealing with the majority of offenders who do not meet the criteria for treatment under the *Mental Health Act 1983*: in 57% of cases seen by the Revolving Doors Agency between October 2000 and January 2003 the community mental health team was not contacted because the client did not have a sufficiently severe form of mental illness to meet the criteria for treatment by the team.[31] In addition, it can often be arbitrary whether offenders with a diagnosis of personality disorder or learning disability end up in prison or receive treatment in a healthcare setting, either because of the paucity of services available, or because their mental disorder has not been recognised or is not considered relevant to tackling the offending behaviour.

There is now increasing recognition that chronic exclusion can result for an individual with multiple needs which compound each other, even though individual services might not see one of these needs alone as a cause for urgent action. The Cabinet Office has recently announced £6 million worth of funding for 12 pilot projects targeted at adults facing chronic exclusion. The criminal justice system needs to take a similarly joined-up response that recognises the complexity of problems faced by those coming into contact with it and the risk of 'boundary exclusion'[32] from statutory services for this group.

The costs of failing to implement a more co-ordinated approach towards mental healthcare for offenders are substantial. They include doctors' fees, the costs of administration, the cost of prison places (approximately £30,000 a year per prisoner), of transfers and hospital beds (£3,000 per week for a medium secure bed) and the cost of visits to accident and emergency for people who are reluctant or unable to use GP services. The financial impact on agencies of not co-ordinating services in the community should constitute a major impetus for change.

Recommendations for a fresh approach

An integrated and responsive approach

Nacro has long believed that an integrated approach is the best way to resolve some of the issues concerning offenders with mental health needs. Where possible, joint initiatives between criminal justice and health and social services should be encouraged – including joint commissioning of services – with the intention of creating better outcomes for offenders.

HOPs needs to engage key stakeholders, propose measurable targets and clearly allocate responsibility

The impetus and efficacy of government policy[33] on offenders with mental health needs appeared to have been lost until the welcome development of the Health and Offender Partnerships Directorate (HOPs) in 2004.[34] In 2008, HOPs will launch an offender health and social care strategy aimed at improving health outcomes for offenders. The challenge for HOPs lies in the successful implementation of this strategy which will rest on its ability to set out the benefits of the approach, recommend measurable local targets and ensure robust local arrangements are in place with clearly defined areas of responsibility.

To ensure its success, HOPs will also need to secure the representation and co-operation of all relevant departments: what has been missing to date is representation from the police and the courts. HOPs must also liaise closely with those outside the current partnership: the Office for Criminal Justice Reform, the Welsh Assembly Government, the Mental Health Tsar, the Learning Disability Tsar, the National Social Inclusion Programme and other Department of Health policy leads (including those for mental health).

Criminal justice and health agencies need to jointly commission services and devote more resources to analyses of offenders' needs

PCTs, regional offender managers, local authorities and the voluntary sector all need to work together more closely in order to jointly review and commission services for offenders with mental health needs. At a regional level, government offices need to focus more of their efforts on monitoring services and arrangements for offenders with mental health needs. Health leads in regional government offices and strategic health authorities should highlight the problems posed by offenders with mental health needs through care services improvement partnerships (CSIPs) and reducing reoffending action plans. Local criminal justice boards also need to link in with this activity making sure they are aware of all the services on offer for this group, taking some responsibility for monitoring their efficacy and identifying any gaps in provision. They should also seek to influence commissioning by PCTs, local authority social services departments and regional offender managers. However, the planned move towards regional based commissioning under NOMS should not be achieved at the expense of local services being tailored to the needs of the local community.

At a local level, social services have a duty to assess local residents' need for care. In addition, PCTs must ensure they comply with their statutory duty to identify the health needs of local people and plan services to improve the health of the local population. NOMS and PCTs in particular must plan and co-commission services to ensure appropriate interventions for offenders with mental health needs, regardless of whether those needs are linked to their offending behaviour. While there are similarities between the Care Programme Approach (CPA) and offender management, they are not synonymous vehicles. The CPA exists to manage mental health issues whereas offender management through community orders is focused on reducing reoffending and may contain sanctions that the CPA can't impose. For offenders with mental health needs, mental health services and probation need to work together in a complementary way to improve health and minimise offending behaviour.

The responsible authorities[35] which make up crime and disorder reduction partnerships[36] (CDRPs) need to proactively consider the needs of offenders with mental health issues as part of their three year audit. To this end, useful information could be provided by mental health trusts, public health departments, social services and criminal justice agencies in the following areas: offender needs data from OASys; areas with high usage of s136 of the *Mental Health Act 1983*; the number of times a forensic physician or nurse has been called to a police station; and the

number of times a mental health assessment was requested at court. Useful information could also be collected from health observatories[37] and CSIP health and social care in criminal justice leads.[38]

PCTs should be established as the lead agency for offender mental healthcare across the criminal justice system

PCTs are the most obvious body to commission services for offenders with mental health needs, but it is often criminal justice agencies who take responsibility for this group. PCTs have responsibility for any prisons within their catchment area, but when a prisoner is released back to their usual place of residence – which can be outside the prison's PCT – the local authority and PCT can be reluctant to provide funds for care and treatment. This can damage relationships between the prison mental health in-reach team and local services; offenders should not be denied services because of their involvement with the criminal justice system. The Healthcare Commission recently found that too many PCTs are also failing young offenders by providing insufficient funds and/or staff to youth offending teams (YOTs).[39] PCTs must ensure that they fulfil their statutory duty to provide at least one health worker to their local YOT and involve themselves with the YOT's activities at management board level.

Services should include interventions at police stations, courts, hostels and probation centres (clinics could also be held in probation offices staffed by healthcare professionals from criminal justice mental health liaison schemes[40] particularly those with experience in mental health and substance misuse). PCTs can also provide healthcare services to 'approved premises'[41] through locally agreed enhanced care arrangements. Dedicated GP slots can then be allocated to hostel residents alongside access to psychiatric nurses as required. Early intervention may reduce the need for prison healthcare, costly transfers from prison to hospital and specialist tertiary services, all of which PCTs currently fund, and is also likely to reduce social exclusion, reoffending and allow for a more holistic approach to treatment.

CDRPs and PCTs must share responsibilities with other health, social care and criminal justice agencies through local area agreements

CDRPs and PCTs should ensure they reflect each other's priorities and staff working at a strategic level within PCTs should be represented within CDRPs to facilitate this. Local area agreements should be employed wherever possible to make the mental health of offenders an agreed priority between a local area and central government and to forge a shared responsibility between health, criminal justice and social care agencies. Multi-Agency Public Protection Arrangements (MAPPA)[42] provide an excellent model of interagency working which could be replicated at local levels with CDRPs.

The challenge is to join up the various bodies and allocate responsibility among them for offenders with mental health needs. Services need to be located within strategic planning and commissioning systems (eg, through CDRPs and mental health local implementation teams[43]) rather than being seen as an add-on service. Furthermore, any arrangements should be integrated with generic services to ensure services for offenders with mental health needs are not seen as 'specialist' or another agency's problem.

Services need to be more inclusive of people with different disorders and offer a wider range of treatments

A review of community mental health services is urgently needed with a view to making services more inclusive and expanding the range of treatments they are able to provide to offenders with mental health issues and personality disorder.[44] Talking therapies such as cognitive behavioural therapy[45] and more assertive outreach work in particular are needed. In addition, mental health trusts should consider establishing a community personality disorder team to treat offenders with personality disorder, in order to minimise the likelihood of unnecessary (hugely costly) transfers to the Dangerous and Severe Personality Disorder Programme at the end of a prison sentence for those whose level of offending does not warrant a move to such high security.

More work is also needed on models to provide services for people with a dual diagnosis.[46] People with a dual diagnosis are more likely to come into contact with the criminal justice system, more likely to have complex needs and are less likely to manage their medication properly. Despite good practice guidance from the Department of Health which says that mental health services should take the lead in this area,[47] often they will

not provide assistance on the premise that the offender's primary problem is a substance misuse problem. Substance misuse and mental health services need to work together better and focus more attention on providing joint funding to create an integrated service.

More criminal justice mental health liaison schemes with multi-disciplinary teams

Offenders with mental health issues often present a complex set of needs which cannot be resolved via one agency. While individual professionals and agencies might be tempted to ration access to scarce resources and services, having a service which encompasses all parts of health, social services and criminal justice agencies helps foster a greater sense of collaborative working. The Department of Health document, *New Ways of Working*,[48] pushes for a cultural change in the way mental health practitioners work, seeking to decrease their reliance on psychiatrists and promote the creation of capable multi-disciplinary teams which support service users towards recovery and self-management.

It has long been Nacro's view that all courts (including youth and crown courts), police stations, prisons and probation offices should have access to a criminal justice mental health liaison scheme (or similar) to provide information to the court or more easily access psychiatric assessment for offenders suspected of having a mental disorder. Such schemes also improve the flow of information between the health and criminal justice systems. These schemes should be integrated into mainstream services rather than existing as 'add on' arrangements with few links to strategic planning. The most effective model is where the service on arrest and at court is provided by the same service provider and where the service works closely with the prison mental health in-reach team and probation.[49]

Nacro's experience is that a wide range of services can be accessed more easily where a criminal justice mental health liaison scheme is comprised of staff from a variety of agencies. At present, however, many schemes consist of one worker or a part-time worker, most often a community psychiatric nurse, so for the majority of offenders with housing, substance misuse and low level mental health needs, the schemes may not always be able to assist.[50] It is important that criminal justice mental health liaison schemes are better evaluated to ensure they meet wider needs and are therefore as effective as possible.

In areas where there are no court diversion or criminal justice liaison schemes, an assessment should be made by the PCT in conjunction with social care and criminal justice agencies as to whether there is a need for such a service. If there are no resources to fund such a scheme, a protocol should be drawn up between police, courts, health, social care and probation which will set out how agencies will work together to provide the necessary services and organise psychiatric reports. For example, the crisis resolution service could provide an 'on request' mental health assessment service to the police station.

Listening to service users and carers

Service users should be represented on strategic groups which audit and develop services for offenders with mental health issues

While many commissioners and mental health service providers have become better at engaging and listening to service users, very few agencies delivering or planning services for offenders with mental health needs have service user representation or have proactively considered service user issues. The views of service users and carers are central to understanding needs, identifying barriers to services, improving users' experiences and promoting trust and engagement with services. Given that many offenders do not trust their GPs enough to ask them for help, and offenders with complex problems may not view primary healthcare as the solution to their needs,[51] it is crucial that service users and carers are involved in strategic groups at all stages of the process from policy development to decisions about care plans and risk assessment and management.

Services must develop a fuller understanding of the issues faced by those with mental health problems who come into contact with the criminal justice system

Offenders with mental health issues and other complex needs may be unable, or unwilling, to express their views or be reluctant to engage with services they may have had bad experiences with in the past. Some may not want to draw attention to the fact that they have mental health problems and have been involved in the criminal justice system or they may be concerned about confidentiality. Others may feel that those in charge may not take them or their opinions

seriously because of their background, or think that their opinions may in some way jeopardise the service they receive. In addition, because offenders are referred from the criminal justice system, some professionals may see them as chaotic, confrontational, disruptive or more likely to bring criminal behaviour (such as violence or drug taking) into mental health settings.[52] Where this is the case, professionals will require support and training to engage with users in a positive way.

Furthermore, a variety of approaches could be used to promote better dialogue between offenders, services and policy makers, for example through surveys, focus group discussions, interviews, employing service users or involving them in service design and recruitment. Users' views should also be used to help evaluate services and targets, ensure actual needs are being met, build positive attitudes between professionals and service users, and dispense with practice that does not meet need. However, any such initiative must be based on clear objectives so both service users and professionals understand the purposes and limits of the consultation to ensure there are real outcomes as a result.

Increasing access to advocates trained in criminal justice issues is another effective way of supporting users, ensuring that their needs are understood and that they get access to the services to which they are entitled. The introduction of independent mental health advocates by the *Mental Health Act 2007* may result in improved access to advocates, who can provide information and assist all those detained under the act to understand and exercise their rights.

When developing local services, it is also important to involve the community in order to increase awareness and understanding of offenders with mental health needs and reduce objections to the creation of local services for this group. This could be achieved by involving leaders from community groups (such as safer neighbourhood panels) in initial discussions when planning new services, involving members of the community at MAPPA meetings or ensuring a wide representation of the community and service users at Local Involvement Networks (LINks).[53]

The importance of carers must be recognised and their views taken into account when making decisions in the criminal justice process

Family and friends rather than agencies often end up providing the vast majority of support to people with mental health needs in the community and in prison, yet carer involvement is much less developed than service user involvement. Barriers to involving carers often include concerns about breaching patient confidentiality, and perceptions that the family are over-protective or in some way part of the cause of the offender's mental health problem. However, maintaining family and social networks is crucial to the future of prisoners on release and will also affect the demands they make on statutory services. Assistance could be provided (by family support services or in partnership with the voluntary sector) to help family members visit prisoners or involve the family in finding solutions to offending behaviour. Ensuring services involve family and friends may also help minimise the negative impact on the family of their relative being involved in the criminal justice system. Professionals should also take seriously concerns expressed by family members about offenders with mental health issues as well as keep them properly informed about the offender's well-being and what steps have been taken to improve the situation. Healthcare teams in prison, defence solicitors and courts should also be more willing to act on information given to them by families about previous mental health issues, treatment that the prisoner may have been receiving prior to being held in custody, and contact they have had with mental health services in the community.

Practice on sharing information between professionals and carers varies and policies between healthcare agencies can be inconsistent. Professionals are often unclear about what information they can share, and carers are usually unaware of their rights to information. To resolve this problem, an offender could be asked to fill out a form with next of kin details and to state who (if anyone) he/she is comfortable for the professional to share their information with (the decision on whether to give or withhold consent should be updated regularly).[54]

Enabling the police to respond effectively

All police areas should have a senior mental health lead officer and all police and detention officers should receive regular mental health awareness training

Police officers and police community support officers are often the first point of contact for

detainees with mental health needs, but may receive little or no standard training in mental health awareness. This is concerning given the important role they have to play in providing early access to support services and passing on information to the Crown Prosecution Service (CPS) in order for decisions to be made about prosecution. While some police areas will either have mental health liaison officers or mental health lead officers, or will have access to criminal justice mental health liaison schemes, there is no statutory requirement for any of these. Consequently, in some areas, it can be difficult for police officers to know who to contact.

As part of their training, police and police community support officers should be instructed on the relevant provisions in mental health legislation and in the *Police and Criminal Evidence Act 1984* concerning mental illness and vulnerable people. They should also receive training on recognising mental illness and learning disabilities to ensure that an appropriate adult is made available or a mental health assessment can be carried out. Beyond training, it is essential that the police also have access to advice from mental health professionals to advise on the most appropriate outcomes.

All police should have 24/7 access to mental health assessments, ideally through criminal justice mental health liaison schemes

Currently each police area purchases healthcare privately, either from an on-call forensic physician or through contractual agreements with paramedics, custody nurses or private contractors who provide nurses. Most forensic physicians are GPs, and not approved doctors under s12 of the *Mental Health Act 1983*.[55] As a result, they cannot detain someone under the act and few have post-graduate training in detecting severe mental health problems.

All police stations should have access to a criminal justice mental health liaison scheme (or similar) to ensure there is assistance available for offenders with mental health needs at each stage of the criminal justice system. Baroness Corston in her recent report recommended that the NHS provide healthcare services to police stations (with 24 hours-a-day capacity in busy areas) ideally through a registered mental health worker.[56] As many people present with both mental health and substance misuse problems, experience of substance misuse issues and of accident and emergency work (as recommended by the Revolving Doors Agency)[57] would also be beneficial. Those with severe and enduring mental health issues could then be referred to mental health teams for assessment and those with less serious needs could be signposted to GPs or other services where they exist. As one assessment of a custody nurse scheme in Kent put it: 'the core business of custody suites is not to become a provider of healthcare'.[58] It is in the best interests of the police force and the detainee if healthcare is provided by the PCT, since this would alleviate concerns about how some pieces of information can be used, for example whether personal clinical notes may be admissible as evidence in court.

A section should be added to the MG form[59] to notify the CPS of any serious health issues relevant to the case

In order to pass on information to the CPS for the purposes of case preparation and for decisions on whether or not to prosecute, the police complete MG forms. The CPS guidance to crown prosecutors indicates that information about a person's physical and mental health may be relevant to the decision-making process on whether it is in the public interest to prosecute and that prosecutors should be proactive in obtaining it.[60] However, there is nowhere specific on the existing forms to highlight a mental health problem or any other relevant health issue. Instead, the CPS is frequently reliant on defence solicitors to bring this to their attention. A failure to pass on relevant information (such as a report of any mental health assessment carried out in custody) may mean that crucial information is not taken into account, or may result in unnecessary delay and cost because the court orders a psychiatric assessment when one has already been done.

Efforts should be made to simplify and improve the recording of mental health conditions

Guidance produced by the National Centre for Policing Excellence (NCPE)[61] makes it clear that the custody record is the essential vehicle for recording information (including health information) from various sources as part of the risk assessment process. While it is recommended that information be sought from healthcare professionals (among others), in practice this is not routinely carried out.

A single document is needed to act as a health record which could then follow the offender from the police station to court, and to prison where relevant. This record should include information on whether a person has received treatment from a psychiatrist, if they have taken an antidepressant or an anti-psychotic drug, and could also act as a suicide or self-harm warning form. Responsibility for reviewing this information and sharing it with the appropriate people at each stage of the process should be carried out by a worker from a criminal justice mental health liaison scheme or, where one does not exist, a healthcare professional.

Due to the current format, any OASys assessment completed as part of the pre-sentence report process may not even pick up an offender's mental health issue. A box should be added on the front page of the offender's electronic file in a prominent position to record if there are mental health needs (including personality disorder). Further details of the particular condition could then be stored in a section further on in the file, accessible only to those with the appropriate authority.

Police stations should not be designated as places of safety for s136 detainees

Given that many deaths in police custody involve vulnerable individuals with mental health issues[62] it is crucial that police have access to the necessary support and advice from local mental health services to reduce this risk as much as possible. Despite guidance in the *Mental Health Act* Code of Practice which states 'as a general rule it is preferable for a person thought to be suffering from mental disorder to be detained in a hospital rather than a police station' many areas still use police stations as the preferred 'place of safety' for people detained under section 136 of the *Mental Health Act 1983*. In 2005-06, 11,500 people were detained in police custody[63] and 5,900 in hospital under s136.[64] The continued use of police stations may be because there is no agreement between the police and mental health services about arrangements or because there is no appropriate hospital nearby where the individual can be taken.

All police areas should have a dedicated 'place of safety' either in the form of a purpose-built suite or a room in a mental health hospital. Ideally, there will also be an accident and emergency department close by to assist in case the person has sustained injuries. Arrangements should be backed up in writing and consist of a policy jointly agreed by the police, the NHS Trust, and the local authority social services department. Policies should include details on s135/136 of the *Mental Health Act 1983*, transporting patients (including ensuring they are safely returned home when they are not to be formally admitted to hospital) and guidance on any decision to prosecute.

Police and the courts need access to solicitors with knowledge of mental health issues and with good links to local services

Criminal justice agencies' access to suitable defence solicitors may alter as a result of recent changes in the law. Legal aid schemes, which have introduced means testing for legal aid and new contracts between law firms and the Legal Services Commission, may lead to firms merging in order to secure contracts, thereby leaving smaller more local firms in a position where they are less likely to be able to provide legal aid. In addition, it will no longer be possible to choose a solicitor; instead one will be allocated from a list and, for less serious offences, advice will be provided by a telephone helpline. As a result of these changes, it may become increasingly difficult for criminal justice agencies to access lawyers who have good links with psychiatrists and social workers.

Lawyers who know what local services are available may often be able to encourage the courts to make use of community based provision. The duty solicitor in a police station should therefore ensure there is a list available of those solicitors who specialise in mental health work and the courts should do the same. In addition, the Law Society has a list of specialists who have been approved to work on mental health review tribunal panels[65] and many of these individuals are able to offer legal advice and assistance in other areas of the law relating to mental disorders.

Appropriate adults should be available for mentally vulnerable detainees

Properly trained appropriate adults or established appropriate adult services are rare for vulnerable adults. Police should encourage discussions at a local level (for example with social services departments, voluntary organisations or law schools) to ensure that professionals and others suitable to act as appropriate adults are available

and properly trained.[66] A duty should also be placed on statutory services to provide an appropriate adult service for a vulnerable adult in custody where no one suitable can be found.

Supporting the courts

All courts should have joint protocols with commissioners and service providers to ensure prompt access to psychiatric advice and psychiatric reports

If courts are to be encouraged to actively consider alternatives to custody for offenders with mental health needs and to explore community options where appropriate, they need prompt access to specialist advice on mental health issues. However, half of the criminal justice mental health liaison schemes surveyed by Nacro had had no sessional input from either a psychiatrist or a psychologist and reported difficulties in obtaining psychiatric reports.[67]

Courts should ensure they have agreements in place with local general and forensic psychiatric services on the maximum time limit for preparing and producing psychiatric reports: for example, a service level agreement could be agreed between courts, commissioners and providers for reports to be obtained within 21 days. In many cases the court can be guided by reports written by community psychiatric nurses or social workers which may expedite the process and reduce the amount of time spent in custody.

Several pilots are emerging which aim to forge a service level agreement between the courts and the NHS for the provision of psychiatric reports and advice. For example, in the south west courts service area region, a service will now be offered to any defendant or offender with mental health issues. The service will provide the courts with the following: information from mental health professionals working from the initial stage at the police station through to the first appearance at court; information from prison mental health in-reach teams if a defendant has been remanded in custody; assessments from mental health workers; and, if necessary, a full psychiatric report. There will also be links with the probation service and defence solicitors to avoid unnecessary delays. At present, a court must purchase psychiatric reports out of court funds which are costed at a rate of £70-100 per hour[68] with a fee of £346-500 for attendance at court. It may therefore be more cost effective for courts to enter into a contract with the NHS than to purchase separate reports. Discussions are underway within the south west courts service area to find out if regulations will allow the court service to pay the NHS for a service in advance and whether the Legal Services Commission could make some financial contribution.

Criminal justice mental health liaison schemes could draw useful lessons from international models of mental health courts

There has been recent discussion about the introduction in the UK of specialist mental health courts[69] which currently operate in North America and Australia. These courts have no formal definition, the models differ with varying admission criteria and appear to target those with severe mental health issues who have committed lesser crimes, usually where there is a causal link between the two. However, as with criminal justice mental health liaison schemes in the UK, there is little outcome data available. Furthermore, mental health courts are equally exposed to the problem of limited access to community mental health services and other support for defendants.[70] Consequently, Nacro believes that rather than introducing a new mental health courts system in the UK, resources should instead be focused on supporting existing criminal justice mental health liaison schemes, while at the same time giving due consideration to how these might be improved by international models. A magistrates' court diversion scheme in South Australia has demonstrated a reduction in reoffending (almost certainly because it gained the commitment of community services)[71] and a number of courts in the US have been identified by the Bureau of Justice Assistance as learning sites which could be studied further.[72]

Criminal justice mental health liaison schemes and court diversion schemes should have agreed protocols on joint working with substance misuse teams

Few criminal justice mental health liaison or diversion schemes have a drug worker on their team. This means duplicate assessments may be carried out by the various arrest referral workers, court based drug workers and workers from the mental health liaison schemes. One solution to this would be integrating the work of existing criminal justice mental health liaison schemes with the Drug Interventions Programme. For

example, a psychiatric nurse could work alongside arrest referral workers in police custody criminal justice intervention teams (CJITs)[73] for people who present with both mental health and substance misuse issues.

This arrangement might also encourage the provision of integrated substance misuse and mental health treatment services and greater use of community orders with mental health requirements. If it is not possible to operate an integrated service, closer working relations should be developed between drug agencies and mental health services offering services at arrest and at court. These arrangements should be cemented with an agreed protocol on joint working.

Minimising unnecessary remands to prison

All courts and prisons should have adequate bail information schemes

Bail information schemes (which provide information to the CPS and defence to help a court decide whether to release a defendant on bail) are provided at some courts by the probation service and in some prisons by the prison service. Many prisons, however, do not provide an adequate bail information scheme (they are not on the list of services that NOMS will provide) and research carried out by the Prison Reform Trust identified inconsistent provision of bail information services to prisoners on remand.

The lack of bail information schemes may mean that offenders with mental health needs are less likely to have their mental health need recognised or receive any kind of extra support to meet bail conditions (eg, housing). As a result, sentencers may end up remanding to prison in order to facilitate a psychiatric report or to ensure the person is in some sort of 'place of safety'. Magistrates may therefore be using custody for those whose mental health condition does not meet the requirements under the *Mental Health Act 1983,* or where hospital admission may be difficult to arrange.

Alternatives to custody should be more fully developed so suspects with mental health needs can be supported on bail in the community

Preparation of a psychiatric report can take several weeks which means prison can be used as a holding facility while information is gathered (which, in turn, may lead to a person's mental health deteriorating further). In the case of offenders who do not warrant hospital admission, the criminal justice system needs to liaise more effectively with mental health services in order to put in place a range of alternatives which would enable suspects with mental health needs to be supported in the community and avoid the need for remand to prison.

Establishing crisis intervention centres that offer assessment services and short term accommodation would be one way to reduce the need for custody. Furthermore, many remand prisoners with mental health issues could be given bail and provided with appropriate bail support and supervision if approved premises[74] for lower level offenders were available. At present offenders may be excluded from approved premises if they have a mental health issue and most accommodation is taken up with high risk offenders. Finally, more supported housing needs to be made available for people with mental health problems to reduce the use of remand to prison in cases where a defendant has no fixed abode.

Making sentencing more responsive

Courts should fully consider community options as part of their sentencing decisions

Wherever possible, efforts should be made to increase the use of community and non-custodial options for offenders with mental health issues, thereby also easing the pressure on the prison population. While the number of community sentences has increased in recent years, criminal justice mental health liaison and diversion schemes reported that courts were less likely to follow their recommendations for treatment in the community than for the person to be sent to hospital,[75] even though a community option could be more appropriate and effective in reducing reoffending.

Community orders[76] need to be made easier to use for offenders with mental health problems

The Centre for Crime and Justice Studies has found that the community order with mental health requirements is under-utilised. Between August 2005 and July 2006 there were only 591 orders made with mental health requirements made compared to 11,361 with drug treatment

requirements.[77] The order can only be made on the recommendation of a registered medical practitioner, treatment needs to be available before it can be made and it is important that psychiatric reports are commissioned from psychiatrists with local connections otherwise it may not be possible to access local mental health services for the offender.

Community orders can be difficult to use for offenders with mental disorders. Those with mental health problems are often unable to access drug rehabilitation requirements because of doubts about whether they could cope with treatment. Many people are also recalled because they do not engage with treatment or miss court appearances, thereby making sentencers reluctant to use community orders for people they don't think will be able to complete them. In addition, compliance with treatment as part of a community order is on a voluntary basis and requires the offender's consent, whereas all other requirements under community orders are compulsory.

Recommendations on how to improve the use of community orders:

- **The probation service should work with local courts and mental health services to ensure effective uptake of community orders with mental health requirements**

  To improve the use of community orders with mental health requirements, regional offender managers should engage with PCTs and NHS trusts in their region to ensure better links with community mental health services, and in order to reach agreement about when orders could be imposed.

- **Offending behaviour programmes and community sentences should be tailored for people with mental health issues**

  Community orders need to be tailored towards the social care needs of offenders and involve local communities in their design. Making orders available more locally would make it more likely that individuals will be able to complete them, would provide tangible benefits for the local community (eg, through unpaid work to clean up local areas) and may decrease negative responses from professionals and local communities towards offenders with mental health needs.

Conclusion

Despite efforts in recent years, offenders with mental health needs continue to experience a wide range of complex problems and barriers in the criminal justice system. The time has come to move the debate on, from discussions about who should take responsibility, towards real action. It is not Nacro's wish to see specialist forensic in-patient units or prison mental health in-reach services expanded, nor does it wish to see hybrid prisons introduced which may divert resources away from general mental health services. The focus instead should be on providing services for offenders as part of mainstream community mental health provision.

Mental health services need to adapt by listening to offenders and should provide for those with multiple and complicated problems by liaising more effectively with colleagues in primary care, substance misuse, criminal justice and social services and housing. Only by moving in this direction will any significant progress be made towards preventing those with complex needs from ending up in the criminal justice system, where they are more likely to cost society several billion pounds through the associated costs of containment, reoffending, damaged family relationships and poor employment prospects.

While some areas of the country have started to look at the bigger picture, to date this has been a piecemeal approach with mental health services for offenders unlikely to be linked to mainstream provision. Ultimately, the extent of mental health need in the prison system will continue to mushroom if services outside the prison gate do not improve. It is hoped that the recommendations put forward in this paper go some way towards setting out how best to meet this challenge and improve outcomes for offenders with mental health needs.

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Nacro's Mental Health Unit

Nacro believes that responses to offenders with mental health needs should focus on their care and treatment rather than on punishment. To help bring about this change, Nacro campaigns for:

- more effective working partnerships between agencies
- the development of specialist skills in the criminal justice system
- better information sharing
- the education and training of staff so that they have the skills and encouragement they need to work with a group who can be difficult and unrewarding.

Nacro's Mental Health Unit has been working to tackle problems faced by offenders with mental health needs since 1990. We work with government agencies at a national and local level to develop more effective ways to deal with offenders with mental health needs. We provide a range of services: information and advice; policy development and other consultancy services; and training. We also run a major annual conference on mental health and crime.

Nacro has a specialist mental health website which offers information and support for practitioners and policy makers working in the field of criminal justice and mental health. To find out more, visit the website or contact the Mental Health Unit on 020 7840 6718, 020 7582 6500 or email mentalhealth@nacro.org.uk

www.nacromentalhealth.org.uk

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