Mental health of adults in contact with the criminal justice system
Consultation on draft guideline
Stakeholder comments table

07 October to 18 November 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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1.	SH	The Disabilities Trust	Appendix W	General	General	Professor Huw Williams's evidence on 'The Role of Traumatic Brain Injury in Crime and in mental health issues in offenders and the management of TBI and comorbid conditions' refers to the Barrow Cadbury report referenced in our comment 2, which describes the Linkworker project funded and delivered by The Disabilities Trust Foundation, and the Brain Injury Screening Index (BISI®) developed by The Disabilities Trust. We are grateful for the Committee's interest in our work and would like to share our experiences of developing and implementing these successful tools and interventions. Contact foundation@thedtgroup.org	Thank you for this comment. The BISI was not identified during our original evidence search and therefore was not appraised by the guideline. Following your comment we have tried to find published evidence about this tool but have not been able to identify any relevant papers. Consequently we are not able to mention the BISI in the guideline.
2.	SH	Association of Directors of Public Health	Full	General	General	There is not enough focus on the link between mental health conditions and substance misuse disorders. There needs to be more of a focus on how mental health conditions and substance misuse disorders are managed in tandem when they occur together (dual diagnosis). Evidence indicates that those with some mental disorders are more likely to be linked to substance misuse; in 2009, the NHS Confederation reported that 70% of prisoners were affected by dual diagnosis.	Thank you for your comment. We have amended recommendation 1.1.2 to draw attention to co-existing mental health and substance misuse problems. We signpost readers to other NICE Guidelines for the treatment and management of substance misuse disorders (e.g. Co-existing severe mental illness (psychosis) and substance misuse – CG 120). We have amended recommendation 1.3.14 to draw attention to the need to asses co-existing substance misuse problems, including novel psychoactive substances.

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3.	SH	Association of Directors of Public Health	Full	General	General	The document contains nothing about the impact of novel psychoactive substances, or drug induced psychosis. The only mention of anxiety induced by the justice system itself is the recommendation that staff should be "aware of the potential impact on a person's health of being in contact with the criminal justice system". There is no recommendation about how this impact might be reduced or remedied.	Thank you for your comments. Recommendation 1.3.5 includes a specific question to prompt professionals to assess substance misuse, including novel psychoactive substances. With regards to drug induced psychosis we have made a number of recommendations on assessment to draw attention to an individual's current and historical use of substances, including novel psychoactive substances. We signpost readers to existing NICE Guidelines to manage this occurrence. Unfortunately there is little evidence regarding NPS-induced mental health problems as it is a relatively new problem. With regards to anxiety caused by someone's involvement with the criminal justice system, we are aware of the effect the criminal justice system can have on someone's mental health. We have made a number of recommendations about assessing someone's mental health when they first come into contact with the criminal justice system, including assessing risk of suicide and self-harm. However, the ongoing treatment or management of anxiety is not part of the scope of this guideline.
4.	SH	Association of Directors of	Full	General	General	The majority of the mental health conditions are listed in isolation. The reality is that many people will have multiple	Thank you for your comments we agree. In our recommendations we

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		Public Health				conditions. It is important to explore what interventions would be effective for those who are affected by multiple mental health conditions. There is also a lack of exploration of the link between poor mental and poor physical health, and what this might mean for prisoners. People with severe mental health problems have an average reduced life expectancy of between 10 and 25 years, are twice as likely to die from coronary heart disease, four times more likely to die from respiratory disease, and are at higher risk of being overweight or obese. Poor mental and physical health are closely linked and improving one may lead to an improvement in the other – it is important to look at interventions which may address the physical and the mental together.	draw attention to assessing multiple disorders including co-existing mental health and substance misuse disorders. In recommendation 1.5.1 we recommend that care plans are integrated across services which would include substance misuse services. We agree there are important interactions between physical and mental health. Recommendations 1.3.3 – 1.3.5 are about first stage assessment which includes assessment of the person's physical health. In recommendation 1.3.5 we recommend the importance of assessing if someone has a chronic physical health problem. The treatment specific guidelines that we cross reference also reflect the importance of both physical and mental health, for example the Psychosis and schizophrenia in adults guideline (CG178) which recommends health professionals monitor physical health, including the effects of treatment on physical health. We also cross reference the NICE guideline on Physical health of people in prison (NG57) in section 1.3. We have revised 1.5.1 to draw attention to the need to include an individual's physical health needs when care planning.
5.	SH	Association of Directors of Public Health	Full	General	General	This document focused on individuals who have come into the criminal justice system in a planned way and who will face a judicial review. There needs to be consideration of those who	Thank you for your comment. We have recommendations about the use of Street Triage (1.8.3 short guideline)

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						end up there through crisis or section 136, or go into custody unexpectedly.	and police custody and court liaison and diversion services (1.8.1 short guideline). The first-stage assessment recommendations (1.3.3 – 1.3.5 short guideline) draw attention to assessing mental health needs of individuals on their first reception to prison. These various recommendations should ensure that the mental health needs are recognised and assessed for individuals who come into contact with the criminal justice system in crisis or go into custody unexpectedly.
6.	SH	Association of Directors of Public Health	Full	General	General	Consider whether mental health training for police officers, as well as staff working in the criminal justice system, would be an effective intervention for improving the mental health of prisoners.	Thank you for your comment. We would consider police officers as being professionals working in the criminal justice system and therefore, the recommendations regarding training should also apply to them.
7.	SH	Association of Directors of Public Health	Full	General	General	In terms of the literature reviews and research, learning could have been found in statutory learning reviews including: Serious Case Reviews, Safeguarding Adult Reviews, Mental Health Reviews, Domestic Homicide Reviews. This doesn't appear to have been sought or considered.	Thank you for your comment. Serious case reviews are not the best type of evidence source to answer the review question posed in the guideline. However, where evidence was lacking the views of the Guideline Committee were used. We used the expert knowledge and experience within the committee to inform the recommendations and decision making.
8.	SH	Association of Directors of Public Health	Full	General	General	There is no mention of the need "Think Family" and consider not only the safeguarding of the adult concerned, but the safeguarding of family members, particularly children. This features in HMIP inspection reports and CQC reports, so it should at least get a consideration/ mention in the introduction.	Thank you for your comment. We have amended the introduction in light of these comments. We have amended recommendation 1.2.1 to include safeguarding issues in the assessment, this would include

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							children.
9.	SH	Association of Directors of Public Health	Full	General	General	National data suggests that the female adult offender population is more likely to have experienced trauma and abuse than in the general population. See: https://www.theguardian.com/society/2014/apr/01/womens-offending-domestic-abuse-link Data from Women in Prison: 46% of women in prison report having suffered domestic violence (general population would be 25% in their lifetime) 53% of women in prison report having experienced emotional, physical or sexual abuse during childhood. Is there any difference in the outcomes for those completing interventions with specialist sexual/domestic abuse providers compared to those accessing interventions with general mental health services?	Thank you for your comment. The Guideline Committee were aware of the increased trauma of women in contact with the criminal justice system. But we are not aware of any difference in outcomes with regard to the treatment and management of trauma between different services. We have referred to other relevant guidelines, for example Post Traumatic Stress Disorder: Management Guideline, for the treatment and management of such disorders.
10.	SH	The British Psychological Society	Full	General	General	The Society very much welcomes national guidelines on this issue and the research that supports the guidelines appears to reflect many of the difficulties practitioners experience in managing the complex care of individuals with mental health problems in the CJS. The strategy for examining available evidence is robust and well explained. There is a clear message, from the reliance on single studies to evidence these guidelines, that we do not know much about 'what works' with this complex population and there is a need for a rethink the strategic approach to individuals with mental health concerns in the Criminal Justice System. This rethink is likely to involve changes to funding and professional responsibility and to include a co-ordinated research response. The Guideline Committee should be commended for seeking expert opinion with regard the relationship between traumatic brain injury and mental health. It may have been beneficial to extend this approach to consult experts in the fields of suicide and self-harm and the pharmacological treatment of those who sexually	Thank you for your comments – we agree. Additional expert advice outside of the guideline committee was not sought on issues of suicide, self-harm and pharmacological treatment of those who sexually offend as it was considered that there was sufficient expert knowledge and experience within the committee to inform the recommendations and decision making. There was significant representation from the psychology specialty on the

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						offend. There is poor representation of forensic psychology within the guideline document and this is of concern. There is quite clearly a need for psychological interventions, which are reflective of the environment and offending population. Community interventions cannot be translated directly and forensic psychologists have the special skills and knowledge to really help here. However, the NHS do not fund many psychology posts in prisons and there is a strong case for a joint psychological team, which includes both forensic and clinical psychologists within prison mental health services. Where this has occurred in the Offender Personality Disorder Pathway, it has been well received and beneficial to the wider staff team. https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/02/opd-strategy-nov-15.pdf Of most concern is the lack of representation on the Guideline Committee Group from the National Offender Management Service. Forensic Psychologists within this service are at the forefront of developing interventions for the whole offender population that take mental health needs into account. The organisation has a large Commissioning Strategies team that consider the evidence around many issues and project teams that specifically consider Safer Custody Strategies, Rehabilitation Culture and Trauma Informed environment approaches. Although, NOMS is cited in the appendix as having been approached there is no reference to the information they were able to provide. It therefore, appears that the GC did not have any representation from a Forensic Psychologist, which appears remiss.	Guideline Committee, all of whom have direct experience of working in prisons. The focus of psychological representation was on clinical psychology as the remit of the guideline was to focus on mental health problems and not on the management of offending behaviour. We understand that, while forensic psychologists can work on a wide range of mental health needs, forensic psychology in prisons tends to focus on the link between mental health needs and offending behaviour. When considering which specialties needed to be represented on the Guideline Committee, the focus was on delivery of mental health interventions rather than interventions for offending behaviour. The Committee included members, from a variety of roles, who had extensive experience of the National Offender Management Service (NOMS) – including prison officers, probation officers and psychologists with experience of working in the prison system. We therefore consider that the Committee were adequately informed about NOMS We sought input from NOMS and they provided an expert witness who provided testimony on co-commissioning mental health services

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							for offenders. However they did not provide any data/reports from the outcome of their Sex Offender Treatment Programme so we are not able to reference such information. Unfortunately we are not able to reference the reports you specify as they either relate to young people (who are outside the scope of this guideline) or are focused on settings other than that in England.
						More generally, a number of recent reports, legislation and position papers could be referred to and effectively linked to the guideline to support those using the resource. Examples are: Justice Committee Report: The treatment of young adults in the criminal justice system: http://www.publications.parliament.uk/pa/cm201617/cmselect/cmjust/169/16902.htm Position Paper: Children and Young People with Neuro-Disabilities in the Criminal Justice System http://www.bps.org.uk/system/files/Public%20files/Policy/pp04_brain_and_justice_dec2015-_final.pdf Nobody made the connection: the prevalence in neurodisability in young people who offend. http://www.childrenscommissioner.gov.uk/publications/nobody-made-connection-prevalence-neurodisability-young-people-who-offend	

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						The Mental Health (Wales) Measure 2010 www.legislation.gov.uk/mwa/2010/7/contents Welsh Government's Policy Implementation Guidance for Mental Health Services for Prisoners (2014). https://www2.rcn.org.uk/__data/assets/pdf_file/0011/577820/2014-05-16_Prison_Mental_Health_-_Policy_Implementation_Guidance.pdf	
11.	SH	Centre for Mental Health	Full	General	General	There is some unclarity over the scope of the report. One example is learning disability (LD). For instance, does it cover people in the criminal justice system who have LD? or only those with LD and co-morbid mental health problems? The same questions can be applied wider to other populations such as those with substance misuse issues.	Thank you for your comment. The scope of this guideline includes people with learning disability and substance misuse disorders whether or not they are co-morbid with other disorders such as psychosis and schizophrenia. We have added a footnote to recommendation 1.1.2 to clarify this.
12.	SH	Centre for Mental Health	Full	General	General	Prisoners by default have complex needs. The guidance could either reflect this more or be much more confined to a group than they currently are to ensure that some populations are not excluded. The former would be better in our opinion and could be worth some consideration.	Thank you for your comment. We agree that prisoners have complex needs. The intention is that this is recognised in the guideline, for example in our recommendations regarding co-existing physical health and substance misuse needs (1.1.2 and 1.3.14). These are of particular importance for the prison population and we direct people to the Physical health of people in prison guideline (NG 57).
13.	SH	Foundation for People with Learning Disabilities	Full	General	General	We are commenting from the perspective of people with learning disabilities in contact with the criminal justice system. We are concerned that the document's intention is unclear in relation to this group. The title and subtitle give readers no clue that this group is supposed to be included. Reading further, it is not until p.53 line 7 that an explanation is given that	Thank you for your comments. The primary purpose of this guideline was to ensure that people in touch with the criminal justice system, including those with learning disabilities, received appropriate assessment and care for

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						neurodevelopmental disorders are included in the term 'mental health problems'. This is potentially very confusing for a range of readers (including criminal justice agencies) who are used to a distinction being made between 'mental health problems' (which they generally understand to mean mental ill health) and learning disabilities. Indeed mental health services, and practitioners with mental health qualifications, are usually distinct from services for people with learning disabilities and practitioners with learning disability qualifications. We think that the intent of the document is in fact confused – it is not clear whether the aim is to include: 1. all people with learning disabilities who are in contact with the criminal justice system 2. people with learning disabilities who also have mental ill health and are in contact with the criminal justice system. If the aim is 1., we think that it does not address the issues adequately; we say more about this in comment 2 below. If the aim is 2., we will suggest some improvements to clarify this and to refer where appropriate to the reasonable adjustments required. We strongly suggest that this aim is more appropriate and achievable for NICE, rather than trying to stretch the guideline to cover all people with learning disabilities who are in contact with the criminal justice system.	any mental health problems. As you will appreciate the scope of this is extremely large and our approach has not been to consider specific interventions for all mental health problems. We refer to the relevant NICE Guidelines for the majority of assessment and management advice, including relevant NICE Guidelines on learning disability such as Challenging behaviour and learning disabilities (NG11) and Mental health problems in people with learning disabilities (NG 54). The scope of this guideline includes all people with neurodevelopmental disorders. We have amended the introduction to ensure this is clear from the onset.
14.	SH	Foundation for People with Learning Disabilities	Full	General	General	If the aim of the guidance is to include all people with learning disabilities who are in contact with the criminal justice system, we would suggest the following: • clarify this in the title and subtitle • insert a clear statement right at the start about who the guidance covers • clarify whether and how people with learning disabilities were involved in the methodology (it is not clear that they were included in the user group mentioned) • note the policy guidance on identifying people with learning disabilities using validated tools (we do understand that there may not be research that meets	Thank you for your comments. The primary purpose of this guideline was to ensure that people in touch with the criminal justice system, including those with learning disabilities, received appropriate assessment and care for any mental health problems. As you will appreciate the scope of this is extremely large and our approach has not been to consider specific interventions for all mental health problems. We refer to the relevant NICE Guidelines for the majority of

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						NICE criteria) • refer to the research and guidance on meeting the physical health needs of people with learning disabilities • refer to the NICE guidance on meeting the mental health needs of people with learning disabilities • note that community based services for people with learning disabilities are separate from mental health services, which requires consideration in planning pathways • note that assessment tools (e.g. for assessing mental health or risk) and interventions (treatments, offending behaviour programmes) are likely to require adaptation to suit people with learning disabilities • note the need to involve practitioners with experience in working with people with learning disabilities, preferably in criminal justice settings • note that, in addition to adapted interventions, people with learning disabilities are likely to need underpinning support to aid compliance with interventions (for example, to secure and sustain settled accommodation and occupation, to pay bills, to attend appointments, to comply with orders) • note the literature on programmes to address offending behaviour in people with learning disabilities, such as anger management and sex offending programmes.	assessment and management advice, including relevant NICE Guidelines on learning disability such as Challenging behaviour and learning disabilities (NG11) and Mental health problems in people with learning disabilities (NG 54). The scope of this guideline includes all people with neurodevelopmental disorders. We have amended the introduction to ensure this is clear from the onset.
15.	SH	Foundation for People with Learning Disabilities	Full	General	General	If the aim is to include only people with learning disabilities who also have mental health problems, we suggest this should be clearly stated at the start. Below we offer a number of detailed suggestions against specific points.	Thank you for your comments. The primary purpose of this guideline was to ensure that people in touch with the criminal justice system, including those with learning disabilities, received appropriate assessment and care for any mental health problems. As you will appreciate the scope of this is

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							extremely large and our approach has not been to consider specific interventions for all mental health problems. We refer to the relevant NICE Guidelines for the majority of assessment and management advice, including relevant NICE Guidelines on learning disability such as Challenging behaviour and learning disabilities (NG11) and Mental health problems in people with learning disabilities (NG 54). The scope of this guideline includes all people with neurodevelopmental disorders. We have amended the introduction to ensure this is clear from the onset.
16.	SH	Inclusion London	Full	General	General	The guidance is focused on offenders with mental health support needs not victims of crime. We suggest this focus could be made clear early in the document.	Thank you for your comment. We have clarified in the introduction that this guideline (in line with its scope) does not cover the needs of victims of crime.
17.	SH	Inclusion London	Full	General	General	Language used We recommend that the use of the terms 'mental health support needs', or as a second choice 'mental health conditions' are used rather than 'mental health problems' and 'mental health disorders'. This is because both the words 'problems' and 'disorders' have a negative connotation. People with mental health support needs face stigmatisation and the language used has an impact on public perception and on people with mental health support needs themselves. Inclusion London is a user led Deaf and Disabled People's Organisation, which uses the term 'mental health support	Thank you for your comments. The use of the terminology around mental health problems and mental health disorders was discussed at the scoping stage. We understand your concerns about the use of this terminology. However, these are the terms used across a range of NICE guidelines and are considered most applicable and appropriate in this guideline.

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						needs'. The term 'mental health condition' is already used by government.[1] We recognised that legislation such as Mental Health Act uses 'Mental Disorder' but we are raising this as a systemic problem throughout the Criminal Justice system and healthcare systems. We give some examples below, where we think the language could change: Page 12, Line 15: '…people with mental health support needs in contact with the criminal justice system and their… ' Page 12 Line 30: '.. provide up-to-date evidence-based recommendations for the management of mental health conditions by healthcare professionals…' Page 13, Line 6: '…recommendations applicable to the majority of people with mental health support needs in contact…' Page 24 Line 48-49: 'Mental health conditions such as schizophrenia and depression…' We recommend these changes are made throughout the guidance document.	
18.	SH	Inclusion London	Full	General	General	Legal obligations We recommend that the legal obligations to make reasonable adjustments and adhere to the Public Sector Duty, (see details below) is mentioned early on in the guidance. Reasonable adjustments	Thank you for your comment. We have updated recommendation 1.2.3 to specify reasonable adjustment needs to be made to take into account any literacy difficulties.

[1] https://www.gov.uk/when-mental-health-condition-becomes-disability

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						There is a legal obligation for reasonable adjustments to be made for people with mental health conditions,[2] initially under the Disability Discrimination Act and now under the Equality Act 2010.[3] We would recommend that a leaflet is designed for healthcare professionals in the Criminal Justice System (CJS) regarding the need to make reasonable adjustments for people with mental health support needs, which gives practical examples such as the guidance for GPs available at: https://www.rethink.org/media/511739/What's_reasonable_-_GP_adjustments_guide.pdf See also the Scottish government's guidance regarding people with learning disabilities and the criminal justice system: http://www.gov.scot/resource/doc/346993/0115487.pdf We recommend that the leaflet is co-designed with people with mental health support needs that have experienced the criminal system and are therefore 'experts by experience' We suggest that the language used in the new leaflet is the same as we have suggested under Comment 1 rather the language used in the referenced above. Lack of reasonable adjustments in the CJS We are concerned that a lack of reasonable adjustments puts people with mental health conditions at a disadvantage throughout the criminal justice system. For instance people with mental health support needs can find it impossible to	Your comments about the production of a leaflet will be considered by NICE where relevant implementation support activity is being planned. It is outside the remit of this guideline to comment on the conduct of courts regarding timing of hearings

[2] https://www.gov.uk/when-mental-health-condition-becomes-disability

[3] http://www.legislation.gov.uk/ukpga/2010/15/contents

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						concentrate or to be coherent in the mornings due to the impact of their medication or because of other issues, so a court hearing in the morning would put them at substantial disadvantage, a reasonable adjustment would be to have an afternoon hearing. Or a person with mental health support needs may need to give evidence remotely or need more time to respond to questions. Understanding information – reasonable adjustments needed Over two thirds of prisoners have verbal comprehensive difficulties, difficulty reading information and filling in prison forms (the proportion rises for those with learning disabilities), as a result prisoners miss out on things such as family visits and going to the gym, or get the wrong things delivered such as canteen goods.[4] A proportion of these prisoners will also have mental health support needs. A reasonable adjustment is needed to provide information and forms for prisoners in 'Easy Read' so they are easily understood by all. Easy read is in large print and provides pictures to aid the understanding of the text.[5] Public Sector Equality Duty There is also a legal obligation for public sector service providers under Public Sector Equality Duty[6] (PSED) to	In recommendation 1.1.2 we highlight that people who use this guideline should take into account any language, literacy or information processing needs. NICE has a duty as a public body to ensure equalities issues are taken into consideration when developing recommendations - which has been done when drafting these recommendations.

[4] http://www.prisonreformtrust.org.uk/Publications/Factfile

[5] http://peoplefirstltd.com/easy-read-one-stop-shop/
http://www.easy-read-online.co.uk/media/10612/comm%20basic%20guidelines%20for%20people%20who%20commission%20easy%20read%20info.pdf

[6] http://www.legislation.gov.uk/ukpga/2010/15/part/11/chapter/1

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						remove or minimise any disadvantage[7] caused by a disability such as a mental health condition. We recommend that this PSED is also highlighted in the guidance.	
19.	SH	Inclusion London	Full	General	General	Social model of disability The social model of disability, which the government supports,[8] says that disability is created by barriers in society, for instance: • the environment – including inaccessible buildings and services such as buildings that are not step free • people's attitudes – stereotyping, discrimination and prejudice • organisations – inflexible policies, practices and procedures: e.g. using outdated language that is derogatory to Disabled people. We recommend that there is a short written commitment to supporting the social model of disability is placed early on in the guidance.	Thank you for your comments. NICE understands the social model of disability and recognises its importance. However, including a written commitment to supporting the social model of disability is not considered appropriate in this guideline.
20.	SH	The Magistrates' Association	Full	General	General	The Magistrates Association (MA) welcome the opportunity to comment on the draft guideline: Mental Health of Adults in Contact with the Criminal Justice System. Whilst the MA cannot comment on the clinical interventions/assessments or NICE compliant studies we would like to suggest some insertions which provide additional relevant information on the existing judicial framework and this vulnerable group of service users.	Thank you for your comments. We have responded to each of your suggestions as they occur in the table below.
21.	SH	Adult Secure	Full	General	General	Title needs to reflect people with learning disability	Thank you for your comments. The

[7] https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty
[8] https://www.gov.uk/government/organisations/office-for-disability-issues/about

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		Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)					primary purpose of this guideline was to ensure that people in touch with the criminal justice system, including those with learning disabilities, received appropriate assessment and care for any mental health problems. As you will appreciate the scope of this is extremely large and our approach has not been to consider specific interventions for all mental health problems. We refer to the relevant NICE Guidelines for the majority of assessment and management advice, including relevant NICE Guidelines on learning disability such as Challenging behaviour and learning disabilities (NG11) and Mental health problems in people with learning disabilities (NG 54). The scope of this guideline includes all people with neurodevelopmental disorders. We have amended the introduction to ensure this is clear from the onset.
22.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Full	General	General	It is apparent that there is a lack of evidence in many of the areas to draw from. It demonstrates a real need for greater investment in research in prison healthcare generally and in prison MH specifically.	Thank you for your comment. We agree and have made recommendations for research in several areas to try and address this lack of evidence

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23.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Full	General	General	The greatest challenge will be in the implementation of NICE guidelines in this area, most particularly due to dramatically low staffing levels and increasing workload.	Thank you for your comments. The Committee agrees that staffing issues across the criminal justice system can make it more difficult for staff to access training. However, it is beyond the scope of this guideline to comment on Ministry of Justice policy on staffing levels in the prison estate.
24.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Full	General	General	"Better care for people with co-occurring mental health and alcohol/drug use conditions" PHE publication is expected in the near future and would supplement NICE guidance with a focus on individuals with substance misuse and mental health problems many of whom present in prison	Thank you for your comments. The Committee are aware of these pending PHE guidelines. If it is published before this guideline we will consider referring to it in the background information section of the full guideline.
25.	SH	Joint comment update between Northumbria Police and Northumberland Tyne and Wear NHS Foundation Trust	Full	General	General	Is this guidance for mental health & learning disability or will there be separate guidance for Learning disability?	Thank you for your comments. The scope of this guideline includes all people with neurodevelopmental disorders. We have amended the introduction to ensure this is clear from the onset. The primary purpose of this guideline was to ensure that people in touch with the criminal justice system, including those with learning disabilities,

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							received appropriate assessment and care for any mental health problems. As you will appreciate the scope of this is extremely large and our approach has not been to consider specific interventions for all mental health problems. We refer to the relevant NICE Guidelines for the majority of assessment and management advice, including relevant NICE Guidelines on learning disability such as Challenging behaviour and learning disabilities (NG 11) and mental health problems in people with learning disabilities (NG 54).
26.	SH	Joint comment update between Northumbria Police and Northumberland Tyne and Wear NHS Foundation Trust	Full	General	General	There is no mention that the CPS and Courts receive training from the Mental health trusts about mental health about offenders on in-patient wards.	Thank you for your comment. Recommendation 1.9.3 draws attention to the importance of having multidisciplinary and multi-agency training including for those working in the criminal justice system and the health care system. We hope this collaborative approach will address the concerns we assume lie behind your comment.
27.	SH	Joint comment update between Northumbria Police and Northumberland Tyne and Wear NHS Foundation Trust	Full	General	General	Consider a recommendation regarding CPS engaging frequently with partner agencies to review process and ensure that people are making fully informed decisions and aware of impact.	Thank you for your comments. Recommendation 1.8.3 draws attention to the importance of joint working between Criminal Justice Agencies. But specific recommendations regarding the operation of the Crown Prosecution Service are outside the scope of this guideline.
28.	SH	Northumberlan	Full	General	General	It would be helpful to have a summary of recommendations at	A complete set of all recommendations

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		d Tyne and Wear NHS Foundation Trust				the end of the document.	are available in the short version of the guideline
29.	SH	Joint comment update between Northumbria Police and Northumberland Tyne and Wear NHS Foundation Trust	Full	General	General	Forensic beds – delays occur particularly around those in an NHS bed (e.g. PICU) diverted from custody but still same risk as if they are in prison. But are not classed as a priority for a forensic secure bed as they are not in prison. There needs to be much work around this area, to ensure that the system isn't inadvertently sending people to prison to access appropriate secure MH care.	Thank you for your comments. The Committee are aware delays in accessing beds is an issue. We made recommendations about the most effective approach to assessment and management of people with more severe mental health problems with liaising and diverting people out of the criminal justice system (1.1.3 & 1.8.1) which we hope addresses some of your concerns.
30.	SH	Rethink Mental Illness	Full	General	General	• Research on whether people in the criminal justice system with severe mental health problems are better treated in prison or secure care settings, should be treated as a priority. Clearer guidelines and protocols for deciding the best setting for the treatment of someone with severe mental health problems in the criminal justice system should be developed as a matter of urgency.	Thank you for your comment. In light of your comment the Committee has made a research recommendation to establish the best setting for treating people who have acute or significant ongoing psychotic illness.
31.	SH	Rethink Mental Illness	Full	General	General	• Approximately 7,000 people with severe mental illness are treated in secure hospitals at a cost of £1.2bn annually. As a top level economic consideration, appropriate management of some people that are currently in secure services that could be treated in either the community or prison (including therapeutic communities aimed at people with personality disorders), would lead to significant financial savings.	Thank you for your comment. However, the management of people with severe mental illness in secure hospitals was outside the scope of this guideline.
32.	SH	Youth Justice Board	Full	General	General	While the YJB appreciates that this guidance has been drafted to address the interface between the adult criminal justice system and adult mental health services, it is important to also consider those young people who transition from the youth to adult criminal justice system, particularly those who move to	Thank you for your comments. The Committee agree on the importance of effective transition between youth and adult criminal justice services and have amended recommendation 1.8.4 to

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						adult custody from the under-18 secure estate. Many of this group have diagnosed mental health conditions for which they may have already received treatment. This means they could be transitioning both between criminal justice systems and from CAMHS to adult mental health care. It is imperative that any identified mental health issues are flagged and included in transition planning to ensure that there is no disruption to their treatment. Ultimately a poorly managed transfer could make the young person become unstable during the difficult transition period, when they are likely to be more vulnerable. This issue was picked up in Lord Harris's report 'Changing Prisons, Saving Lives' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/439859/moj-harris-review-web-accessible.pdf). NICE may wish to also consider the following article on this topic: Saunders, A. (2014). Young adults (18-24) in transition, mental health and criminal justice. The Bradley Commission, Briefing 2. London: Centre for Mental Health. (http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf) Making improvements in the way information is shared between the youth and adult justice systems will lead to more informed assessments, continuity in interventions and advances in addressing the young person's needs. This should, in turn, have a direct effect on reducing re-offending. This continuity principle not only applies to mental health needs but wider health and wellbeing issues. It is also worth noting that young adults who are care leavers may have additional entitlements and support needs and that local authorities and carers may need to be engaged in supporting their mental health treatment in much the same way as they would for children.	make this more explicit. Recommendation 1.8.4 covers the need for care plans to be agreed and shared during transitions and also for protocols to be in place to support routine data sharing, which should address the concerns that you raise. The Saunders (2014) publication was an expert report summarising examples of good practice, it was not included as evidence because it was not a research study evaluating interventions or assessment.
33.	SH	Association of	Full	5	5.4.2	Add also to support mental health staff in identifying potential	Thank you for your comments. The

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		Directors of Public Health				risks posed by those with cognitive impairments. An example from Violence Against Women and Girls Strategy Development Manager, Warwickshire: "This comes from undertaking DHR R02. We were not able to access the perpetrators health records as it was assessed as too risky for us to seek his consent, and services would share without his consent. However, we know he had a traumatic brain injury and it was regularly reported that his impacted on his behaviour towards his family. We have not been able to test this without access to records, but if it did impact, then access to the victim's records have shown that no work was undertaken to offer support in managing/ responding to his behaviour changes resulting from the cognitive impairment."	Committee agree with your comments and feel we have addressed your points in recommendation 1.9.3.
34.	SH	Association of Directors of Public Health	Full	5.6	-	The document considers risks of "self-harm or suicide risk, risk of sexual re offending and risk of relapse" as most beneficial to the public. Were any tools located for assessing risk of harm to partners/ family members? We do seem to be lacking on this front. Warwickshire Violence Against Women and Girls Strategy Development Manager, has expressed that there are more cases where men/ fathers are attempting/ killing their ex/partners and their children. Or just their children. Based on a local case that did not meet the criteria for a children's Serious Case Review as there were not concerns about "multi-agency" working, the LSCB requested the mental health provider undertake a single agency review. What they learnt was that when police handed him to mental health services for assessment following a preceding incident, they simply considered the fact he had children to be a protective factor to his mental health, they didn't consider the risk he could pose to them. He subsequently tried to kill both his children.	Thank you for your comment. We have amended the introduction to include the following sentence "Contact with the criminal justice system can have considerable negative impact on family members, (SCCJR, 2015) and in particular on children (Murray and Farringdon, 2008) which may also raise significant safeguarding issues (HMG, 2015)". The focus of this guideline is on people who have mental health problems and are in contact with the criminal justice system. Therefore prediction of violence not directly related to mental health problems was not looked at in the guideline and we did not look for evidence of tools for assessing risk of harm. We have amended recommendation 1.2.1 to include safeguarding issues in the

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							assessment, this would include children.
35.	SH	Association of Directors of Public Health	Full	6.11	-	We welcome the following recommendation "48. Practitioners should not exclude people with personality disorders from any health or social care service, or intervention for co morbid disorders, as a direct result of their diagnosis." All too often, MARAC, Warwickshire, are advised that the mental health provider will not work offer a service to a high-risk perpetrator because they have a personality disorder which is a diagnosis that they don't work with. This could make a real difference.	Thank you for your comments.
36.	SH	Foundation for People with Learning Disabilities	Full	14	41	Here it is stated that the guideline will be relevant to 'adults with mental health problems'. At this point it should be clarified what NICE intends this group description to cover. For example, the section could include a short list, such as: • mental ill health • substance misuse • personality disorders • people with neurodevelopmental disorders who also have mental ill health	Thank you for your comments. The scope of this guideline includes all people with neurodevelopmental disorders. We have amended section 1.2.2 to read "This guideline will be relevant for adults who are at risk of developing or who have mental health problems (including common mental disorders, severe mental illness, neurodevelopmental disorders, paraphilias, substance misuse and dementia)…" to ensure this is clear from the onset. The primary purpose of this guideline was to ensure that people in touch with the criminal justice system, including those with learning disabilities, received appropriate assessment and care for any mental health problems. As you will appreciate the scope of this is extremely large and our approach has not been to consider specific interventions for all mental health

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							problems. We refer to the relevant NICE Guidelines for the majority of assessment and management advice, including relevant NICE Guidelines on learning disability such as Challenging behaviour and learning disabilities (NG 54) and Mental health problems in people with learning disabilities (NG 11).
37.	SH	The British Psychological Society	Full	17	25	The Society has concerns regarding the wording of this section. Self-harm is not the same as suicidal thoughts or suicide attempts and that separate figures should be provided. A recent study has been published Forrester et al, 2016, which provides this information for a large group of those in contact with MH services, for example, (Forrester, A., et al., 2016).	Thank you for your comment, the Committee agree that self-harm is not the same as suicide although as you will be aware it is related. We have updated the introduction section of the guideline in light of your comment
38.	SH	The British Psychological Society	Full	17	29	This figure is for prisoners – the report provides no figure or reference given for the community although states 12% - The paper by Jo Borrill and Lisa Cook provides some evidence; or there is evidence from Australia which is compelling around risk post-prison release; or the Pratt (2006) paper on UK post-prison release although now 10 years old. There is a need to give an indication of the rate as risk has been shown internationally. (Pratt D, et al., 2006; Cook, L and Borrill, J., 2013; Spittal, M., et al. 2014)	Thank you for your comment, the Committee have reviewed the introduction. Upon reviewing the Cook paper the figure of 12% appears accurate for suicide risk within community settings ("Twelve per cent of the sample were identified as previously or currently 'at risk' of suicide") and so have included this reference. While the Committee agree that risk of suicide amongst post release offenders is important, the applicability of the Australian study may be limited given social and practice differences which may increase risk (for example differences in supervision, housing, social support, access to health and social care).
39.	SH	The British Psychological	Full	17	45	The community figures are inconsistent - it is not clear why one group is reported .56% and another as .004%.	Thank you for your comment. We have amended the text to clarify that 0.56%

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		Society					referred to the percentage of traumatic brain injury in the general population.
40.	SH	Foundation for People with Learning Disabilities	Full	17	41	Here learning disability is presented as a characteristic of some prisoners, just as race is presented in the next paragraph. We think that this is correct – a protected characteristic under the Equality Act, which will require reasonable adjustments to be made in services.	Thank you for your comment.
41.	SH	Prison Reform Trust	Full	17	49-50	We are concerned that, as it is written, contact with criminal justice services as a route into mental health services appears as 'a good thing' rather than as a failure of mental health services in the community to provide timely support and/or treatment.	Thank you for your comment. A message of making contact with the criminal justice system in order to access mental health treatment is not our intention. Our purpose in this guideline has been to set out what we think is best practice to ensure that best treatment is provided. We agree that direct referrals to mental health services would be preferable for many people. But as this is clearly not always the case it is important that we have robust guidance about how people who have mental health problems and are in contact with the criminal justice system are best supported.
42.	SH	Royal College of Psychiatrists	Full	17	11	It would be helpful to add more information about prevalence of mental disorder among people under supervision by the probation service – not all are in approved premises. This is important because probation officers often find it difficult to access relevant mental health service support and an infinitesimally small number of Mental Health Treatment Requirements are made. Brooker et al, for example, estimated 27% of all under supervision had a current mental illness, 40% a life time history; 55.5% were hazardous drinkers; less than 50% of any such people in any health category had access to services at the time. There are also probation officer observations on attempted contacts with health services which	Thank you for your comment. We note the information you provided about the prevalence of people with mental health disorders who are in touch with the National Probation Service (NPS) or Community Rehabilitation Service (CRCs) and have amended the introduction to take this into account. We recognise the importance of NPS and CRCs in providing care for people with mental health problems. We have made a number of recommendations

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						may have implications for the training chapter 4 of this NICE document Brooker C et al (2011) An investigation into the prevalence of mental health disorder and patterns of health service access in a probation population. University of Lincoln: Lincoln. http://www.magnacartalincoln.org/cjmh/RfPB%20Executive%20Summary.pdf	around assessment, training and management within community criminal justice services. We have a research recommendation about development of structured clinical (case) management in improving mental health outcomes using interventions within the CRCs and NPS which we feel addresses your feedback.
43.	SH	The British Psychological Society	Full	18	06	Refers to adults but does not define an adult within the prison population those between 18 and 21 are referred to as Young Adults.	Thank you for your comments. In this guideline we take 18 years and onwards to include adults and young adults. This covers the whole of the criminal justice system not just the prison system. The intention of this guideline is that it applies to anyone aged 18 and over. It will be for local organisations and services (i.e. local young offenders institutes) to determine how these recommendations are applied.
44.	SH	The British Psychological Society	Full	18	15	These figures should reflect the current situation and be updated to 2016 figures.	Thank you for your comment. We have reviewed a more up to date reference (MoJ (2016) Offender Management statistic bulleting, England and Wales. Quarterly April to June 2016; with Prison Population as at 30 September 2016. www.gov.uk/government/uploads/system/uploads/attachment_data/file/562955/OMSQ_Bulletin.pdf). Unfortunately the figures have not changed but we have cited the updated reference in the text.
45.	SH	The British	Full	18	29	The assertions are based on very old reference, as 10 years	Thank you for your comment. The

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		Psychological Society				ago and before the NHS took over the care within the prison system. A more recent review is required to ensure that the evidence is current and reflective of services. A recent paper Slade et al (2016) outlined difficulties in the remit of some services, which although reflective of community needs, do not take account of the differing needs of a CJS pathway (Slade, K. et al, 2016).	Committee agree that the recent paper by Slade et al is relevant and have referenced it in the Introduction. However, we feel that the Thornicroft paper is still relevant to this guideline and have therefore retained this reference in the introduction.
46.	SH	The British Psychological Society	Full	18	41	We are concerned as to the representation of forensic psychologists and that they are being considered, only relevant when working with sexual offenders. Forensic psychologists work with all offending types, all offenders' presentations and in all types of forensic environments; there is no special relationship with sexual offenders suitable for separation in this way and indeed the skill set, knowledge and experience required to work with a criminal justice population more often sits within this specialist psychological discipline.	Thank you for your comment. We have removed the reference to forensic psychologists working specifically with sexual offenders.
47.	SH	The Magistrates' Association	Full	18	15	After "Justice, 2013b)." Insert: "90% of all criminal cases start and finish in the Magistrates Court.9"	Thank you for your comment. We have amended the current wording to include the information you have provided.
48.	SH	The Magistrates' Association	Full	18	17	After "not well developed." Insert: "It is possible that many of these service users don't reach the criteria of secondary care mental health services."	Thank you for your comment. The Committee agree that there is an increasingly strict criteria for mental health services and have made amendments to reflect this.
49.	SH	Royal College of Psychiatrists	Full	18	36-40	Sentence unclear; the next two sentences could be clearer if simply specifying the list of available staff who are not health service staff. What may need adding is that there are growing numbers of staff who are employed neither by the prison not	Thank you for your comment. We have amended the text to make it clearer. The Committee agrees that there are a number of staff who work within

[9] https://www.judiciary.gov.uk/you-and-the-judiciary/going-to-court/magistrates-court/

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						the health service – mainly staff from various third sector organisations, and they will have other different codes and structures.	prisons who are not employed by the prison or the NHS.
50.	SH	The British Psychological Society	Full	19	1-12	This paragraph gives insufficient detail about the mechanics of providing mental health treatment requirements (MHTRs) as part of a court order. It is true that the responsible probation member of staff holds the MHTR as part of a community order, which can be returned to court for re-sentencing if the offender chooses not to comply with the agreed treatment or becomes mentally unwell to a degree that such a community treatment is not possible. However, those preparing court reports on people with a mental disorder who are seeking an MHTR, report significant challenges. Court adjournments are often required for an assessment by community mental health services to make an assessment of treatment need requested by a court report writer. Often this process is too long for the court, which expects considerably faster sentencing than previously was the case due to the streamlining of the sentencing processes. For this reason, MHTRs are often not suggested or pursued, as they are impractical to set up. Even if a timely mental health assessment is achieved, then there can be difficulties in establishing a responsible clinician (consultant psychiatrist or chartered psychologist). As the general community services, are usually non-forensic mental health services. With no clinician experienced enough to take responsibility for the MHTR and oversee the treatment, by a range of health treatment providers. Non-forensic services are often wary of taking on patients who have committed offences as they feel that they lack the specialist skills to deal with such patients and are anxious about being held responsible for their risk or re-offence. In fact such fears are unfounded as the focus of the required treatment is upon the mental health condition of the individual rather than their offending behaviour per se and in this regard they should be treated the same as other citizens with mental health needs; although in practice they are often not. Further to this, the responsibility for the risk of the	Thank you for your comments. This section of the document provides an introduction to the guideline - is not making any recommendations for clinical practice. It is outside the scope of this guideline to make recommendations on the mechanics of the mental health treatment requirements. It is not for NICE Guidance to comment on statutory guidance. The Committee agree that there are problems with statutory services taking up referrals from the criminal justice system. We have made a number of recommendations in light of this in order to support the effective integration of care between the criminal justice system and mental health services. We have amended recommendation 1.8.1 to include the importance of supporting the development of prompt access to appropriate treatment and care (including medication). Recommendation 1.8.3 highlights the importance of agreed referral pathways for urgent or emergency care and routine care. Recommendation 1.9.1 focuses on the importance of staff being aware of referral pathways. We hope these recommendations address the concerns raised in your comment.

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						individual remains managed by the probation staff member not the health worker. A combination of these problematic factors has meant that in the Thames Valley probation region, for example, MHTRs fell from 47 in 2010 to just 9 in 2015. One solution to this problem has come in the form of a pilot project run at Milton Keynes magistrate's court where a 3-way partnership between a health provider, a link-worker agency and probation was funded to provide a rapid access screening and assessment service for defendants going through court who appeared to have mental health problems. The on-site nature of the service meant that a bespoke treatment service designed with the offender client group in mind could be relatively easily recommended and begun often within a matter of days. In this way, magistrates were provided with a treatment option with easy access. Between April 2014 and October 2016, 212 MHTR orders were set up this way, with evidence of positive outcomes for service users (Long, C. 2016).	
51.	SH	The British Psychological Society	Full	19	2	No evidence or specifics of this assertion presented as to those released from prison not getting equality of care and this is important. Forrester and Edworthy, have written some good papers on equivalence in prison which could be considered here i.e. that whether equivalence is the right approach but also where greater than equivalence for some and less for others.	Thank you for your comment. We have amended this section to include a reference to Bradley 2009 in support of the statement about the difficulty people in the criminal justice system face when trying to access health care. Forrester et al (2014) was identified by our searches but it was not included in the guideline because it is an editorial not a research study
52.	SH	The British Psychological Society	Full	19	23	CJLD services are usually based in courts with some pilot schemes in police stations.	Thank you for your comments. We have included reference to Street Triage and liaison and diversion schemes based in police custody suites and courts.

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53.	SH	The British Psychological Society	Full	19	32	The limitations of police specialist services was recently confirmed by Slade et al (2016) regarding suicide risk.	Thank you for your providing this information
54.	SH	Foundation for People with Learning Disabilities	Full	19	37-40	Here concerns are rightly raised that people with a range of neurodevelopmental disorders may not have their conditions recognised and may therefore miss out on appropriate treatments (where treatments are available). However, the sentence gives a slightly misleading impression that 'treatment' may be the answer. There is of course no 'treatment' for learning disability – but someone with learning disabilities who also has mental ill health does need to have both their mental ill health recognised and their need for reasonable adjustments in relation to their learning disability.	Thank you for your comment. We have amended the sentence to reflect the points raised in your comment.
55.	SH	The Magistrates' Association	Full	19	6	After "Criminal Justice Act 2003". Amend sentence to say: "As a high level community order, which can be an alternative to a custodial sentence, the Courts may impose mental health treatment orders or drug rehabilitation orders."	Thank you for your comment. We have changed this to specify a high level community order.
56.	SH	The Magistrates' Association	Full	19	8	After "orders." Insert: "Legislation in 201210 brought in changes relating to the Mental Health Treatment Requirement so that now any medical practitioner can hold the order whereas previously the order had to be held by a Section 12 approved doctor: this means the order can be provided by both primary and secondary care practitioners. However, in 2016 it is still the case that only 0.1% of all community orders given are MHTRs. The Five Year Forward Plan for Mental Health has recommended 'increased uptake of Mental Health Treatment Requirements (diversion through court order to access community based treatment) as part of community sentences for everyone who can benefit from them.' 11 "	Thank you for your comment. The background has been amended to clarify the low uptake of MHTRs.
57.	SH	Joint comment	Full	19	-	It states 'there is no agreed model of Street Triage & Liaison &	Thank you for your comment. The text

[10] http://www.legislation.gov.uk/ukpga/2012/10/section/73
[11] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

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		update between Northumbria Police and Northumberland Tyne and Wear NHS Foundation Trust				Diversion'. But there is an agreed model of Liaison & Diversion in England, and scrutiny and review around this. It is not the same for Street Triage	has been updated as suggested.
58.	SH	Prison Reform Trust	Full	19	6-10	It would be helpful to highlight the very limited use of the Mental Health Treatment Requirement (0.1% of all community orders) and efforts being made to make the order a more realistic and accessible option. For example the Milton Keynes trial site, recommendation in the Five Year Forward View for Mental Health, and the Department of Health expert reference group on treatment requirements.	Thank you for your comment. We have amended the statement about mental health treatment requirements to state they are only used occasionally.
59.	SH	Prison Reform Trust	Full	19	23-24	'Police cells' should be replaced with 'police custody suites'; we are unsure what is meant by 'visiting courts' and suggest that 'criminal courts' be inserted instead	Thank you for your comments. We have changed 'police cells' to 'police custody suites' and 'visiting courts' to 'courts'.
60.	SH	Prison Reform Trust	Full	19	26	There *is* an agreed model and service specification for NHS England liaison and diversion services	Thank you for your comment. The text has been updated to reflect this.
61.	SH	Royal College of Psychiatrists	Full	19	1-2	Suggest rephrasing: Despite the fact that people in contact have the same rights of access to health care as the general population, there is clear evidence that they do not, in fact, have the same access. They generally have reduced access.	Thank you for your comments. We have made some minor edits.
62.	SH	Inclusion London	Full	20	12-13	We very much agree that there are 'pre-existing social factors' such as homelessness' which are important regarding links between mental health and crime. We are aware that there are social factors that can cause or exacerbate mental health support needs, which can include lack of employment, (possibly due to discrimination by employers) or poverty, which can be caused by benefit sanctions or delays.	Thank you for your comment and providing this information.
63.	SH	Joint comment update between	Full	20	-	It states 'the person requires Appropriate Adult after conviction…' but this is not the case it is at the point of interview the person may require an Appropriate Adult.	Thank you for your comment. There was a grammatical error in the guideline which made it appear that

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		Northumbria Police and Northumberland Tyne and Wear NHS Foundation Trust					the statement was saying an appropriate adult was required after conviction. This has been rectified
64.	SH	The British Psychological Society	Full	21	34-39	The phrase "there are cultural and peculiar reasons why people may not engage with this offer, but the (mental health) services do exist" is vague and unhelpful. Even though forensic clients may have access to services in the community, non-forensic community mental health services are anxious about working with offenders. They express concerns about being held responsible for further reoffending and staff safety issues. Therefore, access to these services is not as ready or available as it might be with offenders being considered unsuitable or 'unmotivated' for treatments. Further to this is the key issue that offenders as a group can be 'hard to engage' e.g. they may exhibit traits of impulsivity, anti-authority and lack of problem-solving skills. They are likely to have negative experiences of services and may thus be less likely to respond to recommendations for voluntary interventions regarding their mental health than non-offenders. This is another reason why the MHTR can be a good option if it can be created as, although the offender's original consent to treatment is required, the court mandate to attend can often mean that the offender completes treatment rather than drops out. In effect, the court mandate is reinforcing a treatment recommendation, which is likely to benefit the offender in the longer term.	Thank you for your comments. We have amended the wording of the sentence you cite in your comment to make it clearer. It is outside the scope of this guideline to make recommendations on mental health treatment requirements. It is not for NICE Guidance to comment on statutory guidance. The Committee agree that there are problems with statutory services taking up referrals from the criminal justice system. We have made a number of recommendations in light of this in order to support the effective integration of care between the criminal justice system and mental health services. We have amended recommendation 1.8.1 to include the importance of supporting the development of prompt access to appropriate treatment and care (including medication). Recommendation 1.8.3 highlights the importance of agreed referral pathways for urgent or emergency care and routine care. Recommendation 1.9.1 focuses on the

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							importance of staff being aware of referral pathways. We hope these recommendations address the concerns raised in your comment.
65.	SH	Foundation for People with Learning Disabilities	Full	21	13-17	The issue of mental capacity is rightly raised here in relation to fair treatment by the justice system. An audit of practice in prison healthcare in one region also raised concerns about understanding and implementation of the Mental Capacity Act in healthcare. This affects the increasing population of prisoners with age-related cognitive impairment as well as those with learning disabilities.	Thank you for your comment
66.	SH	The Magistrates' Association	Full	21	39	After "services themselves do exist" suggest insert: "It is worth nothing that for those with multiple needs, there can be difficulties accessing services due to dual diagnoses of substance misuse and mental health problems; especially where there is lack of clarity over responsibility for care in conjunction with offender management.	Thank you for your comment. We have included the sentence about difficulties accessing services.
67.	SH	Prison Reform Trust	Full	21	39	It should be noted here that it can be hard for the high number of individuals with dual diagnosis (mental health and drug/alcohol problems) to access services, and that mental health and substance misuse services should cooperate in determining how best to work together in determining the most appropriate treatment option, in consultation with the service user.	Thank you for your comment. The Committee agree with your feedback and have made a number of recommendations about the importance of multi-agency working, including with substance misuse services. We have also amended the introduction to highlight this issue
68.	SH	Royal College of Psychiatrists	Full	21	38	What are 'peculiar' reasons?	Thank you for your highlighting this typo – we have changed 'peculiar' to 'particular'
69.	SH	Shire Pharmaceutical limited Ireland	Full	21	36-39	This statement is inaccurate regarding services for adults with Attention Deficit Hyperactivity Disorder (ADHD). Adult mental health services for ADHD have been described as 'patchy' (Young et al; Recommendations for the transition of patients with ADHD from child to adult healthcare services: a consensus statement from the UK adult ADHD network. BMC Psychiatry (2016) 16:301 DOI 10.1186/s12888-016-1013-4.) In many areas of the	Thank you for your comment. The comment is on the diversion of drugs not on the provision of services, which we accept vary in availability across the country.

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						country there is little or no specialist care available for adults with ADHD who are either transitioning from the care of CAMHS/community paediatric teams or who present for the first time in adulthood. Nor is care necessarily available from community psychiatric services - as stated in the British Association of Psychopharmacology Evidence-based guidelines for the pharmacological management of attention deficit hyperactivity disorder – updated 2014 (Journal of Psychopharmacology 2014, Vol 28(3) 179–203), "in many areas it is not possible to integrate ADHD care into community psychiatry services. Local psychiatrists often do not have adequate training, may lack experience managing stimulants, or ADHD may not be included in the budget for the range of services agreed with the local primary care provider"	
70.	SH	The British Psychological Society	Full	22	47	There is also an issue with remit of the different services not 'matching' up (Slade et al, 2016) which means there are gaps in assessment or in the availability of information. In addition, there is some disconnect between health staff actively viewing prison information even when there is mental health information available e.g. Prison Escort Forms (PER) forms not directly viewed.	Thank you for your comment, the Committee agrees. We have made a specific recommendation, 1.8.4, regarding the importance of information sharing during transition. In recommendation 1.1.3 we draw attention to the need for staff to review all available information including Prisoner Escort Records.
71.	SH	College of Mental Health Pharmacy (CMHP)	Full	22	52	Though there are particular problems around medicines reconciliation at all points in a person's journey through the Criminal Justice System, there needs to be clarity around improved medicines reconciliation and communication on medicines arrangements for people transferred through the CJS and to other secure environment providers. Medicines reconciliation for people with mental health problems in contact with the criminal justice system will have a positive impact on future patient care. Question 1: This could be challenging for CJS in practice due	Thank you for your recommendations. We have made a number of recommendations about effective care pathways throughout the criminal justice system and joint care plans between multiple agencies. Care planning should include all care and management needs, including medication. Thank you for your response. We will pass this information to the NICE resource endorsement team.

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						to poor or variable integrated information technology solutions available and or the absence of medicines reconciliation at transitions of care and interfaces with the CJS. Question 3 National initiatives - Utilising NHS Summary Care Records to facilitate medicines reconciliation	Thank you for your response. We will pass this information to the NICE local practice collection team.
72.	SH	The Magistrates' Association	Full	22	47	After "with information flow", insert: "There can also be a significant lack of information sharing between agencies working across the CJS. It is particularly important that courts are provided the necessary information to ensure fair participation for all parties as well as sentences that target specific needs of an offender."	Thank you for your comments. We have added in the sentence regarding poor information sharing and the impact poor information can have on sentencing.
73.	SH	Prison Reform Trust	Full	22	47	It would be helpful to highlight the difficulties experienced in timely and proportionate information sharing, and the importance of ensuring information is shared appropriately across and between different health and justice agencies.	Thank you for your comment. We have made several recommendations about the importance of information sharing, primarily in recommendations 1.3.16, 1.4.4 and 1.8.4. We have also amended the introduction to describe this issue.
74.	SH	The British Psychological Society	Full	23	4	The delivery of effective treatment options are also significantly affected by underfunding of psychological treatment options across the criminal justice pathway. There is a need to incorporate broader psychological approaches within offending behaviour treatment to ensure that factors likely to manifest in mental health issues can be managed prior to reaching clinical levels of concerns. The provision of psychological treatment which is suitably reflective of the context and the population e.g. see Forrester et al (2014) re IAPT services issue with trying to directly import a community model into prison. Utilising forensic psychologists more alongside health professionals within prisons is also a clear priority - forensic psychologists understand the client group and the environment and should not be considered only able to work with offending behaviour in isolation; they have a keen role in a more holistic view of the offender and their care.	Thank you for your comments. The guideline is focused on a comprehensive approach to the care and management of people who have mental health problems and are in contact with the criminal justice system. This includes in custody and in the community. Recommendations relating to primary and secondary care services are dealt with in disorder specific NICE guidelines, which we signpost to in section 1.2.5 of the full guideline. It is not the usual practice for guidelines to make recommendations about specific professional groups, but more about the experience and

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							competence needed to deliver the interventions. The focus of the guideline is to ensure that people receive the best care while involved in the criminal justice system by competent and supervised practitioners. The importance of forensic psychologists has been highlighted in the introduction.
75.	SH	Joint comment update between Northumbria Police and Northumberland Tyne and Wear NHS Foundation Trust	Full	23	-	It states 'Prisoners who may be sectioned in the community would go to an NHS facility' language used needs changings as there are no such terms as prisoners in the community.	Thank you for your comments. We have reworded this sentence.
76.	SH	Royal College of Psychiatrists	Full	23	4-9	The main bar to delivering effective treatment options in prison is the lack of staff – failure to acknowledge this could render the rest of an otherwise generally good document pointless. The legislative issues apply only to a very small subgroup of very sick people who can usually be transferred to hospital. For a very long time there has been a shrinkage of prison employed groups such as forensic psychologists, perhaps partly remedied by more purchasing of services from outside, although the evidence base for purchasing outside services of this kind rather than providing them from within the prison is, we believe, non-existent. The guidance committee does not appear to have considered evidence in relation to important questions about whether services should be bought in or provided by the criminal justice system; even reference to buying in clinical services is founded on principle rather than evidence. The principle is not necessarily wrong, but evidence	Thank you for your comment. We note your concern about the evidence base to support purchasing outside services. Unfortunately commenting on the current models of commissioning of services within the Criminal Justice Service, particularly the purchaser/provider model is outside the remit of a NICE guideline and we are not able to make any recommendations in this area. The Committee agrees that staffing issues across the criminal justice system can make it more difficult for staff to access training. However, it is beyond the scope of this guideline to

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						on whether services really have improved or not for being bought in and whether there are any disadvantages or not is important too. Of absolutely central importance is that, while prisoner numbers have continued to increase, prison officer numbers have been reduced. With some variation between individual prisons, the average reduction was by 43% in 2013 and, although the government has now recognised the costly mistake in providing incentives to prison officers to leave the service, it has not to date proved possible to recruit in sufficient numbers to raise the staff numbers available. In this situation, prisoners are increasingly locked in cells for long periods, and cannot be escorted to healthcare, or relevant programmes. The luxury of attending even day courses in health care will not be possible for most officers in most prisons and there will be no question of the kind of reflective practice that could support the 'psychologically informed planned environments' principles.	comment on Ministry of Justice policy on staffing levels in the prison estate.
77.	SH	Royal College of Psychiatrists	Full	23	17-18	While it is true that people with mental health care problems have a substantial need for healthcare services, the existing sentence perpetuates the myth that they would not otherwise 'impose' a financial burden for their healthcare. The same people would have almost the same health problems whether inside or outside the criminal justice system and it is arguable that NHS Healthcare Trusts should be more aware of these people and provide for them more effectively in the first place.	Thank you for your comment. The text has been modified to: "[…] impose a substantial burden on the NHS, criminal justice sector and the wider public sector". Also, the last paragraph of the 'Economic Cost' section addresses your point that there is a need for cost-effective treatment strategies.
78.	SH	Inclusion London	Full	24	13-17	We agree with the case for 'diverting offenders away from sentences in prison towards effective treatment in the community'. We back timely support in the community, and amelioration of social factors such as lack of support in education, homelessness and poverty. A prison record severely disadvantages efforts to find employment after release from prison, which could contribute to the revolving door effect i.e. those released after serving sentence returning	Thank you for your comment and your support

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						to prison.	
79.	SH	The British Psychological Society	Full	24	18	There is concern that despite substantial expansion of Liaison and Diversion services in the last 2-3 years the current practice of identifying mental health issues at the start of the 'offender journey' e.g. when first arrested and processed through police custody suites, is not the best strategy for this kind of assessment. This is because treatment needs identified during this assessment process can, primarily, only be recommended to the offender and there is no method of supporting longer term engagement with recommended treatments, which may require lengthy waiting periods for assessment. Perhaps, a better use of L&D workers would be at the court stage where swift assessments of treatment could be carried out and then treatment providers sought with the recommendations mandated by means of an MHTR. The focus of intervention in police custody (n.b. many defendants taken into police custody do not get charged let alone convicted of offences) represents a missed opportunity to meaningfully connect offenders with mental health needs with treatment services.	Thank you for your comments. We have recommendations about the use of Street Triage (1.8.3 short guideline) and police custody and court liaison and diversion services (1.8.1 short guideline). The first-stage assessment recommendations (1.3.3 – 1.3.5 short guideline) draw attention to assessing mental health needs of individuals on their first reception to prison. These various recommendations should ensure that the mental health needs of individuals can be assessed regardless of how they have entered the criminal justice system journey. Thank you for your comment about the nature of the assessments and the roles of L&D workers. We agree that there is a need for better coordination of care and have included recommendations on this in the guideline (section 1.8).We have also referred to other NICE mental health guidelines which again stress the importance of care coordination. The precise operation of L&D workers is for local commissioners and mangers to determine when implementing the recommendations in this guideline.
80.	SH	Foundation for People with Learning Disabilities	Full	24	13-14	As noted in comment 6 above, 'treatment' may not be what is required for someone with learning disabilities who is diverted from the justice system. We were very pleased that Lord Bradley's report and the consequent national service specification for liaison and diversion services included the	Thank you for your comment. We have updated the sentence about treatment to reflect the point you raise. We agree that adjustments may be needed in order for people with learning disability

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						need for appropriate support for people with learning disabilities; in practice we remain concerned that the main focus has been on mental ill health and that options for people with learning disabilities who do not require treatment for mental ill health are very limited. We suggest (see comment 1 above) that the focus for this guideline should be on the reasonable adjustments required to mental health services for people with learning disabilities who do also have mental ill health.	to access support and services. We have included reference to reasonable adjustments in recommendation 1.2.3 in light of this point.
81.	SH	The Magistrates' Association	Full	24	17	After "Bradley 2009)" insert: "Although the Bradley report identified that service users entering the CJS sometimes struggle to access community services (often due to multiple vulnerabilities); the provision of relevant community rehabilitative orders which provide holistic health and social care aspects have been shown to reduce recidivism."	Thank you for your comment. The Committee have reviewed the relevant paragraph and feel that the outcomes you refer to (e.g reduced recidivism) are adequately covered by the existing text.
82.	SH	Foundation for People with Learning Disabilities	Full	27	22-30	It is not clear that the arrangements described here for involving service users and carers included any people with learning disabilities or their families. It would be useful to state this clearly if there was such involvement.	Thank you for your comment. The text has been updated to clarify that service users and carers had mental health problems and experience of the criminal justice system – which is the focus for this guideline.
83.	SH	Inclusion London	Full	50	-	Staff training Disability awareness training It is important that all healthcare professionals (and all other professionals in the CJS) have disability equality training regarding mental health support needs and learning difficulties (and other impairments) as recommended by Lord Bradley. We would recommend the inclusion of disability equality training delivered by Deaf and Disabled People and their Organisations, (DDPOs), which is led by disabled people who 'experts by experience'.	Thank you for your comment. We have made several recommendations regarding training for professionals who work in the criminal justice system. We envisage this would cover disability equality training. Recommendation 1.9.2 draws attention to the need for all commissioners and providers of health care services to educate all staff about stigma and discrimination associated with mental health.
84.	SH	Royal College of Psychiatrists	Full	51 to 61		Chapter 4 is diminished by its emphasis on lack of RCT evidence for training. While it would be helpful to highlight towards the end of the chapter the lack of evidence for any	Thank you for your detailed comments. We have responded to your specific issues below.

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				57 to 58		particular training approach (surely, as almost implied by the prominence of the RCT message it is training *type* rather than training *per se* which might be called into question) Important issues which need more clarity are: Which staff should be expected to do what training, and to what end? i. The target tasks for which the various staff sectors need training – training strategies would be likely to differ accordingly. The very general recommendations (numbered 1) for all staff seem reasonable, although it may be worth acknowledging that there may be some local-service-specific issues which might be included in what would essentially be an induction process. A possible problem is that many health service staff who might benefit from such an introduction to work with offender-patients would not regard themselves as working in the criminal justice system, and miss out. In particular, occasional work with people on probation would fit this category; there is some evidence that low rates of use of the Mental Health Treatment Requirement follows from uncertainties on the part of general adult psychiatrists or psychologists – most likely to be so involved – about the nature of such work and working relationships.	i. The view of the Committee, drawing on their expert knowledge and experience, was that there was a lack of general awareness and understanding of the mental health problems that affect people in touch with the criminal justice system. Therefore, the emphasis of the recommendations is on general training which the Committee think would be applicable and appropriate across all Criminal Justice Services. This training will be enhanced by the multi-agency and multidisciplinary training approach discussed in recommendation 1.9.3. A clear message of this guideline is that the NHS are primarily responsible for the treatment of people with mental health problems within the criminal justice system. It will be for individual mental health trusts and their partner agencies in the criminal justice system to determine which staff should undertake this training. ii The Committee do not consider it derisory to suggest commissioners and providers should provide training and educate staff. Whilst we acknowledge that educating people not to use inappropriate terminology will not

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						ii. The knowledge suggested for commissioners and providers of services seems derisory – with an implication that all they need is to sign up to a statement that they will avoid the negatives of avoiding inappropriate terminology and stigmatising behaviour. iii. Do all staff really need to know about prevalence of mental disorder – other than perhaps the simple facts that it is common in the wider community and even more common among people charged with or convicted of offences? It is also doubtful if they need a lot of detail about presentations of common mental illness. We would suggest that it may be helpful to differentiate between front line staff (maybe police, court staff, prison reception staff, but generally not clinicians) – who will need simple, easily applied strategies for detecting the most important possible problems in these settings – particularly those which could be life threatening (head injury, acute alcohol withdrawal, suicidal ideation) or compromise justice (possibly lacking capacity for any reason to answer alleged offence related questions and needing an appropriate adult), second responders (may have some clinical training, but may not) - those who can assist in stabilising the situation and linking the person to appropriate further assessment, support or treatment, primary, secondary and/or tertiary clinical care staff, who would complete full	address the issue in its entirety, we think it is a critical first step in addressing inappropriate behaviours iii The section you have provided comment on is the introduction and not recommendations for training. The Committee laid out what they felt were the key elements required for effective training, primarily being multi-agency and multidisciplinary, please see recommendation 1.9.3. It is the responsibility of senior staff to decide on the level of training specific staff will be required to attend. iv The matter of staff issues and freeing time for staff to complete training is a matter for local implementation. We would hope the areas you identified (for example self-harm) is reflected in recommendations 1.9.3 and 1.9.4. v It is not within the remit of a NICE guideline to determine whether training

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						assessments where indicated and deliver or supervise interventions iv. The amount of training suggested does not take staffing constraints into account – indeed it is arguable that a major gap in the guideline is a reasoned estimate of numbers of staff required at each level in order provide a service which will deliver at each level – basic safety (maintaining self-harm, suicide, other mental disorder related deaths and illness related violence held at agreed levels); people in need of responsible adult services appropriately detected; access to full appropriate treatment; health improvement; recovery; improvement/recovery and reduction in re-offending. v. The guideline should make clearer which of the training options should be mandatory – and for whom, which advisory, and at which stage in the staff person's career. vi. Suggestions should be put forward about how training might be incorporated into everyday practice. Without the sense that the guidance recognises the practical difficulties associated with everyday practice, within a prison setting in particular, it is likely that the guidance will not be taken seriously and will be side-lined vii. Related to this point, given the stark reality on the ground at present, an explicit timetable for implementing the guidance would be valuable.	should be mandatory or advisory. It is the responsibility of the NHS and Criminal Justice agencies to arrange and implement training for their staff. Our recommendations for training are clear that they relate to all staff working in the criminal justice system. vi The matter of staff issues and freeing time for staff to complete training is a matter for local implementation vii It will be for local implementation to determine the timetable to implementing these recommendations. As you will see from the guideline the Committee used a formal consensus technique, namely nominal group technique, which we considered to be more appropriate than the Delphi technique for the purpose of this guideline. The Committee considered training to be such an important issue that they placed it at the start of the guideline.

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						Some of us had concerns that, accepting that consensus statements are necessary in this area, a stronger scientific methodology, such as adoption of a Delphi model, would have given them more weight. A final thought on this chapter refers to its placement – it would surely appear more logical if followed the chapters on assessment, interventions and service delivery, each of which should inform training at any level.	
85.	SH	Centre for Mental Health	Full	51	1 (whole section)	Overall, improvements to staff training is fully welcomed and an integral element of improving peoples' experience of criminal justice systems that have mental health problems. Our research recommends that there should be a joint commitment across Ministry of Justice, Home Office, Department of Health, NHS England and the Welsh Assembly that all professionals in criminal justice should receive mental health awareness training (and periodic updates) that helps to achieve a psychologically informed approach to managing offenders. The evidence from this consultation suggests that where awareness training is mandated (e.g. within the police), it works well. (Mental health and criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016)	Thank you for your comments. The Committee agrees about the importance of joint commitment regarding training. Recommendation 1.9.3 draws attention to the importance of having multidisciplinary and multi-agency training including those working in criminal justice system and the health care system.
86.	SH	Centre for Mental Health	Full	51	1	Currently there are some good training courses available to criminal justice staff but the uptake has been relatively low. To overcome these barriers training needs to suit the roles of whom it is being delivered to, be updated regularly (every 12 months) and be mandatory.	Thank you for your comment. Recommendation 1.9.3 draws attention to the importance of having multidisciplinary and multi-agency training including those working in criminal justice system and the health

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							care system. Recommendation 1.9.4 identifies the importance of ongoing support for staff that work directly with adults in the criminal justice system which includes training.
87.	SH	Foundation for People with Learning Disabilities	Full	51	14-16	We fully support the point that health practitioners need to understand justice processes. We would add that mental health services and practitioners also continue to need improved awareness and understanding about people with learning disabilities: how mental ill health may not be recognised in this population and what reasonable adjustments may be required.	Thank you for your comments. In recommendation 1.9.3 the Committee have specified that staff should receive training on how to recognise commonly occurring mental health problems. We have reviewed the introduction to make it clear that mental health problems included neurodevelopmental disorders within this guideline. We also direct people to the Mental Health in Learning Disability Guideline for further advice on the identification and support of adults who have mental health problems and learning disabilities.
88.	SH	Foundation for People with Learning Disabilities	Full	51	28-30	We are pleased to see here that a distinction is made between mental health and learning disabilities; members of the judiciary and other justice agencies also need to understand the different service and support options.	Thank you for your comment.
89.	SH	The Magistrates' Association	Full	51	30	At the end of line 30, add in: "as recommended in Lord Bradley's report in 2009 as a key priority. This recommendation is continuing to be implemented with a view to ensuring increased awareness supports appropriate judicial decisions."	Thank you for your comment. We have amended this sentence about training to include reference to the Bradley Report 2009.
90.	SH	Prison Reform Trust	Full	51	30	Suggest adding, 'As recommended in The Bradley Report 2009.'	Thank you for your comment. We have amended this sentence about training to include reference to the Bradley Report 2009.
91.	SH	Foundation for People with Learning	Full	53	5-8	Whilst welcoming support for increased awareness about neurodevelopmental disorders, we were surprised to come (so far into the document) upon this definition of what seems to be	Thank you for your comment. In light of this we have reviewed the introduction to make it clear that mental health

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		Disabilities				being included in 'mental health problems'. As noted in comment 1 above, we would much prefer to see the focus of this guideline upon recognition and treatment of mental ill health – including in people with neurodevelopmental disorders.	problems encompasses neurodevelopmental disorders much earlier on in the guideline.
92.	SH	Shire Pharmaceutical limited Ireland	Full	57-58	-	Shire agrees with the recommendations on training in particular the need for multi-disciplinary and multi-agency training for the purposes outlined in recommendation 3. The rate of ADHD in the Criminal justice system has been found to far outweigh that in the general population. UK prison studies have indicated a rate of 24% of adult males screening positively for a childhood history of ADHD. Those with persisting symptoms accounted for 8 times more aggressive incidents than other prisoners. (Young eg al. The identification and management of ADHD offenders within the criminal justice system: a consensus statement from the UK Adult ADHD Network and criminal justice agencies. BMC Psychiatry 2011, 11:32 http://www.biomedcentral.com/1471-244X/11/32). This recommendation will be a challenging change in practice due to the challenges of co-ordinating and delivering a multi-agency and multi-disciplinary approach combined with the absence of absence of training interventions with proven effectiveness. Shire has previously worked with a mental health trust in the North West to deliver a half day training session on ADHD for professionals working across the criminal justice system. Demand for places exceeded all expectations and feedback was excellent. It was clear that staff working in the CJS would welcome additional training.	Thank you for your comment and providing information on the rate of ADHD in the criminal justice system. We agree that training is important and have made recommendations on this in section 1.9 of the short version of the guideline. The Committee agree there are challenges with implementation of recommendations for various reasons. The focus of this guideline is to ensure that all people who have mental health problems and are involved in the criminal justice system receive the best care and treatment. Specific implementation of the recommendations is outside the scope of the guideline and falls under the authority of local services.
93.	SH	Foundation for People with Learning Disabilities	Full	57-58	32	We very much welcome the references to inclusion of information sharing policies and clear communication in induction.	Thank you for your comment.
94.	SH	The British Psychological Society	Full	57	32	There is broad agreement with the recommendations under this section – i.e. that mental health staff need specific training regarding the specific nature of the environment, as well as how their service fits in the broader working of the	Thank you for your comments and support of our recommendations. The Committee agree with your views on the importance of effective training and

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						establishment, including other relevant departments and agencies. This should work towards the avoidance of silo working which can be an issue in prison environments. It is positive that specific reference is given to the importance of professional boundaries training for this group as they may be particularly vulnerable to boundary violation. It is also reassuring to see that consideration is given to the value of well-being/resilience training for this group who may be susceptible to work related stress and burn-out. There should perhaps be consideration of training in relation to information sharing specific to working in a forensic environment so that mental health professionals have a clear understanding of when they may be required to 'breach' confidentiality (e.g. by sharing risk-related information about prisoners with wider professionals) in order to fulfil their greater obligation of Duty of Care and public protection. What is less clear is who would deliver this training and perhaps this needs more explicit consideration as this will have an impact on the training's quality and effectiveness. It is also important to highlight that such training should not just be delivered as a one off (e.g. as part of induction) but should be part of a rolling programme of ongoing CPD. The potential role of psychologists in the development, delivery and evaluation of such training could be more explicitly considered. The recommendations for staff training while sensible and likely to be supported by the operational staff within the custodial environment are ambitious within the current climate. The lack of available staff within the prisons means that they are not available for training.	information sharing. In recommendation 1.9.1 (short guideline) we have drawn attention to the importance of staff having a comprehensive induction on legislation and policy relevant to their role, including information sharing. In recommendation 1.8.4 (short guideline) we draw attention to the need to develop protocols to support data sharing. Recommendation 1.9.3 (short guideline) draws attention to the importance of having multidisciplinary and multi-agency training including those working in the criminal justice system and the health care system. As this guideline is focused primarily on the criminal justice system it is considered specific to forensic environments. Considerations to breaching confidentiality are written into the Data Protection Act 1998 and therefore, outside the scope of this guideline. It is not within the remit of a NICE guideline to comment on who should be providing the training. This will be a matter for local determination in conjunction with relevant training bodies e.g. HEE. We have made reference to ongoing CPD in the recommendations on training as you suggest (1.9.3 short guideline).

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							The Committee agrees that staffing issues across the criminal justice system can make it more difficult for staff to access training. However, it is beyond the scope of this guideline to comment on Ministry of Justice policy on staffing levels in the prison estate.
95.	SH	Centre for Mental Health	Full	58	Rec 2	While we feel that for all staff to have supervision is well needed, the distinction between managerial and clinical is not made and could cause confusion. We would recommend that all staff (including Justice Staff) can access clinical supervision or an equivalent form of reflective supervision. Our research found that criminal justice/health staff valued access to clinical/reflective supervision and thought of it as a necessity when working with challenging populations (Mental health and criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016).	Thank you for your comment. The Committee understands the importance of supervision when working with adults who present with challenging behaviour and have made recommendations to ensure all staff receive the right supervision (1.6.1 and 1.9.4. short guideline). Recommendation 1.9.4 highlights the importance of ongoing supervision to support professionals manage the stress associated with working in the criminal justice system, including their mental health and wellbeing.
96.	SH	Shire Pharmaceutical limited Ireland	Full	61	-	The inclusion of outcomes within the research recommendation is welcome.	Thank you for your comment.
97.	SH	Centre for Mental Health	Full	62	1 (whole section)	Improvements to recognition and assessment, again, is a key area that currently needs further attention so we are pleased to see that the need for these improvements is being recognised.	Thank you for your comment.
98.	SH	Centre for Mental Health	Full	62	1	Common problems with initial assessments can include the person in custody being unwilling to disclose personal information on arrival. This could be for several reasons including, feeling anxious due to being in a new place, fear of revealing vulnerability, wanting to get through processing due to hunger or tiredness and so on. One way to overcome this challenge is to offer a secondary screening as standard 48	Thank you for your comment. The Committee agree that the environment in which an assessment takes place can impact on the outcome. However, recommendation 1.1.2 aims to ensure that practitioners who are completing the assessment are aware of this. In

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						hours after arrival. (Mental health and criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016). See also *Standards for Prison Mental Health Services – Second Edition - Quality Network for Prison Mental Health Services – September 2016*	response to your suggestion about having a second assessment 48 hours after their arrival into custody, the Committee felt that it will be for the person undertaking the screening assessment, in conjunction with clinical colleagues, to determine the time between screens or a referral for further assessment.
99.	SH	Centre for Mental Health	Full	62	1	Information systems between teams on different parts of the criminal justice pathways (i.e. Street& Police Triage, Liaison & Diversion, Immigration Removal Centres and Prisons) AND in community mental health services, need to link up so the staff carrying out the assessment can see previous notes. Therefore, the assessment can be built upon but does not need to be carried again necessarily. This is of high importance to both staff and person being assessed. For the person being assessed this demonstrate continuity of care and means that they do not have to repeat their histories (which often contain traumatic events) time and time again which is either retraumatising or disengaging. (Mental health and criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016)	Thank you for your comments. The Committee agreed that repeated assessments are not of value. In light of your comments we have reworded recommendation 1.8.4 to emphasise this.
100.	SH	Centre for Mental Health	Full	62	1	It is not clear if these guidelines are intended to apply to Immigration Removal Centres (IRCs). This needs to be clarified. Centre for Mental Health recently conducted a Mental Health Needs Analysis of English Immigration Removal Centres, and can provide recommendations appropriate to these setting (these will be published in December 2016) if the guidance also covers these settings.	Thank you for your comments. This guideline is only intended for adults within the criminal justice system. While it may be applicable to adults within Immigration Removal Centres (IRCs) the Committee did not consider these as they were outside the scope of the guideline.
101.	SH	Inclusion London	Full	62	-	Recognition and Assessment We support a thorough assessment of a person's mental health support needs and also to ascertain if the person has any learning difficulties or other impairments so the appropriate care and support and reasonable adjustments can be made on	Thank you for your comment.

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						entry to the CJS i.e. when first in contact with the police and again for the court and at reception into prison and at subsequent points and in the community.	
102.	SH	Royal College of Psychiatrists	Full	62 to 117	-	We welcome the thorough reviews of the various screening tools, particularly those which support staff without much mental health training or experience to identify people who could benefit from a full specialist assessment or who might need some special support to reduce their risk of harm to self or others. It would be more helpful, however, to have clear positive conclusions for each cluster reviewed rather than the summary negative statements. What busy people – perhaps including commissioners – need is a simple sentence along the lines of: the best supported screening tools for use in a police station which routinely take five minutes or less are…. They will also need such statements for each location, unless there is evidence that exactly the same screen can be used in each setting; if so, that should be explicit. We are concerned that there is little guidance on how and with what consequences the screens should be used. For example, should all those taken into police custody receive a health check/ brief screen before being placed in a cell? While there is an implied (perhaps not explicit enough) consequence of a hierarchy of assessment – a positive screen leading to a higher order assessment – there is no guidance on any holding measures. What should the inexperienced screener do on identifying a possible mental illness while waiting for a clinician to come and do a full assessment? What when s/he has identified mental illness with suicidal ideation? What if there appears to be suicidal ideation but the screen does not indicate mental illness? At this stage particularly, when the clinically inexperienced are the only possible source of help, exceptionally clear guidance on appropriate actions is necessary.	Thank you for your comments. The Committee agree that a more concise summary of the tools is more useful to practitioners and hope this is reflected in the short version of the guideline – which only contains the recommendations. Given the limited evidence available, it was not possible for the Committee to make differential recommendations for each location. We have provided guidance on the triggers (history and behavioural indicators) from the 1st stage health assessment which might trigger the use of the Correctional Mental Health Screen for Men or for Women. Recommendation 1.3.6 in the short guideline states "Consider using the Correctional Mental Health Screen for Men (CMHS-M) or Women (CMHS-W) to identify possible mental health problems if: • the person's history, presentation or behaviour suggest they may have a mental health problem, • the person's responses to the first-stage health assessment suggest they may have a mental health problem, • the person has a chronic

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						The later part of this chapter gives recommendations about what should be taken into consideration when doing a full mental health assessment. Again, it is unclear if these recommendations apply to all settings, or whether there is a case for any variance. The recommendation is, in fact, for a very high level, comprehensive assessment that is only likely to be possible from a highly trained and experienced clinician. The guidance should be clearer about competencies as well as the nature of assessment. Thorough and comprehensive assessment is to be welcomed wherever indicated by screening tools, but there is a risk that if every screen positive case had such an assessment the system will be overwhelmed. Guidance will not be followed, because it cannot be. It may be prudent to set some minimum standards as well as a gold standard. We accept that this presents a risk of 'dumbing down', but if both minimum and gold were presented, then everyone should be assured of as much safety as possible while bids are made to upgrade services. One matter which the chapter might include to help with this is the evidence that mental state of prisoners tends to improve over the first month/few months of imprisonment, thought to be accounted for in part by the fact that the admission process increases mental turmoil, and in part by the probability that there is a distinction to be made between chronic personal distress and illness (e.g. Hassan et al 2011, prospective cohort study of mental health during imprisonment. British Journal of Psychiatry 198: 37-42; Taylor et al (2010) Improving mental state in early imprisonment. *Criminal Behaviour & Mental Health* 20: 215-231; Walker et al (2014) Changes in mental state associated with prison environments: a systematic review. *Acta Psychiatrica Scandinavica.* 129: 427-236).	physical health problem with associated functional impairment or concerns have been raised by other agencies about the person's abilities to participate in the criminal justice process. Precise details of how matters should be managed between screening and further assessment is a matter for local implementation. There are a broad range of services in this guideline including court, police and probation. Specifying management across them would not be possible. The recommendations made regarding completing the assessment have been that practitioners conducting full assessments should be competent or refer them to someone who is (see recommendation 1.3.8 in the short guideline). The Committee felt this is of utmost importance and have included practitioner competence in recommendations 1.3.10, 1.3.11 and 1.3.14 of the short guideline. We have amended the subheading so it is clear that the recommendations apply to the whole care pathway. With regards to the concerns you raised about minimum and gold standards of assessment, this is a matter for local implementation and not possible to cover in this guideline.

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						While it is essential to have a reception screen, particularly because of the risk of suicide related behaviours and/or substance withdrawal states at this time, it may be that most *full* mental state assessment could follow a second screen after about one month in prison. As a separate issue from use of mental health screening, it should be explicit that every person received into any form of custodial placement should be asked about prescribed medication. A required consequence should be that those reporting use of prescribed medication should be asked for the name and contact details of the prescriber and every effort made to check the prescription and provide continuity of medication. Where contact with the prescriber is not possible, this should be a trigger for a fuller assessment of the person's likely need for that medication. There are some vital clinically related actions such as these which do not require RCT evidence before implementation! Of course the prescription may be reassessed, but that is a next, more detailed step.	In response to your comments regarding the implementation of a second assessment about a month after a person's arrival into custody. The Committee felt that it will be for the person undertaking the screening assessment, in conjunction with clinical colleagues, to determine the time between screens or a referral for further assessment. For example in the case of suspected psychosis it seems inappropriate to wait for a month for further assessment. The cited references (Hassan, 2011; Taylor, 2010 and Walker 2014) were not identified by our literature searches, most likely because they concern the natural history of mental health during imprisonment rather than interventions or tools for assessment. Prescribed medication forms part of the first stage health assessment (see recommendation 1.3.5 in the short guideline). This recommendation is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of people in prison guideline

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							(NG 57). We are therefore not able to make any further changes to this text.
103.	SH	Foundation for People with Learning Disabilities	Full	64	1-11	We note the decisions that shaped the choice of tools for recognition of mental health problems. We return to the question we raised in comment 1 above and our recommendation. If the aim is to identify people with (or at risk of) mental ill health, we can accept this and the recommendations that flow from it later in this section (subject to suggestions below). We assume that the validated tools for recognition of learning disabilities have been excluded because they are not free.	Thank you for your comment. The Committee considered the available evidence on a range of screening tools and agreed that the CMHS-M and CMHS-W was the most suitable tool to assess the potential presence of mental health disorders and neurodevelopmental disorders, based on the evidence review. The CMHS is validated for all psychiatric disorders except borderline personality disorder and antisocial personality disorder. Specifically the area under the curve for diagnosis of Diagnostic Statistical Manual (version 4 revised) Axis II, which includes psychiatric and intellectual disabilities are >0.7 for both men and women.
104.	SH	Newcastle University	Full	66	Table 16	Regarding HELP-PC – column 8 – this tool is available from the MPS or myself at Newcastle University – it is also being used now by Northumbria Police	Thank you for this information
105.	SH	The British Psychological Society	Full	72	8	There appears to be missing information in this section.	Thank you for your comment. This has been corrected
106.	SH	Foundation for People with Learning Disabilities	Full	82 to 88		As no validated tool for recognition of learning disabilities has been recommended, we note that recognition depends on staff 'vigilance'. Curiously at the top of p.85 learning disabilities are listed under 'Other physical health conditions' and staff are urged to ask the prisoner about this. Unfortunately research such as that undertaken for the Prison Reform Trust's 'No One Knows' project shows that prisoners who have learning disabilities may never have been told this, or may choose to hide this for fear of stigma and bullying. A person with learning disabilities may have difficulty with all the questions in the	Thank you for your comment. The recommendations on p87 are taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical

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						following sections. Near the top of p.87 there is a question about whether the person has been in contact with a health professional or service 'about a mental health problem'. A person with learning disabilities who has been in contact with learning disability services for other reasons might say no. Referral to the GP is recommended if a person has been in touch with learning disability services, but it is not stated here what the purpose of that referral would be. It could usefully be added that the person should have a full health check, including both physical and mental health, covering the specific health risks for people with learning disabilities and leading to a health action plan.	health of people in prison guideline. We are therefore not able to make any further changes to this text. It is worth noting that the CMHS tool is validated for all psychiatric disorders except borderline personality disorder and antisocial personality disorder. Specifically the area under the curve for diagnosis of Diagnostic Statistical Manual (version 4 revised) Axis II, which includes psychiatric and intellectual disabilities are >0.7 for both men and women.
107.	SH	Prison Reform Trust	Full	82 to 88		We are concerned that no validated tool for recognition of learning disabilities has been recommended and note that recognition depends on staff 'vigilance'. At the top of p.85 learning disabilities are listed under 'Other physical health conditions' and staff are urged to ask the individual about this. Research undertaken by the Prison Reform Trust shows that individuals with learning disabilities may not be aware of their condition or have a diagnosis, or may choose to hide their disability for fear of stigma, bullying or a more punitive outcome. We strongly recommend that a validated screening tool for learning disabilities is included as an option and indication of possible learning disabilities, and they do exist.	Thank you for your comment. The recommendations on p87 are taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of people in prison guideline. We are therefore not able to make any further changes to this text. It is worth noting that the CMHS tool is validated for all psychiatric disorders except borderline personality disorder and antisocial personality disorder. Specifically the area under the curve for diagnosis of Diagnostic Statistical Manual (version 4 revised) Axis II, which includes psychiatric and

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							intellectual disabilities are >0.7 for both men and women.
108.	SH	Foundation for People with Learning Disabilities	Full	90-91	2-16 on p.91	Under 'Quality of evidence' we note that the GC recommends adding items on learning disability to the CMHS-M/CMHS-W in order to trigger further assessment. However, the research recommendations shown on p.91 focus on acquired cognitive impairment, not learning disabilities, so it is unclear how NICE proposes to approach development of the CMHS to include items on learning disability.	Thank you for highlighting this inconsistency in the text to us. The information in the Quality of Evidence section about adapting the CMHS was incorrect and has been deleted as it would not be possible to adapt the CMHS as we had previously suggested
109.	SH	Foundation for People with Learning Disabilities	Full	91 to 105	General	Assessment of risk: we could see no discussion of the issue that risk assessments designed for the general population may require adaptation to be considered reliable with people with learning disabilities.	Thank you for your comment. We are aware of the specific issues which may be more applicable during a risk assessment for someone with learning disability. In recommendation 1.4.5 the Committee highlight the need to assess someone's risk of exploitation and self-neglect and feel that the risk assessment recommendations should still be applicable to individuals with learning disability.
110.	SH	The British Psychological Society	Full	102	2	It appears incongruous to review tools that consider the risk of sexual re-offending within these guidelines. These tools are not specific to the assessment of mental health problems and offenders who sexually re-offend do not all have issues related to mental health. Current assessment methods include risk in context and a strengths based approach that would not be explored using the tools discussed in these guidelines. This section lacks clarity in terms of how it sits within the guidelines and as it results in no recommendations we would question its usefulness. Guidance on which risk assessments are more effective when applied to adults experiencing mental health problems would be more useful.	Thank you for your comment. We agree that not all offenders who sexually re-offend will have issues related to mental health. To account for this issue, the decision was made (as stated in section 5.5.1) that studies examining risk for sexual reoffending would only be included where >80% of the sample had a paraphilia, to ensure offending behaviour was associated with a mental health problem. When assessing tools for recognition and assessment of mental health problems the GC agreed that

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							preference should be given to tools that could identify or be helpful in assessing a range of mental health problems, as opposed to recommending the use of multiple tools which could detect only single disorders. The only instrument that the GC identified that covered the full range of mental health disorders was the CMHS-M/CMHS-W
111.	SH	Foundation for People with Learning Disabilities	Full	105 to 110		We have read this section as relating to assessment of mental ill health, not assessment of learning disabilities.	Thank you for your comment. When developing these recommendations, the Committee intended them to apply across the range of mental health disorders including neurodevelopmental and learning disability. We make reference to the two learning disability guidelines which will provide further advice for the assessment and management for people with learning disabilities. Recommendation 1.1.2 draws attention to the need to take into account people with neurodevelopmental disorders. Therefore, we hope these recommendations will be applicable in identifying any indicators of mental health disorder, including learning disability and neurodevelopmental disorders. More specific assessments of mental health disorders, learning disabilities or neurodevelopmental disorders should be done in line with relevant condition specific NICE Guidelines.

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112.	SH	Foundation for People with Learning Disabilities	Full	108	10-11	We note and commend the reference to adjusting assessment of mental ill health for a person with learning disabilities, along with involvement of a specialist in working with people with learning disabilities. We are slightly puzzled by the reference here to an appropriate adult, as this role relates specifically to youth and criminal justice processes, not health care. We do not understand why reference is not made (here or elsewhere in this section) to NICE guidance on mental health in people with learning disabilities.	Thank you for your comments. The Committee have made reference to all relevant NICE Guidelines in the first recommendation. In this text we have expanded on the terminology, highlighting that in this guideline mental health problems encompasses neurodevelopmental disorders such as learning disability and autistic spectrum disorders. A 'vulnerable' adult can have an appropriate adult with them (see http://www.appropriateadult.org.uk/index.php/practice/faqs), therefore we have kept the text as is.
113.	SH	Foundation for People with Learning Disabilities	Full	108	12-13	We agree with the emphasis on communication skills.	Thank you for your comment
114.	SH	Foundation for People with Learning Disabilities	Full	108	15-16	We note the point about understanding the relationship between offending behaviour and mental health, and developing alternative adaptive strategies. This will be equally applicable to people with learning disabilities, but the issues may be different. We return to our question in comment 1 and the need to be clear about the population this guideline is intended to cover.	Thank you for your comment. The scope of this guideline includes all people with neurodevelopmental disorders. We have amended the introduction to ensure this is clear from the onset.
115.	SH	The British Psychological Society	Full	110	20	The recommendations should include a directive to work with Forensic Psychologists and Offender Managers, when completing assessments. Within the CJS the expertise exists within these groups and other staff groups completing assessments of risk should be directed to collaborate with these professionals.	Thank you for your comments. The Committee have addressed the points you raised in recommendation 1.3.12 by highlighting the collaborative nature of the assessment which would include the contribution of all people involved, including Forensic Psychologists and Offender Managers.
116.	SH	Foundation for	Full	110	20	We are puzzled that the recommendations start with reference	Thank you for your comments. The

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		People with Learning Disabilities				to "people with learning disabilities and mental health problems". We wonder whether the GC means "people with mental health problems, including those who also have learning disabilities"? The current phrasing seems to exclude people with mental health problems who do not have learning disabilities and we do not believe this is the intention.	Committee agree and have reviewed recommendation 1.1.1 and changed it to specify for people with mental health problems, including neurodevelopmental disorders to make it clearer.
117.	SH	Inclusion London	Full	117	-	Interventions We would support the provision of counselling and psychotherapy for those that are interested.	Thank you for your comment. Unfortunately the Committee were not able to make any recommendations about the most effective interventions to improve mental health and wellbeing because there was very limited evidence available.
118.	SH	Inclusion London	Full	117	-	We recommend that healthcare professionals are aware of/refer to the support provided by Deaf and Disabled People's Organisations and charities that provide services or support available to people with mental health support needs in prison.	Thank you for your comments. Unfortunately we are not able to signpost or refer to particular support organisations.
119.	SH	The British Psychological Society	Full	117 onwards (Section 6)	38	It is positive that a range of treatment options for addressing sexual offending risk has been considered (including more recently introduced initiatives such as the polygraph). However, there is very brief reference to CBT approaches, which is surprising given that this is the mostly widely used (and researched) approach to sexual offending treatment. Nevertheless, the robust approach to the development, delivery and evaluation of sexual offending behaviour programmes by the National Offender Management Service (NOMS) is acknowledged. While medication is considered in the context of paraphilia research the review does not consider existing large scale research in this field – e.g. by Belinda Winder and colleagues (Nottingham Trent University) as part of the Offender Personality Disorder Pathway funded MMSA (Medication for the Management of Sexual Arousal) programme. That said, the review does consider the relevance of Personality Disorder in the offending population in other sections.	Thank you for your comment. The studies about paraphilia that were identified by our literature search and what they showed are documented in the evidence sections of the guideline. The interventions covered were determined by the evidence that was found. We have not been able to identify the study by Prof Belinda Winder that you mention - it may be that it is not published. NOMS did not agree to a GC request to release relevant reports or data from the outcome of their Sex Offender Treatment Programme. Given the absence of evidence from the NOMS programmes and the uncertainty about the evidence reviewed, in particular the UK evidence, the GC decided to make

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						The consideration of environmental adaptations does not consider evidence related to family support and visits in promoting wellbeing. http://tva.sagepub.com/cgi/reprint/1524838015603209v1.pdf?ijkey=WSRPViY1xKsRidg&keytype=finite	no treatment recommendations about interventions for people with paraphilic disorders.
120.	SH	Centre for Mental Health	Full	118	1 (whole section)	Interventions. Leaving custody is an extremely high risk time for people with mental health problems. This should be treated as a time of crisis for people leaving custody and support put in place as a step-down approach either from probation services or health services as appropriate. Support workers with a role in helping people engage with services (health and social care) post police custody and court are currently being piloted in Liaison and Diversion Services in England (covering 70% of the population). This could and should be replicated for people leaving custody that have mental health problems. (Mental health and criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016)	Thank you for your comments. The Committee agree that, for some people, leaving custody can cause some problems. We have addressed these in recommendations regarding transition and information sharing. We have amended recommendation 52 (1.8.1 in the short guideline) to include supporting prompt access to appropriate treatment and care (including medication). Recommendation 54 (1.8.4 in the short guideline) refers to the importance of information sharing when people move between services, this would include release from custody. It is not the usual practice for guidelines to make recommendations about specific professional groups, but more about the experience and competence needed to deliver the interventions.
121.	SH	Centre for Mental Health	Full	118	1 (whole section)	Individual placement support (IPS) could enhance peoples' chances of obtaining employment on leaving custodial settings and therefore be an extremely cost effective intervention relative to how much it would cost to implement (Supporting offenders into employment: a briefing note, *Centre for Mental Health*, 2013)	Thank you for your comment. The evidence on IPS intervention for quality of life, mental health outcomes and substance misuse outcomes was of low quality and inconclusive for the population of interest. The Committee

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							did not think that there was sufficient evidence to recommend the intervention, even though there was evidence from 1 low quality study conducted in the USA that people in the IPS intervention group were more likely to get a competitive job placement. No economic evidence on the IPS programmes in adults with mental health problems who are in contact with the criminal justice system was identified by the systematic search of the economic literature undertaken for this guideline. Briefing notes are not the best type of evidence source to answer the review question posed in the guideline and hence we have not considered the reference you provided.
122.	SH	Centre for Mental Health	Full	118	38	Review question '… effective interventions to promote health and well-being …'. This should be the responsibility of all staff working within criminal justice settings and should not just be the responsibility of a visiting service (a mental health service) but also that of the host service (e.g. a prison and its staff and management). The current default NHSE commissioned model of mental health care is the 'Stepped Care Model', non-health services have a role in the lower steps and need to understand and sign up to these. The Ministry of Justice, Department of Health, NHS England and the Welsh Assembly should jointly work towards all prisons achieving the Royal College of Psychiatrists' Enabling Environments standards. This could include a far greater role for service user involvement including peer mentoring type interventions to support prisoners with	Thank you for your comment. Unfortunately the Committee were not able to make any recommendations for clinical practice on the effective interventions to promote health and well-being for adults in contact with the criminal justice system as the evidence was of such low quality. Because we were unable to make any recommendations on effective interventions, we did not consider it appropriate to make recommendations about who would be most effective at delivering such interventions. It is not

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						vulnerabilities, and it should include training of mentors and research into its impact. (Mental health and criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016)	within the remit of a guideline to make recommendations on policy issues
123.	SH	Royal College of Psychiatrists	Full	118 to 241	-	As a sourcebook, chapter 6 is invaluable, as guidance it is less so. Service commissioners, providers, clinicians and others would be better helped if the data could be synthesised to provide answers to a number of key questions – some but not all of which are set out in the introduction to the chapter on page 118; it is important to define the aspects of the criminal justice system which might render the effects of some interventions different there from the way they impact in the health service, but we can't find this list. It would help to have a complementary section at the end of the chapter with answers, as far as possible, to those questions: 1. Which clinically effective interventions for recognised clinical disorders have different effects (positive nad potentially negative) within *prisons*, what are those differences and how may they best be managed? 2. Which clinically effective interventions for recognised clinical disorders have different effects within *community criminal justice settings*, what are those differences and how may they best be managed? – at present reference is only to 'the criminal justice system – but the issues are different between locked institution and the community – elements of coercion may apply in both, while being different from those for patients detained in hospitals; relevant social-environmental differences are considerable. 3. Given the limits to resources and the fact that there is a substantial difference in availability of interventions around the country, it would help to have an informed discussion about minimum standards for availability. This would be likely to provide a lever for mental health in-reach services and prison governors to ensure that	Thank you for your comments. 1 & 2 The Committee were aware of the potential challenges of implementing a number of NICE recommended interventions in the prison. Our approach has been reflected in a number of recommendations (see recommendations 1.6.4-1.6.6 for the management of personality disorder and recommendations 1.7.2 – 1.7.3 for the management of specific pharmacological interventions. Unfortunately we were unable to find any high quality evidence on effective interventions and so are unable to make recommendations to the level of detail that you suggest in points 1 and 2. 3. You make reference to minimal standards for availability. The purpose of this guideline is not to make recommendations for minimal standards of care but to recommend what high-quality care looks like, based on the best available evidence.

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						services in every prison at least reach these standards. What is essential to health and safety? What is important because it would variously substantially improve quality of life and, in the longer term, help reduce the risk of re-offending? What is desirable because it would improve quality of life? 4. The guidance should make clearer the extent to which improvement in quality of life – and we think 'promotion of mental health and wellbeing' referred to in the section starting on page 118 – is important. This perhaps means making the cost-effectiveness calculations more inter-interventional. Given the resource constraints in prisons and elsewhere in the criminal justice situations, slightly if significantly enhancing wellbeing seems a luxury that is unaffordable, but if that enhancement in wellbeing were to be associated with substantially lower self-harm rates, or substantially lower risk of clinically significant depression, then its relative value would push it up the hierarchy of what should be delivered. 5. It is arguable, but it would be important to see evidence not cited here, that a) treatment is almost exclusively available for people in contact with the criminal justice system and b) that while treatment may be widely available in the NHS, nevertheless many people with some conditions may only get treatment for them in the criminal justice system. Sex offending is likely to be an example of the former and various forms of substance misuse the latter. Such variables should be factored into an algorithm of which interventions should be assured in prison and which would ideally be available, having allowed for other factors such as health and safety.	4. As you will see from the Linking Evidence to Recommendations section associated with these recommendations, the Committee did not think there was sufficient evidence to make a recommendation about promotion of mental wellbeing across the criminal justice system. We agree if there had been evidence on cost effective approaches to this we would have made a recommendation. 5. We think that a broad range of interventions should be available across the criminal justice system including interventions for sex offenders. We did not think any algorithms that might inform treatment choice or decision making would be appropriate. We felt it would be best left to the services to determine the care delivery as set out in recommendations 1.8.1 and 1.8.4. 6. There are currently 2 NICE Guidelines on the treatment of Antisocial Personality Disorder (CG 77) and Borderline Personality Disorder (CG 78). There was little evidence outside what had been included in these guidelines that related to the criminal justice system. It was not within the scope of this guideline to update the recommendations for treatment in those existing guidelines. The

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						6. The sections on personality disorder are weak and inconclusive. It does not help that they are divided between an unaccountably short section on antisocial personality disorder on pp178-9 separated by many pages from a section on personality disorder other than antisocial or borderline personality disorders on page 235, although we do think that it is really valuable to highlight the issue that people in the criminal justice system are likely to have the full range of personality disorders – not just those of an antisocial or borderline type. Given that the prevalence of personality disorder among criminal justice system users is many times higher than that of major mental illness, but suicide rates are comparable and violence to others rates higher, this seems like a grave omission. 7. At the very least, it would be important to consider the evidence that personality disorder has an impact on everyday functioning in a prison and how it may influence the dynamics in ordinary and healthcare locations. It would, therefore, also be important to consider the evidence that interventions to support staff in managing people with personality disorder are deliverable, acceptable and effective. Reflective practice, for example, tends to be the first casualty even in a healthcare setting when the service is very busy – so such interventions may not be easily deliverable; some prison staff may cope by avoidance of reflection – so interventions to help with this not immediately acceptable; the effectiveness of such interventions would perhaps be for the stereotypical but thorough review pattern adopted by the guidelines committee. 8. On a more minor point, rigorous proof reading will be necessary before the final draft – for example on page 198, the central sentences of the section on substance	approach we took was to a) provide advice on the general management and engagement of people with personality disorder into treatment programmes and b) to reinforce the use of existing NICE Guidelines. 7. The Committee agree and feel that these issues are addressed in recommendations 1.6.3 – 1.6.6. 8. We have amended the text throughout the guideline to aid clarity.

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						misuse were not comprehensible.	
124.	SH	Foundation for People with Learning Disabilities	Full	118	11-22	We agree that interventions may well need adaptation for use in criminal justice settings. As noted in relation to personality disorder, interventions may also need to be adapted for people with learning disabilities (and the issues noted in relation to personality disorder may be very similar). Here again it is surprising that there is no reference to the NICE guidance on mental ill health in people with learning disabilities.	Thank you for your comment. We have included a list of relevant NICE guidelines at the start of the full version and have cross-referenced this list in chapter 6.
125.	SH	Foundation for People with Learning Disabilities	Full	130	5	Here there is reference to challenging behaviour that may be related to a person's learning disabilities. Yet there does not seem to be a link given in this section to the NICE guidance on challenging behaviour in people with learning disabilities, nor (again) to the NICE guidance on mental ill health in people with learning disabilities. The studies described further on in this section do not seem to include research on 'what works' for people with learning disabilities who also have mental health problems in criminal justice settings, e.g. adapted programmes relating to anger, sex offending, substance misuse.	Thank you for your comment. We have included a list of relevant NICE guidelines at the start of the full version and have cross-referenced this list in chapter 6.
126.	SH	Centre for Mental Health	Full	197	Rec 37	Transfer from prison to psychiatric care needs to happen faster. This is not mentioned in current recommendations. Transfers to hospital remain a major problem in many prisons, with delays of 3-4 months frequently reported, especially when seeking an 'out of area' bed. (Mental health and criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016). We would wish to see Lord Bradley's recommendation of a 14 days' maximum period for achieving transfer, but that this be from time of referral and not assessment (as considerable delay can take place between a prison mental health team referring to NHS commissioned care outside the prison e.g. secure mental health care). We received evidence of marked decline in mental wellbeing in referred prisons (Mental health and criminal justice: Views from consultations across England and Wales, Centre for Mental Health, 2016).	Thank you for your comments. The Committee agree that there are issues which cause delays for people accessing inpatient psychiatric care when being transferred from hospital. However, transfer times between prison and hospital is within the remit of the Ministry of Justice and consequently it is not possible for this guideline to make recommendations on this issue.
127.	SH	Centre for Mental Health	Full	197	Rec 37	Findings from our recent review found: the availability of psychological interventions (via both prison primary mental	Thank you for your comments. The Committee agree there are challenges

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						health care and prison secondary mental health care) appears to be a relatively rare commodity if the 17 expert consultation events across England & Wales events (attended by over 200 people) were representative. A few of the prisons had either clinical psychologists or nurses with significant training in delivering psychological interventions, and were able to make a significant psychological intervention offer. However most were not so resourced and could not. Psychological interventions need to be more widely available. This may require a change in skill set amongst mental health teams within criminal justice system and in a way that reduces the chances of re-traumatising people with mental health problems. Evidence based psychological interventions adapted for the, often complex, needs of people leaving prison should be available via community IAPT services and made available in a timely fashion (Mental health and criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016)	with implementation of recommendations for various reasons including staffing levels and the impact of treatment setting. The focus of this guideline is to ensure that all people who have mental health problems and are involved in the criminal justice system receive the best care and treatment. Specific implementation of the recommendations is outside the scope of the guideline and falls under the authority of local services.
128.	SH	Janssen Cilag ltd	Full	197	-	We are concerned that there is no specific recommendation concerning the use of pharmacological interventions in schizophrenia within the draft clinical guideline. We suggest that a recommendation, similar to recommendation 1.7.2 for attention deficit hyperactivity disorder (ADHD), is added for schizophrenia. Janssen note that specific recommendation for prescribing of pharmacological interventions in ADHD is based on existing NICE Clinical Guideline (CG) 72, but this does not appear to be based on any specific evidence in the forensic setting and evidence for this recommendation is of low quality. We realise that there is limited evidence for schizophrenia pharmacological interventions in a forensic setting too. However, it has been suggested that there is no reason to believe that response or efficacy of pharmacological intervention are likely to differ between a forensic or general clinical schizophrenia populations [Stone et al]. We therefore suggest that a similar recommendation for use of pharmacological interventions in schizophrenia based on the	Thank you for your comments. The Committee agrees on the importance and relevance of effective treatment of schizophrenia in adults in contact with the criminal justice system. We have not developed any condition specific recommendations in this guideline. We do recognise the importance of the effective treatment of schizophrenia and therefore have directed people to specific NICE guidelines for advice on treatment and management of this condition, as in recommendation 1.7.1. We have mentioned ADHD, along with sleep problems and chronic pain in 1.7.2 because of GCs knowledge and experience about the potential harms which may be associated with under or

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						NICE CG 178 should also be included in the current draft clinical guideline on the same basis. We believe that specific recommendation for the use of pharmacological interventions in schizophrenia is important to include, in order, to tackle the significant burden that schizophrenia places on the mental health system and adults in contact with the criminal justice system. It is estimated that around 9% male remand prisons, 6% of male sentenced prisoners and 13% of female prisoners have schizophrenia disorders [Singleton et al]. This equates to 7,312, 4,875 and 499 people respectively out of a total population of around 85,082 patients based on the September 2016 prison population data [Population and Capacity Briefing]. The burden of schizophrenia on the criminal justice system is therefore significant. A recommendation around the use of appropriate pharmacological interventions based on NICE CG 178 would ensure more appropriate prescribing of antipsychotics in a forensic setting and improve patient care. It would also help address the burden of schizophrenia, especially the cost of forensic beds which cost the NHS an estimated £1.2bilion in England or around 18.9% of all public expenditure on adult mental health [Centre for Mental Health].	inappropriate use of the pharmacological interventions used for these disorders. We did not identify any evidence that these problems exist for the pharmacological interventions widely used for schizophrenia. We have not been able to identify a reference for the Stone paper that you cite and are therefore unable to comment on whether or not it met the inclusion criteria for our review question What interventions are effective, or what modifications are needed to psychological, social, pharmacological or physical interventions recommended in existing NICE guidance, for adults in contact with the criminal justice system.
129.	SH	Janssen Cilag ltd	Full	198 to 199	-	The license for paliperidone palmitate has been incorrectly described as being 'only for people who had previously responded to responsive to paliperidone or risperidone.' The statement does not take into account that paliperidone palmitate can be used in people without prior stabilisation with oral treatment. The license for paliperidone palmitate is *Xeplion is indicated for maintenance treatment of schizophrenia in adult patients stabilised with paliperidone or risperidone.* *In selected adult patients with schizophrenia and previous responsiveness to oral paliperidone or risperidone, Xeplion*	Thank you for your comment. The text has been updated to reflect that the current license of paliperidone palmitate is primarily for those stabilised with paliperidone or risperidone. The Committee did not make a specific recommendation for paliperidone palmitate as they did not think that the evidence was of sufficient strength to support any recommendation. Therefore we direct people to other

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						may be used without prior stabilisation with oral treatment if psychotic symptoms are mild to moderate and a long-acting injectable treatment is needed. We suggest that the wording is updated to reflect the license of paliperidone palmitate. We ask that paliperidone palmitate should be considered as an effective treatment for managing schizophrenia in patients who have been in contact with the criminal justice system based on the Alphs et al study [Alphs et al].	specific NICE guidelines for advice on treatment and management of these conditions, as in recommendation 1.7.1. We have not been able to identify a reference for the Alphs paper that you cite and are therefore unable to comment on whether or not it met the inclusion criteria for our review question What interventions are effective, or what modifications are needed to psychological, social, pharmacological or physical interventions recommended in existing NICE guidance, for adults in contact with the criminal justice system.
130.	SH	Janssen Cilag ltd	Full	198-199		The current wording around the use of depot medicines in the draft full CG focus on the 'potential harms', as opposed to the benefits of depots in the management of schizophrenia. Depots should be considered as one of the many options in the treatment schizophrenia, as outlined in NICE CG 178. We are concerned that the current wording stigmatises patients that are receiving depot and does not adequately represent the appropriate balance between the harms and benefits of taking depots. NICE CG178 notes the benefits of using depots appropriately within the treatment pathway, especially when dealing with non-compliance. It has been suggested that depots could be considered a first line option to combat non-compliance in a forensic setting [Stone et al]. We therefore believe that wording should be revised to reflect recommendation 1.5.5.3 in NICE CG178 which outlines the role that depots can play in people who would prefer such treatment after an acute episode and where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the	Thank you for your comment. We have not developed any condition specific recommendations in this guideline. Instead we direct people to other specific NICE guidelines for advice on treatment and management of these conditions, as in recommendation 1.7.1. We have removed reference to social withdrawal

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						treatment plan	
131.	SH	Janssen Cilag ltd	Full	198-199		We suggest that there is clarification around the sentence that depots lead to 'social withdrawal', as no evidence is cited to support this statement in the draft clinical guideline. We are not aware of any evidence that suggest that depots lead to greater social withdrawal within a forensic setting. We suggest that the sentence should be clarified or removed from the section.	Thank you for your comment. We have removed reference to social withdrawal.
132.	SH	Shire Pharmaceutical limited Ireland	Full	198	-	In relation to the risk of onward sale of methylphenidate, we refer the guideline committee to the chapter of the UKAAN Consensus Statement which covers 'the delivery of drug treatments within the prison setting and abuse potential'. (Young eg al. The identification and management of ADHD offenders within the criminal justice system: a consensus statement from the UK Adult ADHD Network (UKAAN) and criminal justice agencies. BMC Psychiatry 2011, 11:32 http://www.biomedcentral.com/1471-244X/11/32).	Thank you for your comment. We note that the reference did recognise onward sale and abuse of the drugs and factors that may be associated with the misuse of the drugs. The Young et al (2011) paper was found by our searches but is a consensus statement and for this reason did not meet our inclusion criteria for evidence.
133.	SH	Foundation for People with Learning Disabilities	Full	201 to225	General	We did not see any reference to the literature on adapted sex offender treatment programmes for people with learning disabilities.	Thank you for your comment. Unfortunately the Committee were unable to find any research into the adapted sex offender treatment programme. When completing the evidence search we did not exclude any of this research, however, we were unable to find any evidence which we could comment on.
134.	SH	Centre for Mental Health	Full	235	22	Antisocial and borderline personality disorders have been excluded for the purpose of the review question. Therefore it is not clear if the following recommendations are intended to include these populations. Given that these would make up the majority of the personality disorder populations within criminal justice settings this needs to be clarified as could indirectly exclude a substantial population from being offered or accessing support.	There are existing NICE guidelines on Antisocial personality disorder (CG 77) and Borderline personality disorder (CG 78) which cover the criminal justice system population. Therefore we did not include them in this review question and focused on other personality disorders instead. However we found very little evidence and were only able to recommend some general

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							principles around dealing with personality disorders. It is likely that these would be appropriate for people with antisocial personality disorder and borderline personality disorder too
135.	SH	Centre for Mental Health	Full	242	19	A psychologically informed approach to working with offenders, can be seen as one which seeks to understand the motivations and thinking of the person (and indeed to help the person in question understand their own mentalisation and that of others), and where such knowledge informs how staff members react and respond both through day-to-day communication and through specific therapy. Developing such an understanding can allow workers to be proactive. Again, this understanding and training in it should be available to all those working in direct contact with people in the justice system (health and justice staff) (Mental health and criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016)	Thank you for your comment, the Committee agrees. Recommendations 1.9.2 and 1.9.3 aim to ensure that appropriate training is provided to all people working in the criminal justice system. Recommendation 1.9.4 highlights the needs for specific supervision for those who have ongoing direct work with adults with mental health problems in the criminal justice system.
136.	SH	Centre for Mental Health	Full	242	1 (whole section)	Silo working and poor information exchange have long been a complaint of all agencies working in criminal justice and in particular in the prison estate. However, in recent years there have been significant improvements. It was reported that the transfer of health information between prisons was seen as a much less difficult issue since the introduction of the TPP SystmOne electronic information system, which provides transfer of health information between prisons. Further development of systems that allow different teams to share information such as assessments. This will enable teams to have a better understanding of the person prior to their arrival and can help reduce the need for taking repeated histories and would improve continuity of care for the person. SystmOne could also be further developed to encompass phases 'in' and 'out' of the criminal justice system and link directly to other organisations such as NHS mental health systems to ensure continuity of care. (Mental health and	Thank you for your comments. The Committee agreed that repeated assessments are not of value and have tried to reflect this in the wording of recommendation 1.8.4. Unfortunately it is outside the remit of this guideline to make recommendations about how SystmOne could be further developed

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						criminal justice: Views from consultations across England and Wales, *Centre for Mental Health*, 2016)	
137.	SH	Centre for Mental Health	Full	242	1	Skill mix of staff needs to be carefully considered to ensure that mental health problems can be recognised including learning disability, attention deficit disorder, autism spectrum disorder and acquired brain injury. The Disabilities Trust Foundation conducted the largest ever UK research study into the prevalence of brain injury with an adult male prison at HMP Leeds. The study showed that routine screening, coupled with increased awareness, staff training and effective support could prove vital to reducing recidivism. Through the help of a band 3 healthcare assistants, a six question screening questionnaire was conducted within 48 hours of admission to the prison for every new arrival over a six month period (The association between neuropsychological performance and self-reported traumatic brain injury in a sample of adult male prisoners in the UK, *thedtgroup*, 2016).	Thank you for your comments and the information about the trial in HMP Leeds. The first stage assessment which should be carried out at first arrival into custody is a screening tool for a variety of mental health and physical health needs. The Committee were concerned about the identification of cognitive impairment in adults in the Criminal Justice System, and so have made a research recommendation to highlight this point ("What are the reliable and valid tools to identify cognitive impairment among people in contact with the criminal justice system (including people who have experienced physical trauma, neurodevelopmental disorders or other acquired cognitive impairment). It is not within the remit of this guideline to comment on the skill mix of staff. The study you cite did not meet our inclusion criteria because it was about the prevalence of traumatic brain injury rather than mental health problems
138.	SH	Foundation for People with Learning Disabilities	Full	242	3-22	We agree with the description of fragmented services, with poor awareness and communication across agencies. We agree that the developments described are helpful, though we believe much more needs to be done to raise awareness around people with learning disabilities and to offer reasonable adjustments. We are pleased that learning disability co-ordinators or nurses have been appointed in some prisons and look forward to these roles being properly researched.	Thank you for your comment. We agree that adjustments may be needed in order for people with learning disability to access support and services. We have included reference to reasonable adjustments in recommendation 1.2.3 in light of this point.

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139.	SH	Foundation for People with Learning Disabilities	Full	242 to 312	-	This section does not make any mention of the specific needs of people with learning disabilities and the reasonable adjustments required in mental health care plans, pathways, assessments and interventions. We suggest that again the NICE guidance on mental ill health in people with learning disabilities should be referenced.	Thank you for your comment. We have included a list of relevant NICE guidelines at the start of the full version and have cross-referenced this list in chapter 7.
140.	SH	Prison Reform Trust	Full	242 to 312	-	No reference is made, in this section, to the specific needs of people with learning disabilities or autism and the reasonable adjustments required in health care plans, pathways, assessments and interventions. We suggest the NICE Guidelines on mental ill health in people with learning disabilities and on people with autism are referred to in this section.	Thank you for your comment. We have included a list of relevant NICE guidelines at the start of the full version and have cross-referenced this list in chapter 7.
141.	SH	Royal College of Psychiatrists	Full	242 to 317	-	1. The service delivery – or perhaps better: 'service framework' – chapter (7) conflates pathways and models we think it would be helpful to separate these; we also wondered whether therapeutic community approaches (page 274) would be more appropriately dealt with as interventions. 2. There are substantial differences between pathways which are completed within one lead service (e.g. the criminal justice system with a little health input), pathways which involve substantial movements between health and criminal justice and pathways which involve true partnership throughout – it would be helpful to consider these models separately. 3. There seems an imbalance in this chapter between the evidence for effectiveness section and the economic evidence. This may reflect a reality – that there has been insufficient attention to effectiveness in some areas – in which case this should be explicit, because	Thank you for your comments. 1. The Committee took the view that the key elements that support effective service delivery was the development of pathways to link Mental Health and Criminal Justice services. Given the limited evidence for many models of care we took the view not to make recommendations in most cases, but did so for some models of care, such a liaison and diversion. 2. Given the limited evidence we have been wary about being over specific about pathways which may impact on services' abilities to develop effective pathways based on local needs and services. 3. The Committee agree that there is limited evidence in

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						the guidance should provide, amongst its functions, a stimulus to future research. Some service routes – like the mental health treatment requirement, which it is recognised is underused – is conspicuous by its absence from this chapter, and again it is worth drawing attention to this as an area which needs more investigation. 4. There seems to be such a scatter-gun approach to services in this section, that it may be helpful to define more tightly the parameters of this chapter. While the guidance overall is about 'adults in contact with the criminal justice system' – because of the breadth of areas considered, it is sometimes difficult to lose sight of this, and particularly so in the service model section. Accepting that diversion implies moving people from criminal justice to other services – here mainly mental health services – we think the core reference point otherwise is to people who continue to have a criminal justice system affiliation, whether primarily supervised/cared for by criminal justice staff or jointly with health service staff, and it would be helpful to be explicit about that – otherwise some of the sections – like that on medium security hospital units (page 297) appear to have missed relevant studies. 5. We have concerns that the economic sections are insufficiently critical – for example, it would be extremely surprising if the men placed in inpatient medium security hospital conditions were strictly comparable to men placed in a housing association project (page 297) – if they were, that should be explicit; if not that should be considered in relation to cost-effectiveness. 6. The concept of 'impatient security' is delicious! (page 297, line 20 x2). 7. There should be some consideration of guidance on	many areas and we have made a number of research recommendations to reflect this ("What is the effectiveness of structured clinical (case) management in improving mental health outcomes using interventions within probation service providers?" and "What models for the coordination and delivery of care for people in contact with the criminal justice system provide for the most effective and efficient coordination of care and improve access and uptake of services?"). 4. The Committee do not agree that a scatter gun approach has been adopted. We searched for all evidence and what we present is the best available evidence which would inform care and care pathways. We know this is a less than complete picture and so our recommendations have been developed to reflect this rather than specific models of care where there is uncertainty. 5. We have amended the text to clarify the setting. 6. We have amended this grammatical error. 7. Unfortunately we are unable to

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						joint funding of services where joint working is recommended.	make any recommendations regarding this as funding is outside the remit of a NICE guideline.
142.	SH	Rethink Mental Illness	Full	312–313	17	Section 7.3 Recommendations and links to evidence • Recommendation 49: The potential benefits of people with substance abuse issues being referred to a specialist therapeutic community is noted in this section. Consideration should be given to expanding this method of treatment beyond substance abuse to other conditions, such as those with personality disorders, as is currently in development with the Offender Personality Disorder pathway We would welcome the development of the therapeutic community model in secure services and other settings outside of prisons. At present, this treatment does not exist in secure services, so patients with substance misuse and co-morbid conditions, such as personality disorders are unable to access the benefits of this form of treatment. It patients were able to access this intensive, psychologically informed treatment, either in prisons or elsewhere, the overall number of people receiving treatment in more expensive secure care settings would be reduced. • Recommendation 50: If therapeutic community programmes were expanded to cover people with other conditions, such as personality disorders, their treatment should also aim to deliver the criteria set out in this section for people with substance abuse problems. Staff would need to be appropriately train to treat people with other conditions in this setting. • Recommendation 51: This recommendation sets out	Thank you for your comments. Recommendation 49: The available evidence only supporting making a recommendation for therapeutic communities specifically for people with substance misuse problems. We did not have sufficient evidence to support expanding the recommendation to people with other conditions. Thank you for your support. Recommendation 50: As stated above – we did not have sufficient evidence to support expanding the recommendation to other conditions. Recommendation 51: The Committee did not have sufficient evidence to support making recommendations of the kind you suggest.

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						the need to develop systems for police and court custody to that properly identify, assess and treat mental health problems. Of particular importance in this area is that there is currently no mechanism to divert people from a the Courts to secure healthcare services without being initially remanded in prison. As a result, individuals can spend significant periods of time in prison prior to being transferred to secure services when their need for care in this setting has been identified. Given how detrimental prison can be to the health and recovery of someone with a severe mental illness, robust identification of these conditions should take place prior to a Court hearing. Whilst recognition of the need to provide advice on immediate care and management is welcome, signposting to appropriate services is equally valuable. Police should be trained to identify severe mental illness and be confident in referring an individual to a through assessment by appropriately trained Health Care Professionals (HCPs) within police stations. This would allow an individual's need to be identified and appropriately treated in a healthcare setting, such as secure care, as soon as possible. • Recommendation 53: Establishing joint working arrangements between healthcare, social care and police services for managing urgent and emergency mental health is a positive objective, but this process should be informed by users. The co-production model should be used to ensure that user involvement is appropriately embedded. • Recommendation 54: The effective identification, assessment, coordination and delivery of care for all	In response to your comments about training, the Committee agree and have made some recommendations about training precisely to address the points you raise (see recommendations 1-4). Recommendation 53: The Committee think this is important suggestion and one we support, but it is for local services to include co-production models. Recommendation 54: We have amended recommendation 34 to include reference to Care Programme Approach. This recommendation also highlights the importance of reviewing care plans and sharing information between services to support effective management of the care plan. Recommendation 55 also discusses the importance of sharing care plans and having clear pathways to support effective transition between services.

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						people with a mental problem that come into contact with the criminal justice system should be led by a care coordinator. The Care Programme Approach (CPA) model should be used to ensure that the objectives in this recommendation are met. During transitions between services, it is vital that outcomes based care plans should be reviewed regularly with appropriate and well planned coordination. Information sharing needs to improve (as acknowledged in Section 2.4, page 22, lines 46-52), particularly between primary care, secondary care, local authorities and the police. The latter, for example, should also know when an individual has recently been discharged from a secure service. Transitions between services that are commissioned by different organisations should be carefully managed through the CPA. For example, when an individual is released from prison or moves from a nationally commissioned secure service to locally commissioned supported housing, all information relevant to their circumstances should be shared as part of that transition. Although effective protocols need to be in place to ensure data is shared effectively, the individuals involved in these protocols from different agencies need to be specified, both in principle and at the point when a person with a mental health condition comes into contact with the criminal justice system and moves into another setting. It also needs to be clear which individual, at which agency, is responsible for owning these protocols and ensuring that they are followed. In the case of a person leaving prison or a secure service, this person should always be a HCP.	

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143.	SH	Foundation for People with Learning Disabilities	Full	317	3-19	We agree that more research on co-ordination models would be valuable.	Thank you for your comment.
144.	SH	Prison Reform Trust	Full	317	2	Research recommendations: we strongly suggest that research into the specific and particular needs of women with mental health problems, learning disabilities or autism in contact with criminal justice services be added to further research recommendations.	Thank you for your comments. The Committee agrees with the importance of the particular needs of specific populations within the Criminal Justice System. In light of this we have developed an additional research recommendation "3. What is the prevalence of mental health problems and associated social problems for those in contact with the criminal justice system". This research will hopefully identify if there are specific needs for any particular groups e.g. women
145.	SH	Public Health England	Full & Short	General	General	Who is responding: PHE Health & Justice, consulting with other expert teams across our organisation, are leading the response to this document. We have close working relationships with other groups responding separately to this consultation including NHS England Health & Justice Clinical Reference Group and the RCGP Secure Environments Group. We also work closely with justice partners, including the National Offender Management Service and the Home Office. Therefore, our response includes reflections from our partners as well as our own. Further, we have significant experience in implementing health improvement, health promotion and health protection services in prisons in collaboration with our partners and understand fully the operation and policy context in which such programmes are being delivered currently and in the near future. Finally, as the UK Collaborating Centre to the WHO Health in Prisons Programme (WHO HIPP), we have a working knowledge of international evidence and practice in relation to the mental health of people in prisons and are currently	Thank you for your comment and providing information on who is leading your response to the consultation documents.

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						working with the WHO on a minimum public health dataset for prisons which will include metrics relating to mental health needs and services in prisons in European Region of WHO.	
146.	SH	Public Health England	Full & Short	General	General	Descriptor for population of interest: we welcome the use of the phrase 'people in contact with the criminal justice system' rather than 'offender' in the title and throughout the document as this puts the person first rather than the condition of having committed an offence. This helps to challenge stigma and social exclusion both of which are factors which can be barriers to care and negatively impact on mental health. We encourage consistent use of this descriptor where possible throughout the final guidance and in subsequent briefings or publications issued by NICE.	Thank you for your support
147.	SH	Prison Reform Trust	Full & Short	General	General	The Prison Reform Trust welcomes the opportunity to comment on this important Guideline. The task of addressing the mental health of adults in contact with the criminal justice system is significant. The title of the document is, however, misleading. Although entitled 'mental health', the Guideline also includes people with a learning disability and people with autism. This is confusing not only because learning disabilities and autism are not mental health problems, but also because individuals reading the Guidelines, including criminal justice personnel, are used to a distinction being made between individuals with mental health problems and those with learning disabilities or autism. Further, individuals concerned about people with learning disabilities or autism in contact with criminal justice services are unlikely to refer to this Guideline, believing – as the title states – that it refers to people with mental health problems only. We strongly suggest that the title of the Guideline is amended accordingly and a clear statement made about which conditions are covered by the Guideline. Further, throughout the Guideline the emphasis is on mental health. If the Guideline does include other conditions, equal emphasis should be made throughout; as the Guideline currently stands, that is not the case.	Thank you for your comments. We have amended the introduction to make it clearer from the onset who this guideline is intended for.

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148.	SH	Prison Reform Trust	Full & Short	General	General	In response to your questions: 1. *Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why:* routine and systematic identification of support needs and provision of support and treatment in a timely way. Frontline health staff frequently work under pressure of time with little opportunity to engage in a meaningful way with their patients, and can find it hard to secure service provision for individuals in need as oppose to adding their name to a waiting list. Joined up working across health, social care and justice, shared staff training and support for staff, and services commissioned to accommodate the need for such working arrangements would help to support implementation of these Guidelines (see, for example the Good Lives model, Essex County Council). 2. *Would implementation of any of the draft recommendations have significant cost implications?* The draft recommendations seek to ensure necessary treatment and care, equal to that received by individuals in the general population. 3. *What would help users overcome any challenges?* See answer to Q 1.	Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned'
149.	SH	The British Psychological Society	General	General	General	<u>References</u> Cook, L and Borrill, J (2013) Identifying suicide risk in a metropolitan probation trust: Risk factors and staff decision making, Legal and Criminological Psychology, 20(2), 193-383, DOI: 10.1111/lcrp.12034 Forrester, A., Maclennan, F., Slade, K., Brown, P. and Exworthy, T., 2014. Improving access to psychological therapies in prisons. Criminal Behaviour and Mental Health, 24(3), 163-168. Forrester, A., Samele, C., Slade, K, Craig, T and Valmaggia, L.	Thank you for providing these references. Cook and Borrill (2013), Slade (2016) and Forrester et al (2016) were included as evidence in the guideline. The Long (in press) study would not have been published before our cut-off date for inclusion of evidence. Pratt et al (2006) did not meet the inclusion criteria as it was an

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						(2016). Suicide ideation amongst people referred for mental health assessment in police custody. Journal of Criminal Psychology. ISSN 2009-3829 [forthcoming] Long, C (in press, 2016) *Realising the potential of the Mental Health Treatment Requirement: a collaboration between probation and a provider of mental health and social care,* Probation Journal. Pratt, D., Piper, M., Appleby, L., Webb, R., Shaw, J., (2006) Suicide in recently released prisoners: a population-based cohort study. Lancet, 368(9530), 119-23. Slade K, Samele C, Valmaggia L, Forrester A, (2016) Pathways through the criminal Justice system for prisoners with acute and serious mental illness, Journal of Forensic and Legal Medicine. doi: 10.1016/j.jflm.2016.10.007. Spittal, M., Forsyth, S., Pirkis, J., Alati, R and Kinner, S. (2014) Suicide in adults released from prison in Queensland, Australia: a cohort study, J Epidemiol Community Health doi:10.1136/jech-2014-204295	epidemiological study and did not evaluate risk assessment tools for suicide Spittal et al (2014) was not found in the literature searches but it was an epidemiological study and did not evaluate risk assessment tools for suicide and therefore would not have met our inclusion criteria Forrester et al (2014) was identified by our searches but it was not included in the guideline because it is an editorial not a research study
150.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	General	General	General	The Offender PD Pathway could be included perhaps a guideline about considering the pathway within 6/12 of sentence end date as well as referring to Mappa at that point. For those screened in, in prison, the pathway suggests that Forensic Psychologists should be doing the formulation in advance of release but there are at times gaps in the resources to deliver this. This is necessary to prevent high risk offenders being released without any robust risk management plan.	Thank you for your comment. The Committee have made recommendations specifically regarding the importance of identifying and engaging adults in the criminal justice system who have personality disorder (see recommendations 1.6.3 - 1.6.6). We have also made recommendations about sharing information with MAPPA (see recommendation 1.4.5) and about the importance of information sharing

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							during stages of transition (see recommendation 1.8.4) and more generally about the key principles of risk assessments (see recommendation 1.4.2). The Committee hope that these recommendations will be of value to the Offender Personality Disorder Pathway. It is not the usual practice for guidelines to make recommendations about specific professional groups, but more about the experience and competence needed to deliver the interventions.
151.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	General	General	General	The need for robust protocols around information sharing within and between agencies. There are clearly significant problems with accessing information which renders any assessment completed within the prison system redundant unless it is known about and shared with receiving community services, even at times where Mappa 3 is requesting the information. Part of the problem is incoherence around key roles where, unlike the health system, there is not an equivalent roles of CCO or Responsible Clinician for those with mental health problems. Perhaps the SPOC should be the offender supervisor?	Thank you for your comments. The Committee agree about the importance of effective information sharing between, and within, agencies. We feel that recommendation 1.8.3 draws attention to the importance of developing agreed protocols for information sharing. We have reviewed recommendation 1.8.4 to include developing joint plans of care for individuals. It is not the usual practice for NICE guidelines to recommend which specific professional groups should perform the recommendation, but more about the experience and competence needed to carry out the recommendations.
152.	SH	Adult Secure Services Clinical	General	General	General	Consideration of recognising the need to engage with 3rd sector providers, a focus on Recovery models as necessary to promote and sustain engagement and effective transition into	Thank you for your comment. The Committee agree that a range of organisations, including third sector

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		Reference Group (Lead for Reducing Restrictive Practice)				the community.	organisations, can play a valuable role in providing a range of interventions within community settings. We have made a number of recommendations which we feel supports this, particularly recommendation 1.8.4 which focuses on the importance of developed care pathways and joint care planning between services. The Committee hope these recommendations will help guide the development of community based care, regardless of who is delivering it.
153.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	General	General	General	Clarifying the governance around referrals between the prisons and health (e.g. S48) would be a helpful addition to the guidance.	Thank you for your comments. The Committee agree that there are issues which cause delays for people accessing inpatient psychiatric care when being transferred from hospital. However, the Mental Health Act Code of Practice specifies that "unacceptable delays in transfer after identification of need should be actively monitored and investigated by the NHS Commissioning Board." We feel that specifying the time frame in which transfers occur falls outside the remit of the guideline
154.	SH	Royal College of Nursing	General	General	General	The Royal College of Nursing welcomes steps to develop guidelines for the identification and management of mental health problems and integration of care for adults in contact with the criminal justice system. We invited our members who work the criminal justice nursing to review and comment on the draft guidelines on our behalf. The comments below reflect our position and includes the views of our members.	Thank you for your comment. We have responded to your comments as they are detailed below.

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155.	SH	Royal College of Nursing	General	General	General	These draft guidelines are very comprehensive and illustrate what quality care should look like.	Thank you for your comment.
156.	SH	Royal College of Nursing	General	General	General	It was apparent that there was a lack of evidence in many of the areas to draw from and whilst this was somewhat expected, it was still quite shocking. It demonstrated a real need for greater investment in research in prison healthcare generally and in prison mental health specifically.	Thank you for your comment. We agree and have made recommendations for research in several areas to try and address this lack of evidence
157.	SH	Royal College of Nursing	General	General	General	The greatest challenge will be in the implementation of NICE guidelines in this area, most particularly due to dramatically low staffing levels and increasing workload in criminal justice nursing. To ensure safe, effective and quality care – senior managers and commissioners will need to pay greater attention to looking at safe staffing levels to achieve this 'gold' standard guidelines. Nursing staff working in prisons are working with limited support, limited resources and insufficient scope to undertake their own practice development. It is important that challenges are recognised and addressed in order to ensure high quality care across board.	Thank you for your comments. The Committee agree there are challenges with implementation of recommendations for various reasons including staffing levels and the impact of treatment setting. The focus of this guideline is to ensure that all people who have mental health problems and are involved in the criminal justice system receive the best care and treatment. However, it is beyond the scope of this guideline to comment on Ministry of Justice policy on staffing levels in the prison estate
158.	SH	Royal College of Psychiatrists	General	General	General	Overall, while potentially immensely helpful, we found the guideline large, unwieldy and difficult to read. We acknowledge that this is likely to be because this is a first complete draft, but it must be made more streamlined and accessible before publication. We have made a number or organisational suggestions along the way. We would not, however, want to see loss of the valuable reviews, and suggest that while the review questions should be retained in the text, much more of the detail could go into appendices. The document should provide a summary of where new research is most needed because relevant data most lacking.	Thank you for your comments. The Committee agree that it is a substantial document which is not suitable, or designed to be, one that is regularly used by practitioners. Rather it is a source document which practitioners can refer to for evidence to support recommendations. There is a short version of the guideline available which only contains the recommendations and we would expect this version to be the one that is used routinely.

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						Good enough health services cannot be delivered in a vacuum. Consideration ought to be given to the minimum sufficient number of criminal justice staff required to ensure adequate health care assessment and provision in key settings, and especially police cells and prison. In such settings, healthcare can only be delivered in anything approaching and adequate way if discipline staff/police personnel are available to facilitate it. We reiterate that we think it would be helpful for the reader to be provided with both minimum and gold standards. Minimum standards should then be a requirement to ensure short to medium term safety for service users, staff and public alike; it would be expected that all would be working towards the gold standard assessments, interventions, service models and training. It is difficult to know the extent to which enhancing services to at least minimum standards would have cost implications. Anecdotally we can say that at present it is extremely difficult to deliver commissioned services in many prisons because of the state of prison staffing; if that could be improved and health and allied service delivery be made more efficient, then cost implications for health might be minimal. There could be efficiency savings in the community too if some existing provisions, like the Mental Health Treatment Requirement, could be more widely adopted and prove as effective as anticipated. It is inescapable, however, that good services cost substantial sums because they depend on staff who are not only trained for purpose, but have time available to maintain their training and develop their effectiveness.	The short version of the guideline lists those research recommendations which the Committee considered to be the highest priority for implementation. Regarding your comments on staffing, the specification of the number of staff is outside the scope of the guideline. In response to the points you raised about minimum standards, the purpose of this guideline is not to make recommendations for minimal standards of care but to recommend what high-quality care looks like, based on the best available evidence. In response to the points you raise about cost effectiveness of the implementation of options such as the mental health treatment requirement, the Committee have taken potential cost impact into account when developing recommendations Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned.
159.	SH	National Offender Management Service	General	General	General	National Offender Management Service welcomes the development of these guidelines as a welcome support to the continued efforts of all commissioning and delivery partners, to identify baselines for mental health services commissioning and provision. This is especially important in the community	Thank you for your comments. The focus of this guideline is to highlight the best approaches to the assessment and management of people with mental health problems in

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						setting, where commissioning arrangements are entirely local and dependent on the commitments of each Clinical Commissioning Group (CCG) and their local health needs analysis. At this stage in the consultation, we offer some high level suggestions for improvements which we believe will add to the effectiveness of the guidelines in driving good and consistent mental health services for adults in contact with the justice setting. The guidelines set out in useful detail, the processes and range of actions, activities and professional standards, which may give assurance to providers of the compliance with recommended standards of their mental health services. This raises two important opportunities which could be usefully added. Firstly, it would be helpful if the guidelines included a description of the commissioning structures at a national (custody) level and their local (community) counterparts. This would help users at the outset of their reference to the guidelines on how commissioning decisions are made. Secondly, as a general observation, the mental health needs of adults in the community would benefit from being referenced in far more detail. The draft guidelines as they stand refer mainly to custody (prison), and some of the recommendations encourage development of services which already exist across the country.	the criminal justice system. We have not made any recommendations about structures for services as this will be a matter for local implementation. We have revised the introduction to emphasise the relevance of this guideline for people who are in community criminal justice services.
160.	SH	National Offender Management Service	General	General	General	In all the sections of the guidelines, it would be beneficial to include reference to Dual Diagnosis of substance misuse and mental health problems, also referred to as co-morbidity. Dual diagnosis is one of the most common and often difficult to treat presentation. Some services are set up to deal only with one or the other, which can make it difficult for the user to access any service and some guidelines on improving access for this group would be welcome. The guideline development has clearly outlined the stages in processes of assessment, risk, care planning, intervention etc.	Thank you for your comment. We have amended recommendation 1.1.2 to draw attention to co-existing mental health and substance misuse problems. We recognise the importance of identifying the needs of people with coexisting conditions. There are NICE guidelines for the assessment and management of these conditions, for example Coexisting

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						There is an opportunity for the guidelines to go further or recommend new ways to achieve better outcomes. It rather seems the guidelines are following a lot of current practice.	severe mental illness (psychosis) and substance misuse (CG 120), which recommend that professionals actively engage people in treatment and not exclude people who have a coexisting condition from accessing services. We do not agree that the guideline follows a lot of current practice.
161.	SH	National Offender Management Service	General	General	General	Risk: There is no reference to risk of substance misuse for people with mental health problems, and no reference to assessing risk in the community, again arguably where is more needed.	Thank you for your comment. The Committee did not review evidence about people with mental health problems being at an increased risk of substance misuse because the focus of this guideline was on the assessment and management of people with mental health problems in contact with the criminal justice system. Therefore we are unable to make a comment on risk of substance misuse specifically. However, we have several recommendations to draw attention to the importance of assessing substance misuse during assessments, these are not just in custody but extend to all criminal justice services, which include community services. Recommendation 1.4.3 highlights the importance of assessing behaviours that may indicate a risk to self which could include substance misuse. Recommendation 1.3.13 ensures that assessments should be completed by practitioners who are competent in assessing common presenting problems, of which substance misuse

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							would be one. Recommendation 1.3.14 highlights that assessments should take substance misuse problems into account.
162.	SH	National Offender Management Service	General	General	General	Care Planning: This is a good outline of principles again we think these are much in practice and useful to highlight and identify. One suggested improvement would be to include models of good practice to support users of the guidelines	Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned
163.	SH	National Offender Management Service	General	General	General	Interventions: This section makes helpful reference to transition from prison to community treatment and to continuity of care. Here, we believe there is a real need in the system to highlight the legal commissioning duties of local justice and health agencies to ensure that they provide and support access to mental health services at all points of contact with the justice system and the local partnerships needed to partner and share the outcomes of health, wellbeing and reducing re-offending.	Thank you for your comments. It is outside the remit of this guideline to comment on the legal duties of any organisation. However, we have made recommendations about the need to ensure that adults in contact with the criminal justice system will be referred or access assessment and treatment where needed (see recommendation 1.3.9 and 1.5.1). We have recommendations about the importance of having diversion pathways for individuals at various stages of the criminal justice system (see recommendation 1.8.1). We hope these recommendations will address the concerns you have raised in your comment.
164.	SH	National Offender Management Service	General	General	General	Organisation: This section makes a range of recommendations which are currently widely delivered.	Thank you for your comment
165.	SH	National Offender Management Service	General	General	General	Training: This is a welcome set of recommendations. A further suggested recommendation would be to focus on wider multi-agency training for staff working in custody on the possible indicators of mental ill health, especially where these are consistent with being imprisoned. What could be done to mitigate the worst of these effects?	Thank you for your comment. Recommendation 1.9.3 draws attention to the importance of having multidisciplinary and multi-agency training including those working in the criminal justice system and the health

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							care system. Recommendation 1.9.4 identifies the importance of ongoing support for staff that work directly with adults in the criminal justice system which includes training. Recommendation 1.4.2 highlights the importance of being aware of the impact of someone's social and physical environment which would include the effects of being in custody.
166.	SH	National Offender Management Service	General	General	General	Research: Much of this area is poorly researched. There are opportunities to add to the research pool through these recommendations, for example, causal links between mental ill health and criminal behaviour; long term effects of mental health support on reducing re-offending.	Thank you for your comment. The Committee agree that more research is needed in this area and have developed a research recommendation "What is the effectiveness of structured clinical (case) management in improving mental health outcomes using interventions within probation service providers?". The causal links between mental ill health and criminal behaviour was not identified as an area for further research by the GC.
167.	SH	National Offender Management Service	General	General	General	Particular Points Raised by Contributors in NOMS Offender Personality Disorder This is really important and helpful document for the Offender Personality Disorder (OPD) Programme, although the key issues tend to sit with the cohort of the personality disordered population that is not covered by the OPD programme, which concentrates on most risky offenders. On an initial view, the areas for development relate to a greater recognition by both health and forensic practitioners within the CJS of the importance of PD and therefore a need to provide specific PD awareness training to staff working with offenders. There is a specific helpful recommendation to health professionals:	Thank you for your comments and support of the recommendations made by the guideline.

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						• Practitioners should not exclude people with personality disorders from any health or social care service, or intervention for comorbid disorders, as a direct result of their diagnosis. This recommendation may have significant resource requirements that sit with Health and Wellbeing rather than the OPD programme (which is not resourced to extend into all areas of the CJS) There is also a useful reference to research within the community, specifically for Community Rehabilitation Company (CRC) offenders: • A programme of research which would (a) refine the structured clinical management for use in the CRCs and then (b) test this in a large scale randomised control trial should be undertaken.	
168.	SH	National Offender Management Service	General	General	General	Particular Points Raised by Contributors in NOMS Training Broadly, the recommendations under this section are seen as being useful – i.e. that mental health staff need specific training regarding the specific nature of the environment, as well as how their service fits in the broader working of the establishment, including other relevant departments and agencies. This may contribute towards the avoidance of silo working which can be an issue in departmentalised and structured prison environments. The specific reference to the importance of professional boundaries training for this staff group due to the risk of boundary violation. That consideration is given to the value of well-being/resilience training for this group is positive. Mental health treatment staff may be particularly susceptible to work related stress and burn-out. Consideration of staff training in relation to information sharing	Thank you for your comments and support of our recommendations. The Committee agree with your views on the importance of effective training and information sharing. In recommendation 1.9.1 we have drawn attention to the importance of staff having a comprehensive induction on legislation and policy relevant to their role, including information sharing. In recommendation 1.8.4 we draw attention to the need to develop protocols to support data sharing. As this guideline is focused primarily on the criminal justice system it is considered specific to forensic environments. Considerations to breaching confidentiality are written

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						specific to working in a forensic environment may be a useful further recommendation. This would support mental health professionals to have a clear understanding of when they may be required to 'breach' confidentiality (e.g. by sharing risk-related information about prisoners with wider professionals) in order to fulfil their greater obligation of Duty of Care and public protection.	into the Data Protection Act 1998 and therefore, outside the scope of this guideline.
169.	SH	National Offender Management Service	General	General	General	Particular Points Raised by Contributors in NOMS Observations on Section 6 – Treatment It is positive that a range of treatment options for addressing sexual offending risk have been considered (including more recently introduced initiatives such as the polygraph). There is very brief reference to Cognitive Behavioural Therapy approaches, which is surprising given that this is the mostly widely used (and researched) approach to sexual offending treatment. The robust approach to the development, delivery and evaluation of sexual offending behaviour programmes by the National Offender Management Service (NOMS) is acknowledged. While medication is considered in the context of paraphilia research the review does not consider existing large scale research in this field – e.g. by Prof Belinda Winder and colleagues (Nottingham Trent University) as part of the Offender Personality Disorder Pathway funded MMSA (Medication for the Management of Sexual Arousal) programme. That said, the review does consider the relevance of Personality Disorder in the offending population in other sections.	The studies about paraphilia that were identified by our literature search and what they showed are documented in the evidence sections of the guideline. The interventions covered were determined by the evidence that was found. We have not been able to identify the study by Prof Belinda Winder that you mention - it may be that it is not published. NOMS did not agree to a GC request to release relevant reports or data from the outcome of their Sex Offender Treatment Programme. Given the absence of evidence from the NOMS programmes and the uncertainty about the evidence reviewed, in particular the UK evidence, the GC decided to make no treatment recommendations about interventions for people with paraphilic disorders.
170.	SH	National Offender Management Service	General	General	General	Particular Points Raised by Contributors in NOMS Assessments 1.3.9 Is excellent advocating that health care professionals undertaking assessments in the community should have experience of working with people in contact with the Criminal Justice System. This is widely seen among Criminal Justice Mental Health Teams across the country	Thank you for your comments. 1.3.9 Thank you for your support of this recommendation

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						1.3.15 When assessing people in contact with the criminal justice system, all practitioners should recognise potential barriers to accessing and engaging in interventions and methods to overcome these? Clarification is needed on the meaning. Is it that the practitioners should employ methods to overcome these, that the patient should be supported to do so or that these barriers should be addressed beforehand? The rest of the bullet points in that section are excellent 1.3.16 In discussing sharing Treatment Plans this may again benefit from being explicit i.e. with providers of probation services, prison/CRC staff, across health and in the level of detail information may or should be shared. 1.4.5 Could this section be strengthened around duty to co-operate and share information with MAPPA. While clinicians regularly feed into MAPPA reporting this is not as consistent or regular as we would like to see. NICE guideline clarity in this regard could be extremely useful in explaining the grounds for sharing information based on medical need. 1.6 There is a missed opportunity throughout the guidelines to include descriptions and or graphical models of community mental health pathways. This is particularly apparent in this section with no reference at all to published NHS, IAPT guidance in relation to offenders. 1.8 Similar to section 1.6, community mental health pathways are given scant attention here.	1.3.15 We have amended this recommendation to ensure this is understood to be at individual and service level. 1.3.16 We have amended this recommendation to include information sharing with agencies. 1.4.5 The wording we have used in this recommendation is that all practitioners should ensure risk management is integrated with relevant agencies including MAPPA. We feel that this demonstrates the importance of supporting the function of MAPPA 1.6 The focus of NICE guidelines is on clinical practice and service and organisational arrangements (pathways) to support the delivery of care. The pathways you refer to are outside the scope of this guideline. 1.8 In this guideline we develop pathways specific to the criminal justice system, the pathways you refer to are outside the scope of this guideline.

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171.	SH	Mental Health Foundation	Short	General	General	The following comments are reflections on the section: 'Recommendations for research'. The guideline committee's recommendations for research need to stress that good research should be shaped, encouraged and facilitated by the guidelines. At the moment, the guidelines do not address the current shortcomings in both research and data in the area of mental health and criminal justice. In the recommendations, we would like to see: - Recognition that research infrastructure needs to be invested in – this includes funding but also easier access to prison data and prisons to support research and evaluation in prisons - Data linking is of central importance and should be noted in the recommendations. Integrated working is needed between justice, welfare, health among other departments to address data silos. - Effective assessment of mental health and factors that support effective provision of mental health services in prison. People with mental health problems in prison may go unnoticed and thus effective assessment upon entry as well as research into what good care provision looks like is advised. - The effect of the prison environment on mental health and creating trauma informed environments for prisons. The evidence for both approaches would need further support however there is a clear need to address the environment in which prisoners reside to support rehabilitation. We call for place based approaches to be applied across the prison system. For this to happen, there needs to be a focused effort and investment in research into generating evidence around the impact psychologically informed planned environments have on mental health and wellbeing. - Staff levels of mental health and the effects on	Thank you for your comment. This guideline looked at questions on staff training, recognition and assessment, treatment, care plans/pathways and organisation of services. The evidence base for these questions was appraised and reported. Where the evidence base was limited or inconclusive about the most effective options, the Committee were able to make recommendations for further research. However the Committee were restricted to only making recommendations for further research in areas where they had looked at a question. Therefore it is not possible for the guideline to make recommendations about investment in research infrastructure or data linking as you suggest. We agree that effective assessment is very important and have made extensive recommendations about this in the guideline. However, the Committee considered that further research into the structure and process of assessment was unlikely to be practical and so did not make research recommendations in this area. Research in Psychologically Informed Planned Environments has been commissioned from King's College London and a national evaluation is under way therefore we have not made

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						rehabilitation effort. We would also like this section to acknowledge the mental health and wellbeing of those working in prisons. As it is a high stress, high risk work environment, guidance needs to be provided that reflects the pressures experienced by this group. - Effective interventions for rehabilitation and through the gate support planning for prisoners with mental health problems. - Further research into liaison and diversion services to help divert people away from prison in the first place.	a recommendation for research in this area Staff mental health is an important issue but it outside the scope of this guideline We have made a research recommendation on care management which should hopefully identify effective interventions for gate way planning We have made research recommendations on case management and access to treatment which deal with the issue of liaison and diversion
172.	SH	Mental Health Foundation	Short	General	General	The Mental Health Foundation would like to see the James Lindt Alliance (JLA) include a recommendation that calls for 'priority setting exercise for mental health research in prisons' to be conducted. MHF would be very interested to be involved in this process.	Thank you for your comment. In recommendation 1.8 we focus on the importance of developing pathways specific to the criminal justice system and we refer to mental health services. Unfortunately NICE do not have a remit to instruct the JLA on what they should research
173.	SH	Association of Directors of Adult Social Services	Short	General	General	The document makes no reference to the provisions of the Care Act 2014 and specifically the Statutory Guidance that requires organisations to work together to identify and respond to individuals who may have or are developing social care needs. In identifying possible mental health needs all partners, and especially those working in health services should also be alert to possible social care needs, be they in relation to mental health, learning disability or any other disability or long term health condition, and encouraging the individual either to request an assessment from the local authority or for the	Thank you for your comment. We have amended recommendation 1.2.1 to draw attention to the requirements of statutory services under the Care Act 2014

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						health professional to make one on their behalf.	
174.	SH	Association of Directors of Adult Social Services	Short	General	General	The document makes little reference to sensory need where, if observed, a referral to social care should be considered to be essential.	Thank you for your comment. We have reviewed the content of the short guideline and have included reference to the Care Act 2014 in several places within the guideline.
175.	SH	Association of Directors of Adult Social Services	Short	General	General	The document is inconsistent in its use of the phrase "mental health" as on occasions it uses it just to encompass mental health and at others to include learning disability. An early statement to the effect that when using the phrase "meant health" learning disability is also included may be helpful although we would prefer to see more explicit reference to learning disability as people with this condition are over represented but under identified within the criminal justice system (See HMIP Thematic Inspection Report on this in 2015) and as a consequence are particularly vulnerable.	Thank you for your comments. We have reviewed the recommendation 1.1.2 to include greater clarification on the use of the term mental health to include all mental health problems and neurodevelopmental disorders. We have also amended the introduction to make it clear that mental health problems encompasses neurodevelopmental disorders much earlier on in the guideline.
176.	SH	Association of Directors of Adult Social Services	Short	General	General	The document makes no explicit reference to autistic spectrum conditions which are now generally referred to as being something different to a learning disability and, again, this is a vulnerable population that is over represented but under identified within the criminal justice system	Thank you for your comment. The terminology for this guideline was agreed during scoping stage. It was agreed that mental health disorders encompasses neurodevelopmental disorders, including learning disabilities and autistic spectrum disorders. We have revised the introduction to ensure this is made clear from the onset.
177.	SH	Association of Directors of Adult Social Services	Short	General	General	It is surprising to see no reference in the document to "Liaison & Diversion" services which are currently being rolled out across the country and should provide an effective early opportunity to identify health and care needs of people at the earliest stage of their involvement with the criminal justice system.	Thank you for your comments. The Committee have made several comments about liaison and diversion within the criminal justice system including police and street triage diversion services. We made minor amendments to recommendation 1.8.1 to further emphasise the importance for health and criminal justice agencies to develop diversion services.

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							However, the evidence is scarce which limited the recommendations we were able to make.
178.	SH	College of Mental Health Pharmacy (CMHP)	Short	General	General	Check if blood tests are required for any medicines such as antipsychotics, (for example clozapine), lithium, warfarin anti-epileptics . Also take note of associated risks of omitted and delayed medicines.	Thank you for your comment. The first stage assessment, which has previously been consulted on in the Physical health of people in prison guideline (NG 57), assesses someone's current medication. We direct readers to the relevant guidelines for advice on monitoring medication (including delays, omissions and blood tests).
179.	SH	College of Occupational Therapists	Short	General	General	Whilst we recognise the paucity of high quality literature concerning occupational therapy interventions; we are concerned that the our contribution to the assessment and treatment of: • Physical disability and activities of daily living • Environmental adaptation • Occupational depravation • Meaningful occupation as a protective factor against risk • Interpersonal functioning in the context of Personality Disorder has not been made more explicit.	Thank you for your comments. The guideline is focused on a comprehensive approach to the care and management of people who have mental health problems and are in contact with the criminal justice system. This includes in custody and in the community. Recommendations relating to primary and secondary care services are dealt with in disorder specific guidelines, which we signpost to in section 1.2.5 of the full guideline. It is not the usual practice for guidelines to make recommendation about specific professional groups, but more about the experience and competence needed to deliver the interventions.
180.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Short	general	general	The treatment of mentally-incapacitated prisoners/use of Mental Capacity Act 2005 in prisons. The law operates the same in prisons, but there are special considerations (e.g. assessing best interests in that environment, use of coercion in coercive environment, restraint in prisons for healthcare	Thank you for your comments. The Committee agree that mental capacity is relevant within all Criminal Justice Settings. However, all statutory services are required to comply with

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						reasons). This is a very tricky area of practise that would benefit from guidance. A paper on this subject is Davis & Diamond (Mental Care Act in prisons).	the Mental Capacity Act 2005 which is already in place. NICE are in the process of developing the Decision making and mental capacity Guideline which we feel will address the concerns you raised in your comment.
181.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Short	general	general	Admitting mentally-disordered prisoners to psychiatric hospital. This is subject to excessive and increasing delays (see Sharpe et al (2016) Section 4748 transfers). It would be helpful if there was best practise guidance as to achieve this most efficiently.	Thank you for your comments. The Committee agree that there are issues which cause delays for people accessing inpatient psychiatric care when being transferred from hospital. However, the Mental Health Act Code of Practice specifies that "unacceptable delays in transfer after identification of need should be actively monitored and investigated by the NHS Commissioning Board." We feel that specifying the time frame in which transfers occur falls outside the remit of the guideline
182.	SH	Nottinghamshire Healthcare NHS Foundation Trust	Short	general	general	Treatment of NPS-induced mental health problems in prison. This is obviously a massive issue in prison and being relatively new and under-researched so it would be very helpful if guidance were given (e.g. when to treat with antipsychotics, appropriate location for treatment, physical health monitoring).	Thank you for your comments. The Committee agree that novel psychoactive substance induced mental health problems is an emerging and substantial problems in the criminal justice system, particularly within prisons. However, the Committee did not have any available evidence for their specific management given it is a relatively recent issue. We have made reference to relevant guidelines such as Coexisting severe mental illness (psychosis) and substance misuse (CG 120) and Coexisting severe

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							mental illness and substance misuse: community health and social care services (NG 58). If more evidence on novel psychoactive substances it may be considered in any future update of the guideline.
183.	SH	Public Health England	Short	General	General	We are concerned at how substance misuse is dealt with in the overall guidance. While the evidence rightly points out the links between substance misuse and mental health, not all individuals who use substances have or end up with a mental health problem. However, it is right to say that there is a high proportion of individuals in contact with the criminal justice system with undiagnosed mental health problems who may also be using substances and many individuals with complex problems which include co-existing mental health and substance misuse problems and that identification and treatment of these individuals must be a priority for all agencies working in the criminal justice system. We think the guidance should be clear that it is entirely appropriate for some individuals in contact with the criminal justice system to be identified and assessed as requiring interventions for substance misuse without this being considered a mental health problem – although substance misuse services must be able to assess mental health problems in this population and access mental health interventions appropriately. We believe it is right that substance misuse is included in the scope of the guidance but in addressing this issue that its focus should be on those individuals with co-existing mental health and substance misuse need. Including substance misuse within the scope of the guidance, without emphasising the complex reasons as to why individuals use both legal and illegal substances to varying degrees of harm and that not all individuals who use	Thank you for your comments, the Committee agree. It is important to be able to distinguish between people who misuse substances without mental health problems, and those who have mental health issues and co-existing substance misuse problems. The primary purpose of this guideline is to ensure that all adults in the Criminal Justice System who have mental health problems receive the most appropriate treatment regardless of whether or not they have a co-existing substance misuse problem. We refer to other relevant NICE guidelines which deal specifically with the treatment and management of substance misuse (Drug misuse in over 16s psychosocial interventions (CG 51) and Drug misuse in over 16s opioid detoxification (CG 52); Coexisting severe mental illness (psychosis) and substance misuse (CG 120)), which are also relevant for people who have mental health problems.

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						substances do have mental health problems risks confusion for commissioners and practitioners of both mental health and substance misuse services. In the community, substance misuse services are commissioned by local authorities and are generally distinct from mental health services which have a different commissioning structure. Pathways have been developed locally for offenders with substance misuse problems into the same treatment services as can be accessed openly by everyone with a substance misuse problem, and these pathways include those from prisons. Classifying individuals with substance misuse as having mental health problems risks confusing/destabilising existing pathways from the criminal justice system into the appropriate services and could result in a perception, amongst some commissioners, that there are or needs to be separate services for this cohort. There is already some concern amongst practitioners working across the health and justice agenda that there can be difficulties in getting the health needs of offenders in the community recognised and incorporated in local commissioning plans for services. For commissioners, practitioners and stakeholders working in the complex funding and commissioning landscape for health and justice, the focus, over the past few years since the changes implemented by both health and justice reforms, has been on trying to make these systems work together at a local level. There are many challenges in trying to achieve this and we believe that focussing upon the complex needs, in this case the co-existing substance misuse and mental health problems of this population, rather than a specific diagnosis, would better assist the delivery of integrated services and the implementation of these guidelines.	
184.	SH	Prisons and Probation	Short	General	General	Nigel Newcomen CBE - Background	Thank you for your comment and providing this information.

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		Ombudsman				My role as Prisons and Probation Ombudsman (PPO) is to carry out independent investigations into deaths and complaints in custody. My detailed responsibilities are set out in my office's Terms of Reference (www.ppo.gov.uk/about/vision-and-values/terms-of-reference/) which specify two main duties: • To investigate complaints made by prisoners, young people in detention (young offender institutions and secure training centres), offenders under probation supervision and immigration detainees. • To investigate deaths of prisoners, young people in detention (including residents in secure children's homes), approved premises' residents and immigration detainees due to any cause, including any apparent suicides and natural causes. I welcome the opportunity to make a submission to the NICE guidelines on the "mental health of adults in contact with the criminal justice system: identifying and managing mental health problems and integrating care".	
185.	SH	Prisons and Probation Ombudsman	Short	General	General	Fatal incident investigations The learning included in this submission is based on findings from my investigations into deaths in custody. My office's fatal incidents team investigate all deaths in custody, as outlined in the above bullet points. The purpose of these investigations is to understand what happened; to help inform the family of the bereaved and answer any questions they might have; assist the coroner with the inquest; identify how the organisations whose actions we oversee can improve their work in the future; and make a significant contribution to safer, fairer custody and offender management. After notification of a death, an investigator is appointed to lead	Thank you for your comment and providing this information.

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						the investigation. The investigator will find out as much as possible about the circumstances surrounding the person's death. This involves examining all the relevant documentation and policies. The investigator has access to the deceased's prison medical records and prison records (including security information reports), and can request any other information they may need. They interview prison staff, healthcare staff, and serving (and released) prisoners, if necessary. A clinical review is commissioned by NHS England or, in the case of deaths in Wales, the Healthcare Inspectorate Wales. They appoint a suitably qualified clinician to review the healthcare provided to the deceased and produce a report, which is used as evidence in our investigation. Once the investigation is complete, my office issues a report outlining the findings of the investigation. As appropriate, this will include recommendations for improvement.	
186.	SH	Prisons and Probation Ombudsman	Short	General	General	Learning lessons bulletins and thematics In order to contribute more broadly to safer and fairer custody and offender supervision, my office also publishes learning lessons bulletins (LLBs) and thematics. These publications identify lessons to be learned from the collective analysis of our investigations and seek to support improvements in the services we investigate. In January 2016, I published a thematic review on "Prisoner mental health". This report looked at the strong relationship between mental ill-health and self-inflicted deaths of prisoners	Thank you for your comment and providing this information.

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						and how obstacles to timely diagnosis and effective treatment could be overcome.[12] I draw on the learning from this publication in my response.	
187.	SH	Prisons and Probation Ombudsman	Short	General	General	Statistics My thematic review on prisoner mental health contained a sample of 557 prisoners who died in prison custody between 1 April 2012 and 31 March 2014. It included data on 199 self inflicted deaths and 358 natural causes deaths. Just over two in ten (22%) of the prisoners in the sample who died from natural causes were identified as having mental health needs. However, seven in ten (70%) of those who died from self inflicted means had been identified with mental health needs. My office recently updated the figures concerning the self inflicted deaths of prisoners in custody between 1 April 2014 and 31 March 2016. There were 180 self inflicted deaths during this time and my office completed 148 investigations into these deaths. Of the 148 reports we completed, in 102 cases the prisoner had identified mental health needs. Further analysis of these statistics showed that: • In 19 of 148 reports (13%), the prisoner had a severe and enduring mental illness. • In 31 of 148 reports (21%), the investigator indicated that the prisoner should have been referred for mental health care but was not. • In 27 of 102 reports (26%), where mental health needs were identified, the prisoner received no mental health care.	Thank you for your comment and providing this information.

[12] Prisons and Probation Ombudsman (2016), *Learning from PPO investigations: Prisoner mental health.* Available online: http://www.ppo.gov.uk/?p=6737

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						• In 63 of 102 reports (62%), where mental health needs were identified, a drug treatment plan was prescribed. 68% of those on a drug treatment plan were fully compliant, 26% were partially compliant and 6% were non compliant.	
188.	SH	Prisons and Probation Ombudsman	Short	General	General	Response to specific questions Having considered the questions detailed in your draft consultation document, I am able to respond to the areas detailed in bold throughout this submission. I have not responded to areas in which I am unable to provide an evidence based answer. This is, mainly, because the area it is outside the remit of my office or does not fall under our technical expertise.	Thank you for your comment.
189.	SH	Prisons and Probation Ombudsman	Short	General	General	Carrying out a mental health assessment (1.3.9 to 1.3.16), reviewing a mental health assessment (1.3.17 to 1.3.18) and risk assessment and management (1.4) *Mental health assessments* When a referral has been made, this should prompt an assessment from the appropriate healthcare professional. Depending on the nature of the prisoner's issue, and the reason for the referral, the assessment might be carried out by a GP, someone from the primary care team, or a member of a specialist mental health in-reach team. As with reception health screenings, it is important for the health professional carrying out the assessment to review all available documentation, so that they can get as full an understanding as possible of the prisoner's mental health history. There are a number of standard assessment tools, commonly	Thank you for your comments and for citing some of the recommendations for practice that have been made by the Prisons and Probation Ombudsman. The Committee agree with your comments overall. Recommendation 1.1.3 highlights the importance of information gathering from a range of different sources which we feel reflects some of your comments. With regards to the use of a validated tool to diagnose mental health issues, the Committee considered the available evidence on a range of screening tools and agreed that the CMHS-M and CMHS-W was the most suitable tool to assess the potential presence of mental health disorders

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						used in primary care, which can be used as part of the assessment process to help inform and evaluate treatment. Standard depression screening and assessment questionnaires can be used for prisoners suffering from depression, for example, to assess and record levels of depression and response to treatment. Doctors should always use a validated tool to help diagnose mental health issues. There are a wide variety of standard assessment tools available, however, there is little guidance to support the selection of an appropriate tool for use in a prison setting. If better guidance on the use of assessment tools was available for prison healthcare staff, this might help to encourage their use as standard practice. Therefore from my office's perspective, NHS England should produce guidance for prison healthcare staff to advise them on best practice for the selection and use of existing validated assessment tools. *Individual recommendations* I have also examined the individual recommendations my office has made since 2010 from any deaths in custody investigations. There are a number of relevant mental health assessment recommendations to which I draw your attention: • Healthcare should ensure that the referral process and priorities for mental health assessments are clear and fully understood by staff, and that referrals are appropriately monitored. • Healthcare should introduce systems to ensure that prisoners requiring mental health assessments receive these in a timely manner and in line with the Mental Health Act Code of Practice. • A full psychiatric assessment should be completed when there are signs that a prisoner's mental health is deteriorating, particularly if they are on antipsychotic	and neurodevelopmental disorders, based on the evidence review. The CMHS is validated for all psychiatric disorders except borderline personality disorder and antisocial personality disorder. Specifically the area under the curve for diagnosis of Diagnostic Statistical Manual (version 4 revised) Axis II, which includes psychiatric and intellectual disabilities are >0.7 for both men and women. We direct readers to condition specific NICE guidance for more advice on the assessment and management of specific conditions.

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						medication.	
190.	SH	Prisons and Probation Ombudsman	Short	General	General	Care planning (1.5) I have [again] examined the individual recommendations my office has made on the provision of care for prisoners with mental health problems; and considered the findings from my office's mental health thematic. I draw your attention to the following: • Healthcare should ensure that a detailed careplan, including physical and mental health problems, the frequency of observations and any required tests is drawn up for every prisoner on their admittance to the inpatient unit and shared with all relevant healthcare staff. • Healthcare should devise a care pathway for prisoners with personality disorders. • Healthcare should develop clinical pathways that show the interface between primary mental health and in reach services. Criteria for referral to the services should be clear, timely, understood by all healthcare staff and reflected in the service specification. • Governors should ensure that there are mechanisms in place for referral to the mental health team for 'out of hours' on call arrangements. • Healthcare should ensure that prisoners discharged from hospital psychiatric treatment are initially allocated a mental health nurse and receive appropriate support in line with an agreed care plan. • Healthcare should ensure that referrals for a psychiatric assessment are not cancelled unless there is clear evidence that there are no mental health concerns. • Healthcare should ensure that mental health in reach	Thank you for your comments and for citing some of the recommendations for practice that have been made by the Prisons and Probation Ombudsman. We think these raise important points about the development and content of care pathways and their implementation. In terms of a number of your comments specifically, we feel these are dealt with in our recommendations. Regarding detailed care plans for every prisoner admitted to the inpatient unit we have made amendments to the recommendation to reflect the importance of including physical health needs within the care plan along with risk management and crisis plan. We feel that the frequency of observations would come under several sections including risk management and crisis plans, and more specifically around placing people at risk of self-harm or suicide on an Assessment, Care in Custody and Teamwork (ACCT) plan. Recommendation 1.6.3 is specifically about the importance of developing programmes of care for people with personality disorders. Your suggestions regarding implementation are outside the scope of this guideline and are for the individual Criminal Justice Services to implement.

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						patients who miss more than two consecutive appointments are seen personally to establish the reasons and to check whether there are health concerns that need to be addressed. Healthcare should ensure that contingency plans are in place when a member of staff is absent a prolonged period to ensure continuity of treatment.	
191.	SH	Prisons and Probation Ombudsman	Short	General	General	Psychological interventions (1.6) Talking therapies are a common form of treatment to help people to overcome or deal with their mental health problems. In 2008, the government rolled out a programme called 'Improving Access to Psychological Therapies (IAPT)'. The programme was designed to develop and improve access to talking therapies services that offer treatments for depression and anxiety disorders[i]. IAPT was a national initiative, intended to be rolled out in prisons as well as the community, and a good practice guide was published to offer guidance on providing IAPT services to offenders[ii]. Talking therapies, such as counselling, cognitive behavioural therapy, or anger management courses, should now be available in prisons. However, some talking therapies are not always readily available, and long waiting lists can restrict access. In addition, prisoners often have highly complex needs, and may require therapies to be adapted to meet their specific circumstances. Therefore from my office's perspective, the provision of mental health care needs to at least be comparable to that in the community. The services available should be based on assessed need and sufficient to meet demand. Prisoners are also coping with life in a very different environment to the community, and services should be adapted where appropriate to take this into consideration.	Thank you for your comments and for citing some of the recommendations for practice that have been made by the Prisons and Probation Ombudsman. We agree that it is important that psychological interventions are delivered by practitioners that are competent to deliver them and there is adequate supervision and monitoring to ensure they do it effectively and safely. We have revised recommendation 1.6.1 to take into account some of your comments. We have not specifically commented on the role of prison Governors as this is, in part, an implementation issue and the guideline extends to all levels of the criminal justice system including community services. We direct readers to condition specific NICE guidance for more advice on the management of specific conditions, including talking therapies.

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						Individual recommendations were as follows: • Governors should ensure that all staff involved in facilitating therapy sessions have completed the appropriate training. • Governors should ensure that group facilitators are supported by managers whenever there is evidence a group is in difficulty. • Governors should ensure that therapy groups are facilitated by trained staff who are consistently allocated to the same group to ensure consistency of approach and relationships. • Healthcare should ensure that external providers of counselling or other mental health linked services have a formal arrangement with prison healthcare to cover matters such as reporting, disclosure and supervision.	
192.	SH	Prisons and Probation Ombudsman	Short	General	General	Staff training (1.9) *Individual recommendations* There are a number of individual recommendations my office has made to which I draw your attention: • Healthcare should ensure that all medical staff, including locum GPs, are up to date with mental health awareness and mental capacity legislation. • The prison should set up mental health awareness training sessions and all staff should be encouraged to attend. This should be a continuous process and cover mental health conditions and the management of common presentations in the prison environment. • Governors should ensure that officers receive regular mental health awareness training appropriate to their role and educate them about some of the more	Thank you for your comments and for citing some of the recommendations for practice that have been made by the Prisons and Probation Ombudsman. They are welcomed. We hope that the recommendations we have made in this guideline are supportive of these suggestions. With regards to staff awareness, we are aware of the issues you have raised and have made several recommendations for training (recommendations 1.9.1 – 1.9.4) which should help increase awareness. The Committee agree with your views regarding challenging behaviour as a means of communication. We hope that recommendations regarding training and some specific

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						common mental health problems affecting prisoners. • Governors should ensure that all staff working with young people are trained in how to respond to disclosure of past abuse. • Governors should ensure that staff working with prisoners receive adequate awareness training to understand when to refer prisoners to the mental health team. *Staff awareness* While there are specialist mental health teams in prisons to assess prisoners and coordinate care when mental health problems are identified, residential staff have to manage prisoners with mental health issues on the wings as part of their daily routine. Prison staff awareness of mental health issues can be poor and many have received no training in mental health awareness. When prison staff do not have the skills and knowledge to recognise and manage symptoms of mental health problems, unusual or difficult behaviour of a prisoner can easily be misinterpreted as simply a behavioural problem or a side-effect of taking prohibited drugs, such as new psychoactive substances (NPS)[iii]. This can lead to a prisoner being punished, perhaps by removal to the segregation unit or a reduction in their IEP level[iv], rather than being referred to the appropriate healthcare professional and given the care and treatment they need. Punishment can further exacerbate a prisoner's mental health state, compromising their ability to cope. Difficult or challenging behaviour might sometimes be the only way that distressed people with mental health problems are able to communicate when they need help. Prison and healthcare staff need to be aware of the warning signs of mental distress, so that they can act accordingly and put the correct support mechanisms in place.	recommendations about personality disorder (recommendations 1.6.3 – 1.6.6) will address these. In developing recommendations the Committee have been mindful to ensure that they are applicable across a range of Criminal Justice Services, including prison and community services.

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						The learning from my prisoner mental health review thematic includes the need for mandatory mental health awareness training for all front line prison officers and prison healthcare staff. This is to provide them with the necessary guidance for the identification of signs of mental illness and vulnerability.	
193.	SH	Prisons and Probation Ombudsman	Short	General	General	*Sharing information with prison staff* When mental health problems are identified by healthcare staff, it is vital that relevant information is communicated to prison staff, so that they are as informed as they can be about a prisoner's needs and can play a part in providing support. When prison staff are well informed about a prisoner's mental health issues, this can help them to relate to that prisoner's behaviour, to recognised distress, and to respond in the most appropriate manner to support that prisoner. There are some restrictions on the information that can be shared with prison staff due to medical confidentiality. A prisoner's health records are confidential, and, therefore, prison staff do not have access to them. However, consent from prisoners can be obtained to share information with prison staff. Healthcare staff can also provide certain information to prison staff to help protect that prisoner's safety without breaching confidentiality, such as an instruction to alert healthcare staff immediately if the prisoner presents a particular behaviour. It is important that information that might affect a prisoner's safety is available to all necessary staff. Prison staff are not mental health experts, but are heavily involved in the day to day management of prisoners with mental health problems. They should have access to any information that can help them to protect the prisoners under their care. Therefore from my office's perspective, all healthcare	Thank you for your comments. The Committee agree about the importance of effective information sharing between, and within, agencies. We feel that recommendation 1.8.3 draws attention to the importance of developing agreed protocols for information sharing. We have reviewed recommendation 1.8.4 to include developing joint care plans for individuals. Recommendation 1.9.1 draws attention to the importance of a comprehensive induction including knowledge of relevant legislation. We agree that information should be shared to protect self or others, all NHS services are required to comply with the NHS Information Sharing Policy which states information staff should share relevant information in order to protect adults at risk of harm. Therefore, we feel that this recommendation addresses the points you raise.

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						professionals should have a responsibility to share with prison staff any information that might affect a prisoner's safety, within the boundaries of medical confidentiality.	
194.	SH	Prisons and Probation Ombudsman	Short	General	General	*Co-ordinated care* Prisoners with multiple health problems are often treated simultaneously by different healthcare teams. A physical problem might be treated by a primary care provider, whereas mental health treatment is in some cases the responsibility of the primary care provider, but in other instances falls to specialist mental health in-reach teams. In general, specialist in-reach teams will have a fairly small caseload, with a high threshold for entry, and those who are not taken onto the in-reach team's caseload will then fall under the care of the primary healthcare provider. When someone is suffering from mental and physical health problems at the same time, there is a danger that each is treated entirely separately by different clinicians, without any consideration of whether there is any connection between the issues. Care is delivered most effectively when there is a coordinated approach, but communication between primary physical health services and mental health services can be poor, or even non-existent. This can cause difficulties such as diagnostic overshadowing, where physical conditions are overlooked when there are prevalent mental health symptoms, or vice versa. A mental health diagnosis should not prevent a full investigation into physical health problems. Multiple health issues can occur simultaneously, and all symptoms should be investigated in full. The learning from my prisoner mental health review thematic is	Thank you for this information. Our recommendations on care planning (section 1.5) advocate that mental health care plans for people in contact with the criminal justice system should be communicated to all relevant agencies and integrated with care plans for other services.

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						that, all healthcare teams involved in the care of a prisoner should communicate with each other and share information. This is to ensure consistency in diagnosis and a collaborative approach to treatment. I hope that this submission provides a useful response to the draft NICE guidelines on the "mental health of adults in contact with the criminal justice system: identifying and managing mental health problems and integrating care".	
195.	SH	Prisons and Probation Ombudsman	Short	General	General	References: [1] Department of Health (2011), *Talking therapies: A four-year plan of action.* Available online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213765/dh_123985.pdf [1] NHS (2013), *IAPT – Offenders: Positive Practice Guide*. Available online: http://www.iapt.nhs.uk/silo/files/offenders-positive-practice-guide.pdf. [1] Department of Health (2011), *Talking therapies: A four-year plan of action.* Available online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213765/dh_123985.pdf [1] NHS (2013), *IAPT – Offenders: Positive Practice Guide*. Available online: http://www.iapt.nhs.uk/silo/files/offenders-positive-practice-guide.pdf. [1] More information on NPS, and the link between NPS and difficult or erratic behaviour can be found in the PPO Learning Lessons Bulletin 'New Psychoactive Substances' (2015). Available online: http://www.ppo.gov.uk/wp-content/uploads/2015/07/LLB_FII-Issue-	Thank you for providing these references. The listed publications did not meet our inclusion criteria for evidence because they were not research studies of assessment tools or interventions for mental health. Therefore they have not been included in the guideline.

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						9_NPS_Final.pdf#view=FitH [1] IEP (Incentives and Earned Privileges) levels are categories applied to prisoners which determine the benefits they receive or privations imposed on them. A prisoner's behaviour is assessed over time, taking into account positive comments as well as issued warnings, and they are then assigned to one of a number of levels. Those on a higher level will be rewarded, for example having access to television, or being allowed to receive more visitors than those on a lower level.	
196.	SH	Royal College of General Practitioners	Short	General	General	Day of discharge from prison setting. There are recommendations on coordination of care. Did the committee consider evidence about day of the week that the person leaves the prison setting? Controlled Drug Local Intelligence Network says that discharge on a Friday is a particular risk for people with a history of drug misuse because of a lack of support over the weekend. (TL)	Thank you for your comment. The Committee have made research recommendations about co-ordination of care. Factors such as the day someone is discharged from custody may be investigated in this research, however, the Committee did not have any evidence on which to make recommendations for clinical practice about which day of the week people should be discharged
197.	SH	Royal College of General Practitioners	Short	General	General	The accessible information standard states we should be identifying and recording individuals with communication difficulties and providing support. This applies to those with learning disabilities. (IR)	Thank you for your comments. The Committee have reviewed recommendation 1.9.1 to expand on staff knowledge of relevant legislation and policy for their role, this would include the Accessible Information Standard for all NHS staff.
198.	SH	The Disabilities Trust	Short	General	General	The Disabilities Trust welcomes these guidelines, and the particular attention given to Acquired Brain Injury (ABI) [referred to as Acquired Cognitive Impairment (ACI) in this document]. While the inclusion of ABI throughout this document is welcomed we caution that ABI is not itself a mental health condition, though people with ABI are at increased risk of developing mental health problems. Our research has found that prisoners with a history of traumatic	Thank you for your comments. The Committee are aware of the difference in acquired cognitive impairment and mental illness, however, within this guideline the Committee thinks the recommendations can apply to both.

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						brain injury have higher levels of self-reported depression and anxiety than those without a history of traumatic brain injury. [Pitman I, Haddlesey C, Ramos SD, Oddy M, Fortescue D. (2014), The association between neuropsychological performance and self-reported traumatic brain injury in a sample of adult male prisoners in the UK, Neuropsychological Rehabilitation: An International Journal, DOI: 10.1080/09602011.2014.973887]	
199.	SH	The Disabilities Trust	Short	General	General	The Disabilities Trust has developed a screening tool, the Brain Injury Screening Index (BISI®) for use by all levels of professionals to identify people (including offenders) who have a history of ABI. The BISI is available to download for free: www.thedtgroup.org/bisi In our submission to the NICE consultation on Physical health in prisons we recommended the adoption of the BISI as a screening tool for identifying a history of brain injury at the point of entry into prison. We would like to repeat this suggestion in this submission, particularly given the call for screening tools [see our comment number 7 below]. We refer the Committee to Barrow Cadbury's report 'Young People with Traumatic Brain Injury in custody', which evaluates our Linkworker service and use of the BISI with offenders aged 21 and under. [Professor W Huw Williams, Dr Prathiba Chitsabesan (2016), Young people with Traumatic Brain Injury in custody – an evaluation of a Linkworker Service for Barrow Cadbury Trust and The Disabilities Trust, Barrow Cadbury Trust/The Disabilities Trust Foundation/University of Manchester/University of Exeter].	Thank you for this comment. The BISI was not identified during our original evidence search and therefore was not appraised by the guideline. Following your comment we have tried to find published evidence about this tool but have not been able to identify any relevant papers. Consequently we are not able to mention the BISI in the guideline.
200.	SH	Public Health England	Short	1	-	In opening paragraph which describes the scope of the guideline, we should elaborate on '… People in contact with the criminal justice system' and describe in more detail what is meant by this e.g. people in contact with Police, in places of custody and in prison. It would also help to define 'adults' to avoid misunderstandings. We also need to include co-existing mental health and substance misuse problems, as people regularly present with both and frequently do not have care delivered in an integrated way. In opening statement, can we	Thank you for your comments. We have included text to clarify what is meant by 'people in contact with the criminal justice system'. We have also clarified that the guideline relates to 'adults (aged 18 and over)'. The purpose of the text on page 1 of the short version is to provide an

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						say something positive about the promotion of mental health and prevention of ill health being critical, important elements of mental health for people in contact with Justice. In the opening statement, we also need to highlight the need to be proportionate in the delivery of mental health interventions, recognising that many people in prison will need tailored mental health interventions to meet their complex need and in response to prison environments. As a general comment we would also highlight: • The NICE guideline is very MH illness focus – we would like an increased focus on mental wellbeing and impact of prison regime/culture and built environment – e.g. access to opportunity to be physically active and purposeful activity • The lack of reference to the need for robust integrated pathways of care including a stronger reference to diversion and the role of Probation and CRCs	introduction to what the guideline covers and who it is for. Therefore it is not possible for us to include either of the statements that you have suggested here. The guideline looked at mental well-being and promotion of activity but did not find any evidence to support recommendations We have revised the recommendations to reflect a greater emphasis on CRCs
201.	SH	Public Health England	Short	3	1.1.1	We need to include reference to existing NICE guidelines for mental health, reinforcing the message that there are existing NICE guidelines for a large number of mental health problems, and people should have access to NICE approved interventions during their time in contact with Justice services, in custody and in the community.	Thank you for your comment. We have included a section (1.2.5) in the full guideline to list other relevant NICE guidelines. We hope this addresses the points you raise.
202.	SH	Public Health England	Short	3	1.1.2	Include co-existing mental health and substance misuse problems	Thank you for your comments. Recommendation 1.3.5 includes a specific question to prompt professionals to assess substance misuse, including novel psychoactive substances. The text you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees

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							and has already been consulted on as part of the development of the Physical health of people in prison guideline. We are therefore not able to make any further changes to this text. We have made a number of recommendations on assessment to draw attention to an individual's current and historical use of substances, including novel psychoactive substances. We signpost readers to existing NICE Guidelines to manage this relatively rare occurrence. We have also amended recommendation 1.1.1 to specifically mention substance abuse.
203.	SH	Prison Reform Trust	Short	3	5	1.1.1 NICE Guidelines on Mental health in people with learning disability: prevention, assessment and management should also be cited	Thank you for your comments. We have included a section (1.2.5) in the full guideline to list other relevant NICE Guidelines, including Mental health problems in people with learning disabilities: prevention, assessment and management (NG54)
204.	SH	Revolving Doors Agency	Short	3	16	Given the prevalence of coexisting substance misuse and mental ill health, particularly among those in contact with the criminal justice system, 'and/or substance misuse problems' should be considered for addition.	Thank you for your comments. Recommendation 1.3.5 includes a specific question to prompt professionals to assess substance misuse, including novel psychoactive substances. The text you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical

ID	Type	Organisation name	Document	Page No	Line No	Comments	Developer's response
							health of people in prison guideline. We are therefore not able to make any further changes to this text. We have made a number of recommendations on assessment to draw attention to an individual's current and historical use of substances, including novel psychoactive substances. We signpost readers to existing NICE Guidelines to manage this relatively rare occurrence. We have also amended recommendation 1.1.1 to specifically mention substance abuse.
205.	SH	Revolving Doors Agency	Short	3	17	May be worth highlighting risk of diversion or accidental or intentional misuse, particularly where controlled medicines such as methadone or buprenorphine is prescribed.	Thank you for your comment. Recommendation 1.3.5 draws attention to assessing the use of methadone and benzodiazepines, which are controlled substances during the First-Stage Health Assessment. The text you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of people in prison guideline. We are therefore not able to make any further changes to this text. We direct readers to the Self-harm in over 8s guideline (CG 133) which draws attention to the use of assessment of risk when prescribing medication.
206.	SH	Together for	Short	3	20	We welcome the acknowledgment that service users frequently	Thank you for your comment, the

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		Mental Wellbeing				experience difficulties trusting professionals and that a trusting relationship needs to be developed. Q1: Developing an engagement based on trust is a huge challenge for professionals in practice often due to the speedy and swift approach we now have in terms of the justice process – for example, sentencing on a first court appearance. In practice this means that a professional has very little time to develop and establish a rapport with a service users in order to undertake an assessment, identify needs, liaise with other relevant professionals and provide the necessary information to the court in order to support appropriate and proportionate decision-making. Engagement and communication skills also need to be articulated within explicitly stated competencies around any healthcare role working within the CJS	Committee agrees. Recommendations 1.9.2 and 1.9.3 aim to ensure that appropriate training is given to all people working in the criminal justice system. Recommendation 1.9.4 highlights the needs for specific supervision for those who have work directly with adults with mental health problems in the criminal justice system.
207.	SH	Association of Directors of Adult Social Services	Short	4	4	Also make enquiries about whether the individual has had an assessment of their social care needs and whether they are prepared to share the outcomes of that	Thank you for your comment. We have reviewed recommendation 1.1.3 to include gathering information from social services, this would include a social care needs assessment. In recommendation 1.3.11 we highlight the necessity of discussing information sharing and confidentiality with individuals.
208.	SH	Association of Directors of Adult Social Services	Short	4	20	It is also essential to take into consideration any sensory disabilities that the individual may have, they ease with communicating in English as opposed to another language and any relevant cultural or religious issues.	Thank you for your comments. We feel we have addressed this comment in recommendation 1.1.2 which draws attention to the need to take into account individual needs including sensory or communication needs, including language and relevant cultural issues.
209.	SH	Nacro	Short	4	12	It's important to integrate all information while noting that it may have been recorded in different was, for example, the environments it was collected in such as custody can have impact on the content of the information. This can significantly impair disclosure.	Thank you for your comments. We have amended recommendation 1.1.2 to include the assessment or treatment setting. Recommendation 1.1.3 highlights the importance of taking into

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							account how and when information was gathered during the assessment.
210.	SH	Nacro	Short	4	11	Another bullet should be added here to include information collected during a Liaison and Diversion assessment. Please see comment 14 for information on Liaison and Diversion. Nacro's anecdotal experience in designing and rolling out these services has told us that practitioners often have problems with knowing where to send the information and ensuring it arrives in prisons and is directed to the relevant staff.	Thank you for your comments. The Committee have amended 1.1.3 to include information from liaison and diversion services. Recommendation 1.8.1 draws attention to the importance of supporting prompt access to appropriate treatment and care (including medication) and 1.8.3 discusses the need for joint working and agreed referral pathways between criminal justice agencies.
211.	SH	Nacro	Short	4	19	Add here a note that initial answers may not always reflect the actual situation – assessments need to be flexible enough to allow for the fact that disclosure of certain conditions may not be immediate as many individuals may not feel comfortable disclosing certain conditions, but may do so at a later date. It's therefore important to ensure the prisoner knows where/how to access information and guidance outside of the assessment process and at a later date.	Thank you for your comment. We have reviewed recommendation 1.8.4 to reiterate the importance of sharing information between agencies and having joint care plans where applicable. The recommendations in section 1.5 cover care planning which should be done in collaboration with the individual.
212.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Short	4	15	There is no mention of healthcare professionals (HCPs) as a source of information to support the assessment. With the person's consent, other HCPs may be able to provide useful information e.g. GP, community pharmacy (about adherence/collection of medication).	Thank you for your comment. We specify in recommendation 1.1.3 to review primary and secondary medical records which should include information from GPs.
213.	SH	Public Health	Short	4	1.1.3	Include Care Programme Approach and need to maintain	Thank you for your comments. We

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		England				continuity of care when a person enters a place of custody, during time in custody and on release. It would help to refer to obtaining a 'Summary Care Record' as this is the term being consistently used when we advocate for access to summarised health information during times of transition	have expanded on 1.1.3 to include all medical records and reports from other services, which should address your feedback regarding Care Programme Approach.
214.	SH	Public Health England	Short	4	1.2.1	As a principle (and in practice) we have to make sure peoples' mental health is being assessed using an accredited, validated mental health assessment tool. The assessment should include use of substances. As a principle, we should also be advocating for the inclusion of family / carers in the assessment and care planning process. As part of the mental health assessment, we have to include wider determinants, particularly access to housing, employment / occupation and income	Thank you for your comments. The Committee considered the available evidence on a range of screening tools and agreed that the CMHS-M and CMHS-W was the most suitable tool to assess the potential presence of mental health disorders and neurodevelopmental disorders, based on the evidence review. The CMHS is validated for all psychiatric disorders except borderline personality disorder and antisocial personality disorder. Specifically the area under the curve for diagnosis of Diagnostic Statistical Manual (version 4 revised) Axis II, which includes psychiatric and intellectual disabilities are >0.7 for both men and women. We direct readers to condition specific NICE guidance for more advice on the assessment and management of specific conditions. Recommendations 1.3.11 and 1.3.12 refer to the inclusion of family in the assessment process and information sharing. Recommendation 1.3.14 covers the consideration of wider

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							determinants.
215.	SH	Public Health England	Short	4	1..2.2 Lines 4-13 Lines 24-26	We recommend setting the standard that the person undertaking the assessment is sufficiently qualified and experienced to undertake a comprehensive mental health assessment, and of a same level of expertise as we would expect in community settings The examples given are all in a written from which may not be available in a timely manner to ensure that important information is available at key transition points which are also often times of crises e.g. arrest/reception into prison/sudden release from court. This recommendation would be strengthened if the need for pro-active enquiry from practitioners, e.g. telephone contact was emphasised and that commissioners and services should facilitate a timely flow of information at all transition points e.g. developing single points of contact models. We believe the first principle of any assessment is to prioritise safety and risk issues and that this should be set out here.	Thank you for your comment. The Committee agrees on the importance of having trained and competent staff carrying out assessments and delivering interventions. We feel recommendation 1.3.9 addresses this point, highlighting that the practitioner needs to be trained, competent and appropriately experienced. In recommendation 1.3.13 we reiterate the need for competent practitioners. We have reviewed recommendation 1.6.1 to include that staff are trained and competent in the interventions they are delivering and that they require supervision throughout. We recognise that this is an important issue and should form part of any assessment. In the initial scoping of an assessment, it will be for the individual undertaking it, in collaboration with the person who has mental health problems (and where necessary others involved in their care) to determine the structure of the assessment.
216.	SH	Prison Reform Trust	Short	4	4	1.1.3 screening and assessment reports from liaison and diversion services should be added to this list	Thank you for your comments. We have amended 1.1.3 to include liaison and diversion services.
217.	SH	Revolving Doors Agency	Short	4	3	Consider adding 'approved premises'.	Thank you for your comment. We have amended this recommendation which now states "the setting in which the assessment or treatment takes place"
218.	SH	Revolving Doors Agency	Short	4	9	Consider adding 'and information from substance misuse treatment service (where applicable)	Thank you for your comments. We have amended 1.1.3 to mention

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							substance misuse services.
219.	SH	Revolving Doors Agency	Short	4	11	Consider adding 'and information from other relevant services, for example, social care or housing support services'. Adding this may also help to encourage mental health services to work more closely with accommodation providers in particular, which can often be challenging.	Thank you for your comments. We have amended 1.1.3 to include social services and housing services.
220.	SH	Revolving Doors Agency	Short	4	22	Consider adding 'capacity'.	Thank you for your comment. The Committee feel an individual's capacity has been addressed in recommendation 1.1.2
221.	SH	Together for Mental Wellbeing	Short	4	1	The 'treatment' setting may also be police custody suites and court settings, including court cells.	Thank you for your comment. However, the Committee do not agree that police custody suites and court cells are appropriate settings for the routine delivery of treatments.
222.	SH	Together for Mental Wellbeing	Short	4	4	Q1: obtaining all the relevant information, particularly information held by criminal justice agencies, is challenging for healthcare professionals due to barriers around information sharing and access to relevant databases.	Thank you for your comments. The Committee agrees that there may be some difficulties around information sharing between services. Recommendations 1.8.2 and 1.8.3 aim to address the concerns raised in your comments.
223.	SH	Together for Mental Wellbeing	Short	4	15	We welcome the reference to including family members, partner, carers in relation to obtaining information and supporting the person. They are often have detailed knowledge and understanding of the service user. Q1: the challenge, again, is often the time available within justice processes to undertake this kind information gathering particularly when it imperative that professionals are clear as to the service users wishes and have full consent.	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned
224.	SH	Shire Pharmaceutical limited Ireland	Short	5-11	26 -34	We understand the prison entry mental health screen is not open for consultation. However, given the prevalence of ADHD within the prison population consideration should be given to whether the screen is appropriate for ADHD and it is not clear whether this has been done. Section 4 of the screen for example, asks questions about previous interaction with	Thank you for your comment. As you state, this section has already been consulted on and lies outside the current consultation. Therefore we are not able to make further changes to the text.

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						mental health services and may not therefore identify those whose ADHD in childhood was treated by community paediatric teams. Section 2.4 of the screen might include some examples of neurodevelopmental disorders so that those conducting the screen and being screened understand the question.	
225.	SH	College of Occupational Therapists	Short	5	4	Assessment and intervention to mitigate against these issues should be carried out by an Occupational Therapist. We believe they should be integrated as part of teams to effect a meaningful difference; rather than be seen as 'specialist'	Thank you for your comments. The guideline is focused on a comprehensive approach to the care and management of people who have mental health problems and are in contact with the criminal justice system. This includes in custody and in the community. Recommendations relating to primary and secondary care services are dealt with in disorder specific NICE guidelines, which we signpost to in section 1.2.5 of the full guideline. It is not the usual practice for guidelines to make recommendation about specific professional groups, but more about the experience and competence needed to deliver the interventions. The focus of the guideline is to ensure that people receive the best care while involved in the criminal justice system by competent and supervised practitioners.
226.	SH	Nacro	Short	5	26	Nacro submitted comments to this consultation – please refer to these. We can send a separate copy if needed.	Thank you for your comment.
227.	SH	Adult Secure Services Clinical Reference	Short	5	3	Given the risks with medicines diversion in prisons, could assessment adjustments also include a history of drug seeking behaviour?	Thank you for your comment. We have amended recommendation 1.1.2 to draw attention to co-existing mental health and substance misuse

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		Group (Armed Forces and their Families and Health and Justice Commissioning Manager)					problems. We recognise the importance of identifying the needs of people with coexisting conditions. There are NICE guidelines for the assessment and management of these conditions, for example Coexisting severe mental illness (psychosis) and substance misuse (CG 120), which recommend that professionals actively engage people in treatment and not exclude people who have a coexisting condition from accessing services.
228.	SH	Public Health England	Short	5	1.2.3	Pleased to see reference to physical health needs, as these should be given significant attention when undertaking the mental health assessment. Physical health problems effect mental health and wellbeing, and vice versa	Thank you for your comment
229.	SH	Public Health England	Short	5	1.3.1	Can we include people who enter prison with an existing mental health problem, and also refer to the potential negative impact of imprisonment on people in prison	Thank you for your comment. Recommendation 1.3.2 draws attention for staff to be aware of the potential impact being in contact with the criminal justice system may have on someone's mental health as this guideline is for custodial and community settings. Those people with existing mental health problems will be identified by the first stage assessment in recommendation 1.3.5
230.	SH	Public Health England	Short	5	1.3.2	Pleased to see raising awareness among staff of the potential negative impact of being in prison. Can we also include the importance of staff in prison being able to identify mental distress and able to offer brief interventions. We would also recommend the promotion and maintenance of mental health by the establishment of positive prison regimes is included e.g. Trauma Informed Environments and Psychologically Informed Prison Environment programmes, bith currently running in	Thank you for your comments. We have amended recommendation 1.3.14 to draw attention to the importance of recognising when someone may have been exposed to traumatic events during the assessment. Recommendation 1.9.1 notes the need for all staff to be aware

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						several prisons. We would also recommend a focus on building mental resilience as an important preventative intervention for people in prison.	of protocols for dealing with mental health problems in the criminal justice system. We feel we have addressed your point about mental resilience in recommendation 1.3.14 by including assessing someone's capacity to make use of support networks. Prevention of mental health problems is outside the scope of this guideline so we are not able to make any recommendations on this issue.
231.	SH	Public Health England	Short	5	First – stage health assessment at reception into prison	1. Document refers to using 'Physical health in prisons' guideline standards for undertaking the mental health assessments in prisons when a person first arrives, but not other Justice settings. - Guidelines needs to say something about settings, outside of prisons - Because of the complexity and severity of mental health, substance misuse and physical health needs of people in contact with Justice, we would advocate for both the first and second stage assessments of mental health to be undertaken by a person qualified and experienced to undertake such an assessment.	Thank you for your comments. We have amended the sub-title which refers to second stage assessments to make it clear that the recommendations that follow apply throughout the care pathway. We have limited the use of the term second stage assessment to use within the prison system. The Committee agree that any practitioner who undertakes the assessments needs to be trained, competent and experienced. We feel this is reflected in recommendation 1.3.9.
232.	SH	Association of Directors of Adult Social Services	Short	6	1	This section should also make reference to identifying any immediate social care needs that may need to be addressed and ensuring appropriate immediate referral to the local authority.	Thank you for your comments. The text you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of

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							people in prison guideline. We are therefore not able to make any further changes to this text. However, we have made reference to the Care Act 2014 in the Context section which should address the point raised in your feedback.
233.	SH	Association of Directors of Adult Social Services	Short	6	4	Include "dignity" and "decency" alongside health and safety	Thank you for your comments. The text you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of people in prison guideline. We are therefore not able to make any further changes to this text.
234.	SH	Association of Directors of Adult Social Services	Short	6	8	Include also ability to undertake basic functions of independent living e.g. toileting, dressing, washing, understanding instructions, retaining information	Thank you for your comment. The text you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of people in prison guideline. We are therefore not able to make any further changes to this text. However, we have made reference to the relevance of the Care Act 2014 for people who are involved in any stage of the

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							criminal justice system, this assessment should identify functions associated with independent living.
235.	SH	Association of Directors of Adult Social Services	Short	6	8	This is also a key point to consider whether the individual requires independent advocacy, as described within the Care Act, to enable them to engage effectively in any assessment of and planning for their health and social care needs	Thank you for your comments. The text you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of people in prison guideline. We are therefore not able to make any further changes to this text. However, we have made reference to the importance of involving advocates within the assessment and care planning stages (see recommendations 1.2.1 and 1.5.1)
236.	SH	Association of Directors of Adult Social Services	Short	6	14	This should also include taking account of the NHS England Accessible Information Standards requirements.	Thank you for your comments. The Committee have reviewed recommendation 1.9.1 to expand on staff knowledge of relevant legislation and policy for their role.
237.	SH	Association of Directors of Adult Social Services	Short	8	2.8	It is not just the prison staff who need to be advised of any difficulties with issues of independent living but also the local authority social care services – See Care Act Statutory Guidance Chapter 17	Thank you for your comments. The Committee have reviewed recommendation 1.2.1 to include statutory requirements under the Care Act 2014. We have also amended the Context section to draw attention to the relevance of the Care Act 2014 for adults involved in the criminal justice system on any level.
238.	SH	College of	Short	8	2.8	As before: Assessment and intervention to mitigate against	Thank you for your comments. The

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		Occupational Therapists				these issues should be carried out by an Occupational Therapist. We believe they should be integrated as part of teams to effect a meaningful difference; rather than be seen as 'specialist'	guideline is focused on a comprehensive approach to the care and management of people who have mental health problems and are in contact with the criminal justice system. This includes in custody and in the community. Recommendations relating to primary and secondary care services are dealt with in disorder specific NICE guidelines, which we signpost to in section 1.2.5 of the full guideline. It is not the usual practice for guidelines to make recommendation about specific professional groups, but more about the experience and competence needed to deliver the interventions. The focus of the guideline is to ensure that people receive the best care while involved in the criminal justice system by competent and supervised practitioners.
239.	SH	Association of Directors of Adult Social Services	Short	10	4.1	The local authority social care services may be at least as relevant than the GP for someone who has previously been in contact with learning disability services	Thank you for your comment. The text you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of people in prison guideline. We are therefore not able to make any further changes to this text.
240.	SH	Association of	Short	10	4.1	A learning disability team may not just be a health service	Thank you for your comment. The text

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		Directors of Adult Social Services				provision or even an integrated health and care one but could be a standalone local authority social care service so it would be helpful to advise that the assessor seeks to know if there has ever been contact with either specialist health or social care services	you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of people in prison guideline. We are therefore not able to make any further changes to this text. However, we have reviewed 1.1.3 and included social services and tertiary services as sources of information. This should address the concerns raised in your feedback.
241.	SH	RECOOP	Short	10	general	Due to the high number of older people entering prisons, is there scope to build a quick memory test into the induction screening to assist with early dementia identification. At the recent Perrie Lectures the Mental Health Facts Sheet stated that '64% of older prisoners have a mental health problem. Between 850 and 4200 older prisoners are estimated to have dementia.' The figures around dementia tell us that basically no-one knows and a lot more needs to be done with assessment and recording in this area. As there are currently 12,700 older people in prisons across England and Wales which equates to around 15% of the overall population (MoJ June 2016) with numbers set to rise, it's most important to raise the profile of dementia within mental health assessment and treatment.	Thank you for your comment. The text you refer to is taken from the NICE guidance on Physical health of people in prison (NG 57). This material, was developed jointly by NICE's physical health of people in prison and mental health in the criminal justice system committees and has already been consulted on as part of the development of the Physical health of people in prison guideline We are therefore not able to make any further changes to this text. We have amended 1.3.14 to include assessment of cognitive function in light of your comments.
242.	SH	Public Health England	Short	11	1.3.6	Reinforce need to have second stage assessments based on validated, accredited assessment process, and inclusive of substance misuse, physical health, housing, employment /	Thank you for your comment. We have amended the sub-title which refers to second stage assessments to make it

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					Lines 2-3	occupation and income. There's another opportunity at second stage assessment to raise profile of Care Programme Approach and consistency of care and treatment Would the term 'second stage assessment' be a recognised phrase for practitioners, and others?	clear that the recommendations that follow apply throughout the care pathway. We have limited the use of the term second stage assessment to use within the prison system. We have amended recommendation 1.5.1 to include reference to the Care Programme Approach.
243.	SH	Public Health England	Short	11	1.3.6 1.3.7 1.3.8	The recommendation to consider the use of the Correctional Mental Health Screen requires careful thought before it is included in this NICE guideline. This screen is not a mental health assessment and does not offer sufficient breadth or depth of enquiry into a person's mental health to help formulate a view about the individual's mental health. There is a concern that if the use of the CMHS is approved by NICE, it could replace the individual's right to a comprehensive mental health assessment. We would recommend taking a view from a professional body e.g. The Royal College of Psychiatrists on the inclusion of CMHS	Thank you for your comment. The Committee considered the available evidence on a range of screening tools and agreed that the CMHS-M and CMHS-W was the most suitable tool to assess the potential presence of mental health disorders and neurodevelopmental disorders, based on the evidence review. The CMHS is validated for all psychiatric disorders except borderline personality disorder and antisocial personality disorder. Specifically the area under the curve for diagnosis of Diagnostic Statistical Manual (version 4 revised) Axis II, which includes psychiatric and intellectual disabilities are >0.7 for both men and women. We recommend the CMHS as a screening tool to identify those who need a comprehensive mental health assessment, not as a replacement for such an assessment.
244.	SH	Revolving Doors Agency	Short	11	9	Consider adding 'or substance misuse problem' – comorbidity is high, particularly among those in contact with the CJS, and the presence of one may suggest the presence of the other.	Thank you for this comment. We have amended recommendation 1.1.2 to clarify that people with substance

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							misuse problems are covered by the recommendations in this guideline.
245.	SH	Shire Pharmaceutical limited Ireland	Short	11	4-14 &17-19	We understand that the guideline committee did not review the specificity of the CMHS-M or the CMHS-W for individual conditions however it seems unlikely that the CMHS would identify people potentially having ADHD. It would be more likely to identify people with ADHD and co-morbidities because the co-morbidities would be more likely to score on the scale. As stated in comment 2, UK prison studies have indicated a rate of 24% of adult males screening positively for a childhood history of ADHD. Those with persisting symptoms accounted for 8 times more aggressive incidents than other prisoners. On the whole, the draft guidelines are unlikely to improve the identification of prisoners with ADHD, which means the chances of prisoners receiving treatment will not improve. We refer the committee to the UKAAN consensus statement recommendation that ADHD specific items are added to the screen. (Young eg al. The identification and management of ADHD offenders within the criminal justice system: a consensus statement from the UK Adult ADHD Network and criminal justice agencies. BMC Psychiatry 2011, 11:32 http://www.biomedcentral.com/1471-244X/11/32)	Thank you for your comments. The majority of studies you have sign posted are assessment tools used to identify the presence of ADHD. None of the instruments used involved a full assessment of behaviour and mental health and as such would not be appropriate for use in the UK prison system. The Committee considered the available evidence on a range of screening tools and agreed that the CMHS-M and CMHS-W was the most suitable tool to assess the potential presence of mental health disorders and neurodevelopmental disorders, based on the evidence review. The CMHS is validated for all psychiatric disorders except borderline personality disorder and antisocial personality disorder. Specifically the area under the curve for diagnosis of Diagnostic Statistical Manual (version 4 revised) Axis II, which includes psychiatric and intellectual disabilities are >0.7 for both men and women. No screening tool has been recommended in the NICE Attention deficit hyperactivity disorder guideline (CG 72). The Young et al (2011) paper was found by our searches but is a consensus statement and for this reason did not meet our inclusion criteria for evidence.

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246.	SH	Association of Directors of Adult Social Services	Short	12	16	It is also essential to consider the threshold for advocacy as defined within the Care Act as while this has a lower threshold than that for mental capacity it is still an essential requirement for ensuring effective engagement with the individual	Thank you for your comments. We have made reference to the Care Act 2014 and the importance of involving advocates within the assessment and care planning stages (see recommendations 1.2.1 and 1.5.1)
247.	SH	Nacro	Short	12	7	There needs to be consideration that the assessment environment can affect information and outcomes. For example, prison staff present or the physical setting and how comfortable the prisoner feels in their setting which can impair disclosure.	Thank you for your comment, the Committee agree. Recommendation 1.3.13 draws attention to the importance for practitioners to understand the impact the setting and context can have on an assessment.
248.	SH	Nacro	Short	12	17	Practitioners need to ensure that as well as discussing the assessment process, the prisoner fully understands the process (or their advocates). The prisoner also needs to be aware that they can ask for an advocate at any point if they do not understand the assessment or what it means, or how information is used and passed on.	Thank you for your comment. We have included the importance for services to consider their statutory obligations under the Care Act 2014, this obliges professionals to explain individual rights to independent advocacy. Recommendation 1.5.1 draws attention to involving advocates in care planning. Recommendation 1.2.1 draws attention to the importance of advocates during assessment stage.
249.	SH	Nacro	Short	12	17	Practitioners should not just discuss consent for who can see information but also give the opportunity to discuss who they don't want it shared with.	Thank you for your comment. We feel that recommendation 1.3.11 would address the concerns raised in your comments.
250.	SH	Public Health England	Short	12	1.3.9	Very pleased to see NICEs endorsement that the person undertaking the assessment has to be experienced and competent. We would also add the standard of being 'professionally qualified'	Thank you for your comments. The Committee strongly agrees on the importance of having trained and competent staff who are responsible for assessment and delivering interventions. We have drawn attention to this in three recommendations,

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							which we feel addresses the points in your feedback (see recommendations 1.3.9, 1.3.13 and 1.6.1)
251.	SH	Revolving Doors Agency	Short	12	5	Consider referring to 'urgent referral' as per CMHS	Thank you for your comment, however, the Committee did not think that specifying urgent referral for a CMHS was appropriate because its purpose is to screen for underlying indicators of mental health problems. If someone was exhibiting indicators of risk, psychosis or other acute symptoms of mental illness that required an urgent referral, this should be picked up during the initial check in.
252.	SH	Together for Mental Wellbeing	Short	12	7	Our experience is that professionals may have the perquisite experience of working with mental health problems but have limited understanding of both how contact with the CJS impacts on service users as well limited understanding of justice processes, procedures and the role and responsibilities of criminal justice agencies. We welcome the explicit reference to the competencies identified.	Thank you for your comment and your support
253.	SH	Together for Mental Wellbeing	Short	12	17	We would suggest that there should also be an explicit reference as to the recording of any discussions regarding the rights to confidentiality and the outcome of those discussions	Thank you for your comment. The Committee agree that a record should be kept of such conversations. However, this would be covered in local policy and so we have not made any changes to the guideline in light of this comment.
254.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	Short	12-15	-	The impact of previous trauma should be included in this section, in addition cultural context may have a significant impact on assessment, in addition the assessment should cover the impact on the person of their reception into prison. Resilience factors could also be explored in more detail. The persons goals and needs could also be jointly assessed which would be more in keeping with recovery based models in mental health. It would also be helpful for the document to	Thank you for your comment. We have included specific reference to assessing if an individual has been exposed to traumatic events (recommendation 1.3.14). We feel we have addressed your point about goals in recommendation 1.5.1, which specifies identifying goals and working

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						make reference to the quality of the outcome document at the end of the assessment and the key areas this should contain e.g a very brief formulation of any health difficulties, psychological needs, conflict/ risk triggers etc.	towards them as part of care planning.
255.	SH	Association of Directors of Adult Social Services	Short	13	9	Using an independent advocate if necessary	Thank you for your comments. The Committee have made reference to the importance of involving advocates within the assessment and care planning stages (see recommendations 1.2.1 and 1.5.1)
256.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissionin g Manager)	Short	13	6	There is no mention of healthcare professionals (HCPs) as a source of information to support the assessment. With the person's consent, other HCPs may be able to provide useful information e.g. GP, community pharmacy (about adherence/collection of medication).	Thank you for your comment. We specify in recommendation 1.1.3 to review all medical records which should include information from GPs and other primary care services.
257.	SH	Public Health England	Short	13	1.3.13	Can we define 'common presenting problems'. Outside of places of custody the term ' common mental health problems' is frequently used and understood to mean depression and anxiety. It would help to have consistency with language and understandings held more broadly, and use the term 'common mental health problems'	Thank you for your comment. We have reviewed this recommendation to reduce the risk of confusion between common presenting problems and common mental health problems.
258.	SH	Public Health England	Short	13	1.3.13	We would recommend using assessment tools used widely in community settings, e.g. the Improving Access to Psychological Therapies assessment tools	Thank you for your comment. The Committee considered the available evidence on a range of screening tools and agreed that the CMHS-M and CMHS-W was the most suitable tool to support the effective recognition of potential mental health disorders and

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							neurodevelopmental disorders, based on the evidence review. The CMHS is validated for all mental health disorders. The IAPT tools you refer to are used for initial assessment and routine outcome monitoring in IAPT and not for screening or recognition. We cross refer to condition specific NICE guidance on treating mental health problems, for example the Depression (CG 90) and Social Anxiety Disorder (CG 159) guidelines which recommend IAPT tools for initial assessment and outcome monitoring.
259.	SH	Revolving Doors Agency	Short	13	6	Consider adding 'and other services involved in the person's care, including substance misuse services and housing and/or resettlement services'.	Thank you for your comments. We have amended 1.1.3 in light of your comment.
260.	SH	Revolving Doors Agency	Short	13	23	Consider adding 'and limitations' – omissions may also be likely to moderate the likelihood of providing an effective intervention.	Thank you for your comment. Upon reviewing the recommendation we feel that appraising the reliability and validity of records would imply that the limitations of those records would be assessed.
261.	SH	Together for Mental Wellbeing	Short	13	9	We welcome the reference to putting service users at the centre of discussions about their own care and treatment. Q1: This can be experienced as particularly challenging for professionals as they balance potential coercive elements of working within the justice system with creating an environment of practice that encourages choice and empowerment for the service user. This may require a shift in thinking for professionals – working collaboratively with service users rather than 'doing to'. This can only be driven by the provider organisation that has an ethos and values that put service users at the centre of their care.	Thank you for your comments. Your comments will be considered by NICE where relevant support activity is being planned
262.	SH	Together for Mental	Short	13	17	Q1 Whilst this is a description of best practice relating to an assessment, justice settings, processes and procedure often	Thank you for your comments. Your comments will be considered by NICE

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		Wellbeing				mean that assessments are extremely time-limited and may need to be completed with the information available at the time, which may be partial. Assessment templates related to the setting (e.g. police custody; courts) can support professionals focus on both the person's needs but on obtaining the information that will most support the person in terms of their interface and journey along the justice pathway. We welcome the reference to adjusting the assessment as new information emerges as our experience is that people in the CJS are often subjected to multiple assessments, often duplicating information.	where relevant support activity is being planned
263.	SH	Together for Mental Wellbeing	Short	13	3	We would suggest that assessments should also take a gendered approach, particularly around the distinct and specific needs of women and be trauma-informed and any other concerns related to protected characteristics. They should also take into account a person's cultural needs. We would also advocate that the assessment references the impact of all types of care and support that the person may have had access to, including family and other social networks as well as contact with voluntary sector organisations.	Thank you for your comments. We have reviewed recommendation 1.1.2 to ensure attention is given to cultural and ethnic differences as part of the assessment. We feel recommendation 1.3.12 addresses your point about considering other types of care and support someone has had access too including formal and informal support. Recommendations 1.3.5 includes specific questions to be asked for women.
264.	SH	Association of Directors of Adult Social Services	Short	14	12	It is disappointing that reference to social care needs does not appear until page 14 of the document and then does not reference how social care needs may manifest themselves. Perhaps a link to a document describing what social care needs encompass would be useful here.	Thank you for your comments. The Committee have reviewed recommendation 1.2.1 to include statutory requirements under the Care Act 2014. We have also amended the Context section to draw attention to the relevance of the Care Act 2014 for adults involved in the criminal justice system on any level.
265.	SH	Nacro	Short	14	3	Pre-existing trauma needs to be taken into consideration; this can often be sub-threshold and therefore not immediately apparent, but needs to be factored in to all mental health assessments. For example, this is prevalent amongst gang-	Thank you for your comment. We have amended recommendation 1.3.14 to include assessing someone's exposure to potentially traumatic

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						involved individuals.	events.
266.	SH	Public Health England	Short	14	1.3.16	Would recommend making a positive statement about sharing of assessment with persons family / carers as they very often have a key role to play in the care plan and care after custody	Thank you for your comment. Recommendations 1.3.11 and 1.3.12 refer to the inclusion of family in the assessment process and information sharing.
267.	SH	Nacro	Short	15	7	We would suggest that assessments are reviewed on a more regular basis and don't depend on a significant event – new information may not reach practitioners through other sources and people could slip through the net. Routine assessments would ensure that the individuals also has a forum to disclose any escalating mental health problems before it gets more serious. This should also include an assessment when an individual is released from custody into the community and the information should be passed to relevant agencies.	Thank you for your comments. The Committee have made changes to recommendation 1.3.17 to include review periods and mention of CPA and Care Treatment Plan.
268.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Short	15	9	It is important that non-adherence to treatment for mental illness is included here, including medicines adherence. I'm not convinced this will be interpreted as included in the generic term for "new information about their mental health problem". Can the GDG consider how this is could be rephrased so it's clearer to readers that this includes where the person becomes disengaged with or reduces adherence to treatment?	Thank you for your comment. We have amended recommendation 1.3.17 in light of your comments.
269.	SH	Adult Secure Services Clinical Reference	Short	15	21	This list ought to include consideration of any patient safety incidents that have been recorded involving the person - e.g. omitted doses of medicines, incidents of self-harm; SIRs involving the person as these may provide additional	Thank you for your comment. We have amended recommendation 1.3.18 in light of your comment.

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		Group (Armed Forces and their Families and Health and Justice Commissioning Manager)				information to ensure a holistic review.	
270.	SH	Public Health England	Short	15	1.3.17	We would again advocate for the use of an accredited process for reviewing of care plans	Thank you for your comments. The Committee have made changes to recommendation 1.3.17 to include review periods and mention of CPA and Care Treatment Plan.
271.	SH	Revolving Doors Agency	Short	15	6	Consider adding 'including substance misuse services'.	Thank you for your comment. The Committee think that other agencies will include substance misuse services and so have not made any changes to this recommendation.
272.	SH	Revolving Doors Agency	Short	15	23	Consider adding 'substance misuse (where applicable)'	Thank you for your comment. The Committee think that the involvement of substance misuse services has been made explicit within the guideline and therefore has not made this suggested change.
273.	SH	Nacro	Short	16	5	Any triggers specific to the individual should be considered here, for example an anniversary of an event. This could affect behaviours and should be considered in assessments. It is also worth considering whether the risk is general to everyone or to specific groups of people or individuals.	Thank you for your comment. The Committee agree that assessments should take into account significant events, such as anniversaries or triggers, which we would expect would come under recommendation 1.3.14 either through their history or social and personal circumstances. We have added in the specific assessment of exposure to traumatic events which would also impact on the assessment. In response to the risk assessments,

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							these are general as opposed to specific risk assessment.
274.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	Short	16	15-19	This section appears to be unclear – in what way will they be monitored and is the latter part relating to self-monitoring	Thank you for your comment. The Committee reviewed this recommendation but felt that, as the methods for monitoring risk and behaviour will need to vary between individuals, it was not possible to specify a particular method. We have amended recommendation 1.4.3 to clarify which part relates to self-monitoring.
275.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	Short	16	1-28 10 17	The risk assessment and management section could focus more on involving the person in a safety partnership to prevent and manage risk. The general tone is one of 'doing to… rather than working with…' Predation (10) is a negative and emotive term Shared with appropriate parties (including families) implies that the person has no consent in this process In general a more preventative focus may be introduced in this section.	Thank you for your comments. We have removed the word predation in light of your comments. The Committee considered your comments but do not agree with your points entirely. The risk assessments completed with someone who is involved with the Criminal Justice System may include risk of harm to self and others. Where a risk of harm is identified against others there is a duty for this to be shared where relevant to prevent harm. As this guideline applies to all criminal justice settings it is felt that the way this is worded is appropriate.
276.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health	Short	16	7	The list needs to include medicines non adherence, diversion and substance/medicines misuse	Thank you for your comment. The Committee think that assessment of risk to self and risk to own health would allow for the assessment of substance misuse or diversion of medicines. As this guideline is applicable across all criminal justice settings it is important that it supports

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		and Justice Commissioning Manager)					the development of appropriate assessments dependent on the setting.
277.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Short	16	27	Consider adding "for example enabling the person to receive their medicines under supervision (not in-possession) until their level of risk improves". This addition will help readers included medicines in the risk assessment and link it to the wider medicines recommendations in the physical health in prisons guidance.	Thank you for your comments, however, the Committee do not feel it is appropriate to make your suggested change. The Physical health of people in prison guideline (NG 57) is specific to a prison setting, whereas this guideline is applicable across all criminal justice settings including prison, police custody, within court settings and within probation service providers. In-possession medicines would not apply across all these settings.
278.	SH	Public Health England	Short	16	1.4.2	Very pleased to see a broad approach to identify risks, including vulnerability. Again, we should be recommending the use of validated risk screening / assessment tools when undertaking this element of the assessment	Thank you for your comments. The Committee considered the available evidence on a range of screening tools and agreed that the CMHS-M and CMHS-W was the most suitable tool to assess the potential presence of mental health disorders and neurodevelopmental disorders, based on the evidence review. The CMHS is validated for all psychiatric disorders except borderline personality disorder and antisocial personality disorder. Specifically the area under the curve for diagnosis of Diagnostic Statistical Manual (version 4 revised) Axis II, which includes psychiatric and intellectual disabilities are >0.7 for both men and women.
279.	SH	Revolving Doors Agency	Short	16	11	Consider adding 'including substance misuse (if applicable)' here or elsewhere in 1.4.2	Thank you for your comment. The Committee feel that assessment of risk

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							to self and risk to own health would allow for the assessment of substance misuse.
280.	SH	Revolving Doors Agency	Short	16	13	Consider adding 'including their housing situation (if in a community setting)'	Thank you for your comment. We have included the importance of assessing someone's social and physical environment which would be applicable to community and custodial settings.
281.	SH	Nacro	Short	17	27	We strongly agree with and support this section – and it is important to remember that there can be a number of agencies and individuals involved in care planning for an individual and it all needs to be integrated. We also suggest this comment reads 'develop a mental health pan of care……when possible AND appropriate….'. A multi-agency approach is important, all services need to be on board and aware. Consideration needs to be given to the fact that where many 18 year olds who have previously been looked after, children's services may also have relevant information. This section should also include information on transferring care plans when the individual gets released to the relevant agencies/services to ensure limited disruption into the community.	Thank you for your comment. We have made some amendments to recommendation 1.8.4 to highlight the importance of effective transferring of care plans and having transition pathways between agencies (such as between Young Offender and Adults services). We have added in developing joint care plans where appropriate, this would incorporate your feedback of multi-agency working.
282.	SH	Nacro	Short	17	27	Information on the process of review for the care plan should be added here, as there needs to be contingency in case problems escalate. The care plan needs to be able to adapt to this.	Thank you for your comment. In recommendation 1.4.4 we have stated that risk assessments need to be reviewed regularly and adjusted if the risk level changes. In recommendation 1.5.1 we draw attention to the importance of reviewing care plans and developing crisis plans as part of the care planning process. Crisis plans

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							and risk management plans should identify triggers for escalation and mitigation plans.
283.	SH	Prison Reform Trust	Short	17	26	1.5 Care planning: the importance of integrating mental health plans of care with adult social care plans should be explicitly stated. This is especially important if an assessment of social care needs has been undertaken or requested under the requirements of the Care Act 2014, and relevant for individuals with eligible social care needs and social care needs.	Thank you for your comment. We have made some amendments to recommendation 1.8.4 to highlight the importance of effective transferring of care plans and having transition pathways between agencies (such as between Young Offender and Adults services). We have added in developing joint care plans where appropriate, this would incorporate your feedback of multi-agency working. We have referred to the Care Act 2014 in recommendation 1.1.2 and the Context section to highlight the relevance of this legislation for people in any setting of the criminal justice system.
284.	SH	Revolving Doors Agency	Short	17	26 onwards	Consider amending title to 'care and support planning'. While 'care plan' might be the commonly used term in mental health and some other services, different services may use the term 'support plan' to mean effectively the same thing. If not in the title, line 30 could be amended to read 'integrated with care and support plans…'	Thank you for your comment. However, the Committee does not feel that this change is needed as the correct use of care planning should include support planning and support needs.
285.	SH	Shire Pharmaceutical limited Ireland	Short	17,18	26-30, 1-11	The importance of a clear strategy to access all identified interventions and services is extremely important but will be challenging to implement for people with ADHD as GPs can be reluctant to prescribe stimulant medication under shared care arrangements and specialist or AMHS services for adults with ADHD (as noted in comment 1) are patchy across the country and non-existent in some areas.	Thank you for your comments. The Committee agree that the management of ADHD in adults is important and should be managed through the recommendations made in the NICE guidance on Attention deficit hyperactivity disorder (CG 72). In this guideline we have referred readers to this condition specific guideline.
286.	SH	Rethink Mental	Short	17–18	-	Care Planning recommendations	Thank you for your comment. The

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		Illness				• When a mental health care plan is developed, this should be led by the person concerned, and produced in collaboration with other supporters of their care. The only occasions where family, carers and advocates are not involved in the production of a mental health plan should be when the person concerned does not give consent, or family, carers and advocates are either unwilling or unable to participate. No structural barriers should prevent them from taking part, and where these exist, they should be removed. Co-production is once again the model that should be followed. • Clear strategies to access all identified interventions and services should be developed with the person themselves and this process should all feed into the development of local services, and to identify gaps in service provision. • Where risk management and crisis plans are developed, they should include advance directives that determine what the person concerned wants to happen in certain situations. • The professionals responsible for giving individuals the chance to discuss the outcomes and implications of their assessment, as well as the content of their care plan, must have sufficient training to carry out this process effectively. Alongside establishing desired outcomes, care plans must also include an action plan for how they can be achieved and measured. • Where individuals struggle to take in and remember information, families, carers and advocates should be consulted to help the person understand the content of their care plan. Where appropriate, families and carers should also be provided with any additional information that helps the implementation of care plans. • Additional clarity is required on what is meant by 'any adjustment to the social or physical environment'. This is an extremely broad statement with potentially very	Committee agree with the points you raise and consider them important in the development of any care plan. We have reviewed our care planning recommendations and are of the view that all the issues you raise are addressed in our recommendations. We have made a number of minor amendments to the wording in light of yours and other's comments, which have further clarified that our recommendations are in line with your comments. With regards to your comment on advance directives there is a guideline in development, Decision making and mental capacity, which we feel will deal specifically with this issue.

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						significant implications.	
287.	SH	Nacro	Short	18	15	Integrated care needs to be considered when developing and implementing care plans. This section should also include a point about easy read materials being available.	Thank you for your comment, we agree. We have amended recommendation 1.8.1 to include prompt access to appropriate treatment and care to encourage integrated care. In recommendation 1.1.2 we highlight that people who use this guideline should take into account any language, literacy or information processing needs.
288.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Short	18	7	Add the words" treatment monitoring and" before "outcomes". This is because therapeutic drug monitoring or other clinical monitoring responsibilities and expectations need to be included in the care plan. This can often get missed if not specified (e.g. cardiac monitoring with antipsychotics).	Thank you for your comments. The Committee think that in this recommendation outcomes will include appropriate monitoring which would be agreed at the time of care planning. Therefore no amendments have been made.
289.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Short	18	18	Just a note to sign post the GDG to the current NICE consultation on Managing medicines for adults receiving social care in the community and are currently consulting on the draft version. https://www.nice.org.uk/guidance/GID-MANAGINGMEDICINESCOMMUNITYSOCIALCARE/documents/draft-guideline This may be worth referencing as the guideline will be relevant for people taking mental health medicines in prison who also require social care.	Thank you for your comment. The Committee are aware of the pending publication of the guideline you discussed. If this has been published within the timeframe of this current guideline we will make reference to it.
290.	SH	Public Health	Short	18	15-25	We think that it is important to include in this section the impact	Thank you for your comments. We

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		England				of/upon specific events on the criminal justice pathway, for example court/prison release dates of any treatment interventions and vice versa in care planning. Similarly, care planning should take into account the requirements of any mandated offending behaviour programmes	have amended recommendation 1.5.1 to reflect your comments about the impact of mandatory offender treatment programmes and significant events such as transfer between institutions.
291.	SH	Revolving Doors Agency	Short	18	17	Consider adding 'the role to be played by other agencies providing care, treatment or support to the individual'.	Thank you for your comments. We have amended recommendation 1.8.4 to include joint care plans, including with health and criminal justice agencies to promote effective intervention.
292.	SH	Together for Mental Wellbeing	Short	18	12	We would also advocate that service users are provided with copies of their assessments and care plans	Thank you for your comment. The Committee agree and feel we have already addressed this in recommendation 1.5.1 and in directing people to use this guideline in conjunction with the service user experience in adult mental health and patient experience in adult NHS services guidelines.
293.	SH	Together for Mental Wellbeing	Short	18	17	Consideration should also be given to any barriers relating to language	Thank you for your comment. In recommendation 1.1.2 we draw attention to specific needs people may have which need to be considered throughout the guideline. These needs include those associated with language barriers which we feel addresses concerns raised in your feedback.
294.	SH	College of Occupational Therapists	Short	19	26	Occupational functioning should be recognised within the context of occupational therapy rather than a psychological intervention.	Thank you for your comments. The purpose of recommendation 1.6.2 is to remind people of the potential areas of difficulty that people in contact with the criminal justice system who are having psychological treatment may

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							experience - so that these can be taken into account. Occupational functioning is one such issue. Recommendation 1.6.2 does not seek to imply that occupational functioning is a form of psychological intervention
295.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	short	19	11-26	This section appears to focus on personality difficulties and there could be more inclusion of axis 1 difficulties such as anxiety and depression if the section is covering common difficulties.	Thank you for your comments. The Committee developed these recommendations because of the high prevalence of personality disorders in adults within the criminal justice system. There are issues in the recognition of personality disorder and management of some of the behaviours which may be associated with it, such as emotional dysregulation, and the difficulty of engaging people with personality disorder in treatment. Anxiety and Depression are covered by existing condition specific NICE guidance which we have cross referenced – we have therefore not mentioned them in our recommendation.
296.	SH	Public Health England	Short	19	1.6.1	We should also be mentioning the wider NICE guidelines for mental health, reinforcing the point that people in prison should have access to NICE approved mental health interventions that are available to the general population	Thank you for your comment. We have amended the full guideline to include a list of other relevant NICE guidelines (section 1.2.5).
297.	SH	Public Health England	Short	19	1.6.3	We welcome the inclusion of Personality Disorder. We need to say something here about the breadth of Personality Disorders (at least 10 different types), how the vary greatly and do require a qualified professional to reach the diagnosis. There is a risk that we use the term Personality Disorder as if it's all the same thing and treat people in a completely uniform way because of this diagnosis	Thank you for your comments. As we have indicated in our recommendation on assessment, people undertaking assessments should be competent in assessing presenting problems. This assumes the disorders are identified and commonly understood. The

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							recommendations we have made about training should address the specifics of these disorders and how they present.
298.	SH	The Disabilities Trust	Short	19	1	Point 1.6 – We recommend that, where appropriate, consideration is given to whether the CJS is the appropriate place to deliver psychological interventions when a history of ABI has been identified. Our case study of Byron illustrates that specialist brain injury rehabilitation in a healthcare rather than custodial setting can save in excess of £80,000 per individual in the short-term and prevent the cycle of recidivism. [The Disabilities Trust (2015), Brain Injury Linkworker Service, http://www.thedtgroup.org/media/4082/160115_linkworker_service_report.pdf]	Thank you for your comments. As you point out, there are many different ABI and, the range and nature of the impairment varies significantly. For many people having ABI should not be a barrier but might require adjustment of the content and delivery of the intervention. For some people who require more specific rehabilitation, identifying this will be through the assessment and care planning stages. In order to support this we provide recommendations about this and the principles which should apply during the assessment (1.2.3 short guideline).
299.	SH	Together for Mental Wellbeing	Short	19	8	Q1: Continuity of intervention is a huge challenge when people move between justice settings or out of justice settings. It is often challenging for professionals within prisons for example, to identify services in the community that will be able to offer continued intervention in a timely and supportive way for people on release. We know that very often women particularly may make significant treatment gains in prison but have no support or care pathway on release. Q2 Lack of robust information sharing pathways and joined up IT system also present huge barriers and potential costs	Thank you for your comment. We have included reference to the Care Act 2014 which has relevance for individuals within all Criminal Justice Settings and should support transition between settings. We have amended 1.8.1 to include the importance of supporting the development of prompt access to appropriate treatment and care (including medication).Your comments will be considered by NICE where relevant support activity is being planned
300.	SH	Together for Mental Wellbeing	Short	19	11	It is welcomed that there is greater awareness of how people in the CJS may respond and behave. We would suggest that the issue of trust is again emphasised as lack of trust underpins much of the difficulties experienced by people particularly in	Thank you for your comment. Recommendation 1.1.2 highlights that that professionals need to take into account the importance of developing

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						settings where they experience disempowerment more acutely	trust in an environment where health and care staff may be held in suspicion. We feel this addresses the concerns raised in your comment.
301.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	Short	19 -20	-	Symptoms of psychosis and axis 1 disorders should be given some focus in this section.	Thank you for your comments. The Committee developed these recommendations because of the high prevalence of personality disorders in adults within the criminal justice system. There are issues in the recognition of personality disorder and management of some of the behaviours which may be associated with it, such as emotional dysregulation, and the difficulty of engaging people with personality disorder in treatment. The recommendations for treating personality disorder are in the relevant NICE guidelines which are referred to in this guideline. The group felt it was important to emphasise. We also make reference to other guidelines and general principles for the delivery of psychological therapies.
302.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	Short	20	-	The section on specific psychological interventions appears very over prescriptive and narrow in focus to the extent of potentially being unhelpful to guiding professionals in the interventions available. It is narrowly focussed and does not cover the range of options for mental health difficulties. The comment regarding only providing interventions relating to	Thank you for your comments. The focus of this guideline is to highlight the best approaches to the assessment and management of people with mental health problems in the criminal justice system. We have not made any condition specific recommendations, instead we have directed people to refer to the relevant NICE guidelines for advice on how to assess and treat those conditions.

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						paraphilia's only being delivered as part of research whilst in direct response to the lack of information provided by NOMS appears unhelpful for professionals and prisoners who require psychological interventions to reduce risk.	Unfortunately the Committee were not able to make any recommendations for clinical practice for treating paraphilias given the limited quality of the available evidence. We hope that the recommendation to consider psychological interventions as part of a research programme will help generate the evidence that is needed to give more definitive guidance on this issue
303.	SH	Public Health England	Short	20	1.6.7 Line 23	When we refer to substance misuse, we need to say that many people in contact with Justice have co-existing mental health and substance misuse problems, and that their care should be delivered in accordance with NICE guideline for Dual diagnosis. In the light of comments set out at 1 above, we think this should be headed 'Specific psychological interventions for co-existing substance misuse problems.	Thank you for your comment. In section 1.2.5 of the full guideline we direct people to related NICE guidelines which includes those guidelines on Coexisting severe mental illness (psychosis) and substance misuse (CG 120) and Drug misuse in over 16s: psychosocial interventions (CG 51). These indicate that the main recommended treatments for substance misuse are psychosocial interventions. We feel that the recommendations within these guidelines are relevant and include sections for people in contact with the criminal justice system. The Committee did not feel able to make a recommendation about interventions specifically for co-existing substance misuse problems due to not having any evidence to this effect. Therefore we are not able to make your suggested change to the heading.
304.	SH	Revolving Doors Agency	Short	20	20	No specific suggestions, but this section may benefit from being strengthened given the history of personality disorder as	Thank you for your comment. Unfortunately the wording of this

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						a diagnosis of exclusion.	recommendation is as strong as we can make it, based on the quality of the evidence reviewed by the committee.
305.	SH	Together for Mental Wellbeing	Short	20	20	We welcome the reference to personality disorder not being a diagnosis of exclusion. Q1In reality our experience is that service users with comorbid presentations are often excluded and it is a challenge in terms of the practice of professionals that may require further training and a testing of competencies to ensure that professionals have the motivation and skills to work with service users with a personality disorder diagnosis	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned
306.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissionin g Manager)	Short	21	26	Please add a bullet point about taking into account "choice of medicine based on risk of diversion and harm in prison". This is separate from the IP risk. Guidance has been published by the RCGP "Safer Prescribing in Prisons 2011" which includes a chapter on choice of mental health medicines. This guidance is being revised in 2017.	Thank you for your comments. In response to your comment on the risk of diversion or harm, recommendation 1.7.1 addresses the importance of taking into account the risks associated with in-possession medicines which would include risks of diversion or harm. We did not look at a question specifically about prescribing and therefore have not appraised this document. Consequently we are not able to cross reference the guidance you mention.
307.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissionin g Manager)	Short	21	26	Please add a bullet point about "prescribing medicines within licenced indications and local formularies"- this integrates care within the wider community and will link well with physical health GDG.	Thank you for your comment. Recommendations on the prescribing of medicines in NICE guidelines are based on licensed indications and therefore we have not added a bullet point as you suggest. Where a drug is not being recommended within its licensed indications, a footnote to that effect will be included

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308.	SH	Revolving Doors Agency	Short	21	26	Consider adding 'including the risk of medicines being diverted or misused' (although this does appear under 1.7.3, medicines for sleep problems and pain, where the risk is probably highest).	Thank you for your comment. The Committee agree there are concerns about the potential misuse of prescribed medicines in prisons. However, recommendation 1.3.5 there is a specific question for assessing someone's use of prescribed medicines. Recommendation 1.7.1 highlights the importance of assessing the risk of in-possession medicines. We direct people to condition-specific NICE guidelines for prescribing pharmacological interventions as these will deal with the concerns you raised in your comment.
309.	SH	Public Health England	Short	21-22	22 - 09	In the light of comments set out at above, we think there should be an additional heading in this section of 'Pharmacological interventions for co-existing substance problems ' and references to the appropriate NICE guidelines inserted	Thank you for your comment. In section 1.2.5 of the full guideline we direct people to related NICE guidelines including the Drug misuse in over 16s: psychosocial interventions (CG 51) Guideline which indicates the main recommended treatments for substance misuse are psychosocial interventions. The Committee did not feel there was sufficient evidence to recommend any particular pharmacological interventions for substance misuse.
310.	SH	Janssen Cilag ltd	Short	22	2-4	We are concerned that there is no specific recommendation concerning the use of pharmacological interventions in schizophrenia within the draft clinical guideline. We suggest that a recommendation, similar to recommendation 1.7.2 for attention deficit hyperactivity disorder (ADHD), is added for schizophrenia. Janssen note that specific recommendation for prescribing of pharmacological interventions in ADHD is based on existing NICE Clinical Guideline (CG) 72, but this does not	Thank you for your comments. The Committee agrees on the importance and relevance of effective treatment of schizophrenia in adults in contact with the criminal justice system. We have not developed any condition specific recommendations in this guideline. We direct people to the specific NICE

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						appear to be based on any specific evidence in the forensic setting and evidence for this recommendation is of low quality. We realise that there is limited evidence for schizophrenia pharmacological interventions in a forensic setting too. However, it has been suggested that there is no reason to believe that response or efficacy of pharmacological intervention are likely to differ between a forensic or general clinical schizophrenia populations [Stone et al]. We therefore suggest that a similar recommendation for use of pharmacological interventions in schizophrenia based on the NICE CG 178 should also be included in the current draft clinical guideline on the same basis. We believe that specific recommendation for the use of pharmacological interventions in schizophrenia is important to include, in order, to tackle the significant burden that schizophrenia places on the mental health system and adults in contact with the criminal justice system. It is estimated that around 9% male remand prisons, 6% of male sentenced prisoners and 13% of female prisoners have schizophrenia disorders [Singleton et al]. This equates to 7,312, 4,875 and 499 people respectively out of a total population of around 85,082 patients based on the September 2016 prison population data [Population and Capacity Briefing]. The burden of schizophrenia on the criminal justice system is therefore significant. A recommendation around the use of appropriate pharmacological interventions based on NICE CG 178 would ensure more appropriate prescribing of antipsychotics in a forensic setting and improve patient care. It would also help address the burden of schizophrenia, especially the cost of forensic beds which cost the NHS an estimated £1.2bilion in England or around 18.9% of all public expenditure on adult mental health [Centre for Mental Health].	guidelines for advice on treatment and management of these conditions, as in recommendation 1.7.1. We have mentioned ADHD, along with sleep problems and chronic pain, in 1.7.2 as the pharmacological interventions used for these disorders can be misused which we felt was important to highlight. We have not reviewed evidence which would raise similar concerns regarding the pharmacological interventions widely used for schizophrenia.
311.	SH	Nacro	Short	22	24	There needs to be a reference to Liaison and Diversion services (street triage is referenced but not L&D services).	Thank you for your comments. The Committee have made several comments about liaison and diversion

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						The L&D Programme was established in 2010 in response to The Bradley Report's recommendation to divert offenders with mental health problems from custodial settings. L&D services identify offenders who have mental health issues, learning disabilities or other vulnerabilities when they first come into contact with the criminal justice system. Service users are supported through the criminal justice system or diverted into treatment, social care or other support services. L&D aims to improve health outcomes, reduce re-offending and identify vulnerabilities earlier, thus reducing the likelihood that offenders will reach crisis-point. Ten pilot L&D schemes were established in April 2014, and a further 16 schemes went live in April 2015, bringing national coverage up to 53%. The L&D programme plans to roll out L&D services across the remainder of England in the coming years. Throughout the pathway, data about the health needs of the service user are captured and used by agencies such as police, judges and probation so that they can make informed decisions about case management, sentencing and disposal. The police and judiciary make appropriate decisions, based on the evidence and information presented to them. L&D services will also provide a route to treatment for people whose offending behaviour is linked to their illness or vulnerability with the principle of preventing crime, reducing re-offending and providing better and more timely information to agencies in the criminal justice system. If you require any more detailed information please contact caroline.drummond@nacro.org.uk.	within the criminal justice system including police and street triage diversion services. We made minor amendments to recommendation 1.8.1 to further emphasise the importance for health and criminal justice agencies to develop diversion services. However, the evidence is scarce which limited the recommendations we were able to make.

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312.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Short	22	1	All medicines should be available on release from prison, so I'm not sure why this is included. For complex medicines (e.g. clozapine, high risk depot injections) planning for release for medicines continuity will be needed. Perhaps this bullet point could be re-phrased to "planning of care to ensure post-release medicines continuity for example for clozapine".	Thank you for your comment. The Committee felt that while medicines should be available for people upon release this may not always be the case and so have not made any changes to this recommendation.
313.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Short	22	5-9	This sentence implies that mental health practitioners will review pain medicines. It is recognised that persistent pain requires a multidisciplinary approach between mental health and physical health clinicians. This is also true for sleep problems as the factors for this may also be physical health diagnoses. Perhaps the first bullet point can be adjusted to read " establish the best course of treatment in partnership with physical health clinicians" In addition there is no mention of national guidance on sleep including NICE guidance- there are lots of NICE documents/publication types about this. A bullet point about managing sleep problems in line with NICE guidance would be helpful here (even though NICE guidance inclusion is mentioned in section 1.7.1.) Consider adding a bullet point that states "avoid prescribing antidepressants for their hypnotic properties alone"- *(this is due to the prescribing of antidepressants such as mirtazapine to avoid prescribing short courses of hypnotics or other sleep hygiene treatments).*	Thank you for your comments. This guideline is applicable for all prescribers as there is the potential misuse of medications which may be prescribed for sleep disorders and as pain management. This is reflected in recommendations 1.7.2 and 1.7.3.
314.	SH	Public Health England	Short	22	12 - 19	Liaison and Diversion is a current a national programme that is being rolled out by NHS England. This recommendation could	Thank you for your comment. The Committee agrees on the importance

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						be strengthened by stating that this programme should not be developed in isolation; should be fully integrated with other services in for example, police custody health care; drug interventions for offenders and with community treatment and support services to provide a holistic service which avoids repeat assessments on individuals and duplication of service. One of the challenges at a local level is that there is no lead body responsible for championing the complex health needs of individuals in contact with local criminal justice systems. A recommendation from NICE as to who could fulfil this role would be welcomed	of integrating liaison and diversion with local services and have made amendments to recommendation 1.8.1 to encourage local pathways to be developed. However, it is not possible for this guideline to specify exactly how this should be implemented.
315.	SH	Prison Reform Trust	Short	22	12	1.8.1 Liaison and diversion should be cited as an example of a service, in the opening paragraph, that can assist with effective identification and recognition of people with mental health problems and learning disabilities (and other needs, such as autism and substance misuse problems); will undertake screening and assessment, where necessary; and provide advice on immediate care and management.	Thank you for your comments. The Committee have made several comments about liaison and diversion within the criminal justice system including police and street triage diversion services. We made minor amendments to recommendation 1.8.1 to further emphasise the importance for health and criminal justice agencies to develop diversion services.
316.	SH	Revolving Doors Agency	Short	22	16	While I appreciate this draft guideline relates to mental health, please consider adding 'and any substance misuse problems'.	Thank you for your comment. We have amended recommendation 1.1.2 to include a definition of the disorders which should be considered throughout this guideline. We feel this addresses your feedback.
317.	SH	Revolving Doors Agency	Short	22	20	Consider adding 'where available' – current provision of these courts is extremely small scale and may in fact have ended entirely. They may return in future, so suggest making the addition rather than deleting the section.	Thank you for your comment. We are aware that current provision of drug courts may currently be limited and varied. However, we hope that implementation of this recommendation (by local services) will help to address this variation.
318.	SH	Shire Pharmaceutica	Short	22	2-4	The NICE clinical guideline on ADHD was written in 2008 and is currently being reviewed. Options for pharmacological	Thank you for your comment. The focus of this guideline is to highlight

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		l limited Ireland				therapy have changed. More up to date guidelines have been published by the British Association of Psychopharmacology (Evidence-based guidelines for the pharmacological management of attention deficit hyperactivity disorder – updated. Journal of Psychopharmacology 2014, Vol 28(3) 179–203)	the best approaches to the assessment and management of people with mental health problems in the criminal justice system. We have not made any condition specific recommendations, instead we have directed people to refer to the relevant NICE guidelines for advice on how to assess and treat those conditions.
319.	SH	Shire Pharmaceutical limited Ireland	Short	22	1	The availability of medicines after release from prison is also important for ADHD as adults receiving treatment for ADHD in prison will typically be discharged with enough medication for only a few days. Given the problems (see comments 1 and 8) with access to care for adults with ADHD in the community - in particular the unwillingness of many GPs to prescribe stimulant medication - attention needs to be given to how the treatment needs of discharged prisoners could be better met.	Thank you for your comment. The focus of this guideline is to highlight the best approaches to the assessment and management of people with mental health problems in the criminal justice system. We have not made any condition specific recommendations, instead we have directed people to refer to the relevant NICE guidelines for advice on how to assess and treat those conditions.
320.	SH	The Disabilities Trust	Short	22	24	Point 1.83 – We welcome joint working. We have delivered brain injury training to over 1,000 professionals, many of whom are employed within the CJS, and we are currently exploring street/police custody setting training in pilot areas of the country. We believe that, in addition to the key stakeholders highlighted in the draft guidance, the knowledge and experience of the third sector should be utilised as far as possible. We offer our expertise to the Committee if they are considering commissioning specialist brain injury training and specialist support. Contact foundation@thedtgroup.org	Thank you for your comment and your support. It would be sensible to use the existing knowledge and experience you describe but it is outside the scope of this guideline to recommend that this should happen
321.	SH	Together for Mental Wellbeing	Short	22	12	We wholeheartedly support the liaison and diversion national programme led by NHSE that is leading on the delivery of mental health care and support in police and custody settings. A standard national operating model within a national service specification allows for consistency in provision and care and ensures that the key tasks such as identification, assessment	Thank you for your comment and your support.

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						and care management are undertaken as part of any service provision. The programme is already having a huge impact on practice and the availability of timely support to people experiencing distress in our justice system and we would advocate the continued rollout of the programme nationally.	
322.	SH	Nacro	Short	23	10	Again, we would reiterate the need to refer to L&D services here – there needs to be clear channelling of information flow from these services to appropriate agencies. We strongly reiterate the importance of sharing care plans and services having responsibility to uphold them. Data sharing between these agencies is extremely important to ensure no important information falls through the cracks.	Thank you for your comments. The Committee have made several comments about liaison and diversion within the criminal justice system including police and street triage diversion services. We made minor amendments to recommendation 1.8.1 to further emphasise the importance for health and criminal justice agencies to develop diversion services. We have reviewed recommendation 1.8.4 to reiterate the importance of sharing information between agencies and having joint care plans where applicable.
323.	SH	Nacro	Short	23	16	It is worth considering that some individuals may fall below clinical thresholds of 'severe or complex' yet may need a care plan as their situation may escalate, especially if they are entering custody for the first time or have pre-existing trauma. Consideration needs to be given to the fact that mental health problems can escalate quickly.	Thank you for your comments. We agree that all people should have an agreed care plan and this is the intention set out in the guideline. Our recommendation for a designated care coordinator and responsibilities associated with that is reserved for those with severe and enduring mental illness. This is in line with current guidance (for example Care Programme Approach) and is an efficient use of resources.
324.	SH	Nacro	Short	23	24	We would suggest adding a point on training staff on the effects of different environments and the effect involvement in the criminal justice system has on the assessment process, as	Thank you for your comment. In recommendation 1.1.2 we draw attention to the importance of taking

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						this can affect disclosure and this can affect care planning and ongoing assessments. We would also reiterate the point that staff should be trained on the importance of data and information sharing (where consent has been gained and is appropriate).	the environment and setting into account. Recommendation 1.9.1 highlights the importance of ensuring staff have a comprehensive induction which covers legislation and policy for information sharing between agencies. Any considerations for breaching confidentiality to manage risk or health should be included in this induction. Recommendation 1.3.11 draws attention to the importance of explaining consent for information sharing with others.
325.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Short	23 24	34 13	Commissioners are not responsible for providing staff training and commissioners include this expectation in service specifications. Training provision is the responsibility of service providers. Commissioners can however sign post and support providers to access appropriate training for their staff. Please consider re-phrasing these lines to account for the different roles of commissioners and providers.	Thank you for your comment, the Committee agree. We have reworded 1.9.1 to clarify the responsibilities regarding providing training.
326.	SH	Public Health England	Short	23	1.9.1	We can refer to the established training standards for mental health professionals and training programmes supported by Health Education England	Thank you for your comment. We are aware that Health Education England are a significant provider of training but other organisations will also be responsible for the provision of training, including in social care and the criminal justice system. Therefore we do not think it is appropriate to refer to HEE as suggested.
327.	SH	Prison Reform Trust	Short	23	2	To help ensure integrated services, add liaison and diversion services alongside street triage.	Thank you for your comments. The Committee have made several

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							comments about liaison and diversion within the criminal justice system including police and street triage diversion services. We made minor amendments to recommendation 1.8.1 to further emphasise the importance for health and criminal justice agencies to develop diversion services.
328.	SH	Revolving Doors Agency	Short	23	24	Consider adding 'social care services'.	Thank you for your comment. Social care is already mentioned in recommendation 1.9.1.
329.	SH	The Disabilities Trust	Short	23	23	Point 1.9 – We reiterate our offer to provide our expertise based on our extensive experience developing and delivering training to staff within the CJS on identifying and supporting individuals with ABI. Contact foundation@thedtgroup.org	Thank you for your comment and for offering your expertise.
330.	SH	Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)	Short	24	-	Staff training it is unclear why the sections are introduced in this way. It maybe more beneficial to describe the overall structure of the training components e.g. roles and responsibilities, awareness, interventions, staff support etc. Recovery models and basic functional understanding of behaviours which challenge the system and the inappropriateness of punishment for mental health related difficulties may also be included. Prevention could also be included here.	Thank you for your comment. The Committee have set out the responsibility of commissioners and providers regarding the need for training, focusing on multidisciplinary and multi-agency input. It is for local services to develop their own training depending on what is required in their service and area.
331.	SH	Together for Mental Wellbeing	Short	24	19	We would also advocate that all training needs to be gender-responsive and trauma-informed	Thank you for your comment. The Committee feel that the recommendations 1.9.3 would cover the point you raise.
332.	SH	Association of Directors of Adult Social Services	Short	25	6	It would also be valuable to train staff to understand how to identify potential social care needs and when and how to refer on to the relevant local authority social care assessment services.	Thank you for your comments. The Committee agree that social care needs should be considered and this point is addressed in the context section by drawing attention to the applicability of the Care Act 2014. However, making specific recommendations about identifying

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							social care needs or processes of referrals would be outside the scope of this guideline.
333.	SH	Nacro	Short	25	6	This section refers to staff delivering direct care training in dealing with critical incidents, etc. but this could be extended to staff not just in direct care. Increasing the knowledge and awareness of the importance of addressing mental health problems and associated behaviour would be extremely beneficial to all staff.	Thank you for your comments. The Committee agrees that it is important for all people who work in the criminal justice system to have awareness and understanding of mental health problems and associated behaviour which we feel we have addressed in recommendation 1.9.3.
334.	SH	Revolving Doors Agency	Short	25	5	Consider adding a bullet point: 'understanding the high comorbidity of substance misuse and mental health, and recognise and respond to coexisting drug and/or alcohol misuse where it exists'.	Thank you for your comment. The Committee did not review evidence about people with mental health problems being at an increased risk of substance misuse and therefore feel unable to make a recommendation on this specifically. However, we have several recommendations to draw attention to the importance of identifying substance misuse during assessments. These recommendations are not just for people in custody but extend to all criminal justice services, which include community services. Recommendation 1.4.3 highlights the importance of assessing behaviours that may indicate a risk to self which could include substance misuse. Recommendation 1.3.13 ensures that assessments should be completed by practitioners who are competent in assessing common presenting problems, of which substance misuse

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							would be one. Recommendation 1.3.14 highlights that assessments should take substance misuse problems into account.
335.	SH	Revolving Doors Agency	Short	25	8	Consider adding 'and opioid overdoses, including use of naloxone'.	Thank you for your comment. The Committee has directed readers to the Drug misuse in over 16s: opioid detoxification (CG52) for advice on managing opioid overdose. Additionally, emergency life support would include a range of issues including overdose.
336.	SH	Together for Mental Wellbeing	Short	25	-	Q1: the challenge to practice is that private and confidential spaces in assessment settings can be extremely limited – for example, limited interview rooms in police custody suites, within court cell areas and within probation settings. This is likely to become more challenging as the respective estates are being reviewed across the key criminal justice agencies	Thank you for your comments. The Committee agree there are challenges with implementation of recommendations for various reasons. The focus of this guideline is to ensure that all people who have mental health problems and are involved in the criminal justice system receive the best care and treatment. Specific implementation of the recommendations is outside the remit of the guideline and falls under the authority of local services. Your comments will be considered by NICE where relevant support activity is being planned
337.	SH	Together for Mental Wellbeing	Short	25	6	Our experience of working with healthcare partners is that all too often mental health practitioners working in challenging non-clinical settings as in the CJS do not get the level of supervision and SH training they need to support and sustain them in their roles. Often staff are working within dispersed service arrangements and may only be working within small teams with long-arm management support. There are also additional pressures, often from commissioners, of staff not	Thank you for your comments. We have focused on the importance of training and supervision in the recommendations in section 1.9. We agree that supervision and training may be vulnerable to pressures on budget but we have stressed the

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						being away from the frontline in order to engage with the required supervision – clinical and line-management. Robust supervision and training is also a necessity of good clinical governance and without it there are risks to the quality of service being provided and assurance around decision-making. Q2: Robust supervision and training will attract costs and when budgets are tight it is often these kind of budget lines that are reduced particularly when budgets are often predominantly related to fixed salary costs. Peer support / supervision as part of a governance framework could be considered an approach that is effective both from a staff support point of view and from a cost point of view.	importance of supervision in 1.9.4. Specific implementation of the recommendations is outside the remit of the guideline and falls under the authority of local services
338.	SH	Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)	Short	26	19 (before line 19)	Consider including a definition of in-possession: The physical health GDG used "Medicine is said to be held in-possession if a person (usually in a prison or other secure setting) is responsible for holding and taking it themselves"	Thank you for your comment. We have made this suggested addition to the glossary of terms.
339.	SH	Public Health England	Short	27	Putting guidance into practice	We need to reinforce message that staff in custody settings and prisons do not have to create their own standards for physical or mental healthcare. Many of these already exist for wider population. The challenge is to deliver these in challenged places e.g. prisons	Thank you for your comments and this information. Specific implementation of the recommendations is outside the remit of the guideline and falls under the authority of local services. Your comments will be considered by NICE where relevant support activity is being planned. This information is standard text and we are not able to amend the content
340.	SH	Revolving	Short	28	9	Consider adding 'organisations will need to give careful	Thank you for your comments. The

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		Doors Agency				consideration to how effective and consistent practice can be maintained and promoted across multiple services and settings'.	Committee agree there are challenges with implementation of recommendations for various reasons including staffing levels and the impact of treatment setting. Specific implementation of the recommendations is outside the remit of the guideline and falls under the authority of local services This information is standard text and we are not able to amend the content
341.	SH	Association of Directors of Adult Social Services	Short	29	18	It would also be useful in this section to include a paragraph on learning disability and autistic spectrum conditions and another on the roles and responsibilities of local authorities in relation to both people in the community and specifically those in prison or approved premises where the responsibilities have changed since the implementation of the Care Act in April 2015	Thank you for your comments. We have reviewed the Context section to reflect your suggestion, making specific reference to the Care Act 2014.
342.	SH	Revolving Doors Agency	Short	29	22	'Were' should presumably be 'are'.	Thank you for your comment. We have amended this sentence.
343.	SH	Revolving Doors Agency	Short	29	24	Consider changing 'subgroups' to 'groups'	Thank you for your comment. We have amended this sentence.
344.	SH	Revolving Doors Agency	Short	30	2	Suggest changing to: 'the urge to use illicit drugs may drive individuals to commit acquisitive crime'.	Thank you for your comment. We have amended this sentence.
345.	SH	Revolving Doors Agency	Short	30	6	Suggest inserting 'England' after 'NHS' and 'commissioning' after 'for'.	Thank you for your comment. We have amended this sentence.
346.	SH	Revolving Doors Agency	Short	30	22	Suggest adding prisons.	Thank you for your comment. We have amended this sentence.
347.	SH	Revolving Doors Agency	Short	32	4	Consider changing to '… interventions in community rehabilitation companies and the National Probation Service'.	Thank you for your comment. We have changed the title to focus on probation providers as this is what the research recommendation covers
348.	SH	Revolving Doors Agency	Short	32	7	Consider changing 'centres' to 'companies' and 'national probation services' to 'the National Probation Service'.	Thank you for your comment. We have made this change in the short and full guideline.
349.	SH	Revolving	Short	32	12	Typo – structured rather than structure.	Thank you for your comments. We

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		Doors Agency					have amended this typo.
350.	SH	Revolving Doors Agency	Short	32	23	Consider adding broader quality of life measures such as reduced substance misuse, improved housing outcomes and participation in ETE.	Thank you for your comment. The Committee agree and have updated the recommendation to include a broader measure of social functioning which will include substance misuse, stable housing and engagement with ETE.
351.	SH	Mental Health Foundation	Short	33	19	The title 'Tools for case identification for mental health problems and populations common in the criminal justice system' is not indicative of the content covered in the following paragraph. The title should read as follows: Tools for case identification for mental health problems and other populations in criminal justice'.	Thank you for your comment. We have changed the text for clarity.
352.	SH	Mental Health Foundation	Short	33	21	Cognitive impairment is not mentioned in the title. This should be separated out into a section of its own. We raise issue around the context in which cognitive impairment is referred to. As it stands, the inference is that cognitive impairment is the same as a mental health problem, which is wholly inaccurate.	Thank you for your comment. We have revised the title to make sure the focus of the research recommendation is on cognitive impairment.
353.	SH	The Disabilities Trust	Short	33	19	Point 4 – We believe that the BISI should be adopted as a screening tool within the CJS. The Scottish National Prisoner Healthcare Network in their recommendations to the Justice Committee in Holyrood shortlisted the BISI as a suggested screening tool for use in the Scottish prison system. [Scottish National Prisoner Healthcare Network (2016), Brain Injury and Offending http://www.nphn.scot.nhs.uk/wp-content/uploads/sites/9/2016/07/NPHN-Brain-Injury-and-Offending-Final-Report.pdf] Our current work is exploring two aspects of the tool that were highlighted as an area for development, and we are going to submit this work soon, fulfilling the Committee's request for data to support the use of screening tools.	Thank you for this comment. The BISI was not identified during our original evidence search and therefore was not appraised by the guideline. Following your comment we have tried to find published evidence about this tool but have not been able to identify any relevant papers. Consequently we are not able to mention the BISI in the guideline.

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354.	SH	Her Majesty's Inspectorate of Prisons	General	General	General	I notice your draft guidelines make no reference to the identification of victims of torture who are experiencing mental or emotional disturbance as a result. Are you aware that the FFLM is developing standards and guidance on this issue?	Thank you for highlighting the development of standards and guidance on the identification of victims of torture who are experiencing mental/emotional disturbance. We have amended 1.3.14 to highlight that practitioners need to be aware of exposure to traumatic events during assessment. Unfortunately the guidance you mention is still in development so cannot be cross referenced in this guideline

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*