NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

SCOPE

1 Guideline title

Mental health of people in prison: Identification and management of mental health problems of people in prison.

1.1 Short title

Mental health of people in prison.

N.B. It is anticipated that the title above will change in the final version of the scope to one more reflective of the need for this guideline to look not only at an integrated model for addressing mental health in prisons but also at interventions for the prevention and early treatment of the mental health problems of offenders taking account of the whole offender pathway, e.g. 'integrated mental health care for adults in contact with the criminal justice system.'

2 The remit

The Department of Health has asked NICE to develop guidance on the identification and management of mental health problems of people in prison.

3 Need for the guideline

3.1 Epidemiology

a) Mental health problems are very common in people in contact with the criminal justice system. An estimated 39% of people detained in police custody have some form of mental disorder, and over 25% of

residents in approved premises (previously known as bail hostels) have been found to have a psychiatric diagnosis. An estimated 39% of adults serving community sentences have a mental disorder, and it has been estimated that over 90% of prisoners have at least one of the following psychiatric disorders:

- psychosis
- anxiety or depression
- personality disorder
- alcohol misuse
- drug dependence.

b) Rates of mental disorder in remand prisoners have been found to be even higher than in sentenced prisoners. Gender inequalities in the prevalence of mental health problems have also been reported, with 40% of women compared with 20% of men in prison having had treatment for a mental health problem in the 12 months before entering prison.

c) An estimated 8% of people detained in police custody and 11% of adults serving community sentences have a psychotic disorder. Among the prison population, an estimated 14% of women (remand and sentenced prisoners combined), 7% of men serving prison sentences and 10% of male remand prisoners have a psychotic disorder. This compares with 0.5% in the general population. A slightly larger proportion of the prison population has been reported to have psychotic symptoms (25% of women and 15% of men).

d) The prevalence of common mental disorders is also high among people in contact with the criminal justice system. An estimated 15% of people detained in police custody have a mild or moderate depressive disorder. Among people serving community sentences, 21% have an anxiety disorder and at any given time an estimated 15% will be having a major depressive episode. An estimated 76%

of female remand prisoners, 63% of female sentenced prisoners, 59% of male remand prisoners and 40% of male sentenced prisoners have an anxiety disorder or depression. This compares with 16% of the general population.

e) The prevalence of personality disorders is very high among people in contact with the criminal justice system. Among people serving community sentences, an estimated 47% are likely to have a personality disorder. Among the prison population, an estimated 58% of male remand prisoners, 64% of male sentenced prisoners and 50% of female prisoners (remand and sentenced combined) have a personality disorder. This compares with 5% of the general population.

f) Self-harm is also very common among people in contact with the criminal justice system. Of people detained in police custody, 10% said they had current suicidal thoughts and 18% said they had made a suicide attempt before. An estimated 12% of people serving community sentences are at high risk of suicide. Among prisoners, 46% of men and 21% of women said they had attempted suicide at some point in their lives. This is considerably higher than in the general UK population, with 6% of people saying they have ever attempted suicide.

g) Illicit drug use is high, with an estimated 12% of adults serving community sentences thought to have substantial or severe levels of drug misuse, an estimated 49% of prisoners thought to be dependent on at least one drug and 41–51% of (remand and sentenced) prisoners reporting dependence on drugs in the year before prison.

h) Rates of alcohol misuse are also high. An estimated 56% of people serving community sentences show current hazardous drinking behaviour, and 60% of male prisoners (remand and sentenced

combined) and 38% of female prisoners (remand and sentenced combined) report hazardous drinking in the year before going to prison.

i) Sexual offenders comprise 13% of the prison population.

j) Estimates for the prevalence of learning disabilities among people in police custody range from 0.5% to 9%, while an estimated 7% of the prison population have a learning disability.

k) Comorbid mental health problems, particularly a dual diagnosis of drug or alcohol misuse and another mental health problem, are so common as to be considered the norm in the prison population and are over-represented across the criminal justice system. It has been estimated that 76% of prisoners (remand and sentenced combined) have two or more mental disorders. Among adults with mental health problems serving community sentences, an estimated 72% also screened positive for either an alcohol or a drug problem.

l) Comorbidity of physical and mental health problems is also high, with 40% of the prison population suffering from a chronic physical health problem.

m) Black and minority ethnic (BME) groups are over-represented in the prison population. It is estimated that BME groups constitute 26% of the prison population compared with 9% of the overall population. For BME groups, in particular young black men, contact with the criminal justice system may be an important route into mental health services, with BME groups found to be 40% more likely than white British groups to access mental health services through a criminal justice system gateway.

3.2 Current practice

a) Police custody is the only time in the criminal justice system when healthcare is not the responsibility of the NHS (but legal responsibility for commissioning of custodial health services is expected to move to NHS England by April 2015).

b) Many liaison and diversion schemes, mostly funded by health services and based at magistrates' courts, have been developed. These have many responsibilities and functions, including:

- improving identification of mental health problems
- making transfer to hospital (when appropriate) easier
- assessing people appearing in court to help magistrates with case completion options
- supporting and working with people with mental health problems and the agencies involved in their treatment and care.

c) For adults in the prison service mental healthcare is provided by separate primary care services, specialist mental health services and drug and alcohol services. Identification of mental health problems, particularly for depression and anxiety disorders, is poor. Many disorders go unrecognised.

d) Identifying mental health problems in police custody is complicated by:

- the high number of people being detained who are drunk or on drugs on arrival at the police station (both of which can hide the symptoms of mental health problems)
- the lack of a standard mental health assessment
- the lack of a national standard for police training in mental health
- a reliance on self-reporting
- barriers to disclosure including stigma, previous negative experiences and the custody suite environment.

e) Mental health awareness among, and training provision for, staff working in the criminal justice system (including police officers, duty solicitors, probation staff and prison officers) varies.

f) Even when mental health problems are suspected or identified, prompt access to a mental health assessment is often limited. Factors contributing to this include:

- a lack of trained professionals to do the assessment
- the settings for the assessment (custody suites) being unsuitable
- frequent transfer of people between different custodial settings
- the lack of common assessment and effective information transfer systems across the criminal justice system.

g) The prevalence of mental health problems is high, particularly among women and BME groups. There is also an increasing incidence of dementia as the prison population ages. As well as the high levels of disorder there is considerable comorbidity between different mental health problems and chronic physical health problems that makes treating and managing these disorders more difficult.

h) In some prisons specialist services are provided for people who are deemed vulnerable (the PIPES programme) or who have a personality disorder (HMP Grendon Underwood).

i) In addition to treatments offered by specialist mental health services, interventions for sexual offenders or people with severe antisocial behaviour may be provided by the prison forensic psychology service or by the probation service.

j) Delivering effective treatment options in the prison environment may be limited by the need to supervise the administration of medication and the fact that the Mental Health Act does not apply

to the prison population. (Note: the Act does apply to those in the community in contact with the criminal justice system.)

k) People with comorbid alcohol or drug misuse and mental health problems frequently fall through the gaps between services and receive no treatment at all. Dual diagnosis can often be used as a reason for exclusion, preventing people from accessing services in prison and in the community.

l) Provision for people with severe mental illness is limited (see (j) above concerning the Mental Health Act) and as a result people with severe mental illness may need to be transferred to NHS inpatient facilities. There are often long delays in such transfers going ahead.

m) There are considerable difficulties arranging effective community-based care for people in contact with the criminal justice system. For example, effective aftercare for people with mental health or substance misuse problems on release from prison is often difficult to arrange, with many barriers to their acceptance into community services. For instance, 50% of sentenced prisoners are not registered with a GP prior to entering prison, and experience considerable difficulties in finding a GP willing to accept prisoners after release. Referral to a mental health service or adequate support for substance misuse is also commonly not put in place prior to release. For those already living in the community similar barriers exist. For both groups, this significantly impairs their resettlement and rehabilitation.

4 The guideline

The guideline development process is described in detail on the NICE website (see section 6, 'Further information').

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health.

The areas that will be addressed by the guideline are described in the following sections.

4.1 Population

4.1.1 Groups that will be covered

a) Adults (aged 18 and over) with, or at risk of developing, a mental health problem who are in contact with the criminal justice system. This includes people:

- in police custody
- remanded on bail
- remanded in prison
- serving a prison sentence
- serving community sentences under the probation service.

b) 'Mental health problems' includes common mental health problems, severe mental illness, personality disorders, drug and alcohol problems, paraphilias, neurodevelopmental disorders and acquired cognitive impairment. Specific consideration will be given to:

- people with learning disabilities and neurodevelopmental disorders
- women
- victims and perpetrators of domestic violence
- people with severe mental illness
- older adults (aged 55 years and over)
- adults in immigration removal and detention centres
- adults in segregation units
- black and minority ethnic groups.

4.1.2 Groups that will not be covered

The guideline will also be relevant to, but will not cover, practice involving:

- people in special hospitals (for example, Broadmoor)
- people in medium to low secure units
- children and young people (aged under 18 years)
- people who are in contact with the criminal justice system solely as a result of being a witness or victim.

4.2 Setting

a) The guideline will cover the care and shared care provided or commissioned by health and social care services, within the criminal justice system.

4.3 Management

4.3.1 Key issues that will be covered

The primary source for the evidence in this guideline will be drawn from existing NICE guidance for the relevant mental health problems. A key concern for this guideline will be adapting existing NICE recommendations to the criminal justice system.

a) Identification and assessment:

- identifying people at risk of developing a mental health problem (including formal identification tools)
- identifying people who have a mental health problem (including formal identification tools)
- assessing mental health problems (including formal assessment tools).

b) Interventions and their adaptation to the criminal justice system:

- interventions to prevent mental health problems, including environmental adaptations, individual and population-based psychoeducational interventions and staff training
- pharmacological interventions for the care and treatment of mental health problems (including adaptation to the prison environment)
- psychological and social interventions for the care and treatment of mental health problems (including adaptation to the prison environment).

c) The organisation and provision of services for mental health problems in the criminal justice system:

- care pathways and transitions through the criminal justice system, in particular from juvenile to young offender services
- the interface with community based services for mental health problems, and between the criminal justice system and primary, secondary and tertiary healthcare provision.

d) Training or education needed to allow health, social care and criminal justice professionals and practitioners to provide good-quality services and carry out all the above interventions when there is evidence to support their use.

4.3.2 Issues that will not be covered

a) Managing violent and physically threatening behaviour in mental health, health and community settings.

4.4 Main outcomes

a) Mental health outcomes

b) Re-offending

c) Service utilisation

d) Adaptive functioning (for example, employment status both within and outside of prison, development of interpersonal skills and quality of life)

e) Rates of self-injury in service users

f) Experience of care

4.5 Economic aspects

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is the quality-adjusted life year (QALY) but a different unit of effectiveness may be used depending on the availability of appropriate clinical and utility data for people with mental health problems in prison. The costs considered will usually be only from an NHS and personal social services (PSS) perspective, although economic analyses will attempt to incorporate wider costs associated with the care of people with mental health problems in prison if appropriate cost data are available. Further detail on the methods can be found in 'The guidelines manual' (see ‘Further information’).

4.6 Status

4.6.1 Scope

This is the consultation draft of the scope. The consultation dates are 24 September to 22 October 2014.

4.6.2 Timing

The development of the guideline recommendations will begin in December 2014.

5 Related NICE guidance

5.1 Published guidance

5.1.1 NICE guidance to be incorporated

This guideline will incorporate the following NICE guidance: TBC

5.1.2 Other related NICE guidance

- Psychosis and schizophrenia in adults. NICE clinical guideline 178 (2014).
- Social anxiety disorder. NICE clinical guideline 159 (2013).
- Patient experience in adult NHS services. NICE clinical guidance 138 (2012)
- Autism in adults. NICE clinical guideline 142 (2012).
- Service user experience in adult mental health. NICE clinical guidance 136 (2011).
- Self-harm: longer term management. NICE clinical guideline 133 (2011).
- Common mental health disorders. NICE clinical guideline 123 (2011)
- Psychosis with coexisting substance misuse. NICE clinical guideline 120 (2011).
- Alcohol-use disorders. NICE clinical guideline 115 (2011).
- Alcohol dependence and harmful alcohol use. NICE quality standard 11 (2011)
- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011).
- Alcohol-use disorders: physical complications. NICE clinical guideline 100 (2010)

- Depression with a chronic physical health problem. NICE clinical guideline 91 (2009).
- Depression in adults. NICE clinical guideline 90 (2009).
- Borderline personality disorder. NICE clinical guideline 78 (2009).
- Antisocial personality disorder. NICE clinical guideline 77 (2009).
- Attention deficit hyperactivity disorder. NICE clinical guideline 72 (2008).
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007).
- Interventions to reduce substance misuse among vulnerable young people. NICE guidelines PH4 (2007).
- Dementia. NICE clinical guideline 42 (2006).
- Obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).
- Post-traumatic stress disorder. NICE clinical guideline 26 (2005).
- Violence. NICE clinical guideline 25 (2005).
- Self-harm. NICE clinical guideline 16 (2004).

5.2 Guidance under development

NICE is currently developing the following related guidance (details available from the NICE website):

- Violence and aggression. NICE clinical guideline. Publication expected April 2015.

- Challenging behaviour and learning disabilities. NICE clinical guideline. Publication expected May 2015.
- Physical health in prisons. NICE clinical guideline. Publication expected November 2016.

6 Further information

Information on the guideline development process is provided in the following documents, available from the NICE website:

- How NICE clinical guidelines are developed: an overview for stakeholders the public and the NHS: 5th edition
- The guidelines manual.

Information on the progress of the guideline will also be available from the NICE website.