Mental health of adults in contact with the criminal justice system: identifying and managing mental health problems and integrating care

NICE guideline: short version

Draft for consultation, October 2016

[at publication this information will go on the guideline overview page]

This guideline covers the care and shared care provided or commissioned by health and social care services, for people in contact with the criminal justice system.

Who is it for?

- Commissioners and providers of health and justice services.
- All health and social care professionals working with adults in contact with the criminal justice system in community, primary care, secondary care and secure settings.

This version of the guideline contains the draft recommendations, context and recommendations for research. Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the guideline committee's discussion and the evidence reviews (in the full guideline), the scope, and details of the committee and any declarations of interest.

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Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Using this guideline together with other NICE guidelines

1.1.1 Use this guideline with the NICE guidelines on service user experience in adult mental health and patient experience in adult NHS services to improve the experience of care for people with learning disabilities and mental health problems.

1.1.2 Use this guideline with NICE guidelines on any specific mental health problems when available. Take into account:

- the nature and severity of any mental health problem
- the presence of a learning disability or any acquired cognitive impairment
- other communication difficulties (for example, language, literacy, information processing or sensory deficit)
- the nature of any coexisting mental health problems
- limitations on prescribing and administering medicine (for example, in-possession medicine) or the timing of the delivery of interventions in certain settings (for example, prison)
- the development of trust in an environment where health and care staff may be held in suspicion
- any differences in presentation of mental health problems

- the treatment setting (the person's home, in the community, primary or secondary care health services, mental health or learning disabilities services, and prison).

1.1.3 Obtain, evaluate and integrate all available and reliable information about the person when assessing or treating people in contact with the criminal justice system. For example:

- person escort record (PER)
- pre-sentence report
- primary and secondary medical records
- custody reports
- Offender Assessment and Sentence Management (OASys).

Take into account how up to date the information is and how it was gathered.

1.2 Principles of assessment

1.2.1 Work with a family member, partner, carer, advocate or legal representative when possible in order to get relevant information and support the person, help explain the outcome of assessment, and help them make informed decisions about their care. Take into account:

- the person's wishes
- the nature and quality of family relationships
- any statutory or legal considerations that may limit family and carer involvement.

1.2.2 Carry out assessments:

- in a suitable environment that is safe and private
- in an engaging, empathic and non-judgemental manner.

1.2.3 When assessing a person, make appropriate adjustments to assessment that take into account any suspected neurodevelopmental disorders, cognitive impairments, or physical disabilities. Seek advice or involve specialists if needed.

1.3 Identification and assessment throughout the care pathway

1.3.1 Be vigilant for the possibility of unidentified or emerging mental health problems in people in contact with the criminal justice system, and review available records for any indications of a mental health problem.

1.3.2 Ensure all staff working in criminal justice settings are aware of the potential impact on a person's mental health of being in contact with the criminal justice system.

First-stage health assessment at reception into prison

This subsection covering what happens when a person first arrives into prison is taken from the NICE guideline on physical health in prisons. It does not apply to other criminal justice system settings.

This material, was developed jointly by NICE's physical health in prisons and mental health in the criminal justice system committees has already been consulted on as part of the development of the physical health in prisons guideline. It is therefore not open to consultation.

The final, amended version of this section will appear for the first time when the physical health in prisons guideline publishes in November 2016. This amended version will also appear in the final version of mental health in the criminal justice system guideline when it is published in October 2017.

1.3.3 A healthcare professional (or trained healthcare assistant under the supervision of a registered nurse) should carry out a health assessment for every person on their first reception into prison.

This should be done before the person is allocated to their cell. It should include identifying:

- any issues that may affect the person's immediate health and safety before the second-stage health assessment
- priority health needs to be addressed at the next clinical opportunity.

1.3.4 The first-stage health assessment should include the questions and actions in table 1. It should cover:

- physical health
- alcohol use
- drug use
- mental health
- self-harm and suicide.

1.3.5 Take into account any communication needs or difficulties the person has, and follow the principles in NICE's guideline on patient experience in adult NHS services.

Table 1 Questions for first-stage prison health assessment

Topic questions	Actions
1 Status	
Has the person been charged with murder or manslaughter?	Yes: refer for urgent mental health assessment by the prison mental health in-reach team. Ensure that the person is seen by the GP while they are in reception. No: record no action required.

2 Physical health	
2.1 Prescribed medicines	
Is the person taking any prescribed medicines, including preparations such as creams or drops, and if so: • what are they? • what are they for? • how do they take them?	Yes: make a note of any current medicines being taken and generate a medicine chart. Refer the person to the GP for appropriate medicines to be prescribed and continued. If medicines are being taken check that the next dose has been provided (see recommendation 1.7.10). No: record no action required.
2.2 Physical injuries	
Has the person received any physical injuries over the past few days, and if so: • what were they? • how were they treated?	Yes: assess severity of injury, any treatment received and record any head, abdominal injuries or fractures. Refer the person to the GP at reception. In very severe cases, or after GP assessment, the person may need to be transferred to an external hospital. Liaise with prison staff to transfer the person to the hospital emergency department by ambulance. Document any bruises or lacerations observed. If the person has made any allegations of assault, record negative observations as well (for example, no physical evidence of injury). No: record no action required.
2.3 Head injuries or loss of consciousness	
Has the person ever suffered a head injury or lost consciousness, and if so: • how many times has this happened? • have they ever been unconscious for more than 20 minutes? • do they have any problems with their memory or concentration?	Yes: refer the person to the GP at reception. No: record no action required.
2.4 Other physical health conditions	
Does the person have any of the following: • allergies, asthma, diabetes, epilepsy or fits • chest pain, heart disease • tuberculosis, sickle cell disease • hepatitis B or C virus, HIV, other	Ask about each illness listed. Yes: make short notes on any details of the person's condition or management. For example, 'Asthma – on Ventolin one puff daily'. Make appointments with relevant clinics or specialist nurses if specific needs have been identified.

sexually transmitted infections • learning disabilities • neurodevelopmental disorders • physical disabilities?	No: record no action required.
2.5 Are there any other physical health problems the person is aware of, that have not been reported?	Yes: record the details and check with the person that no other physical health complaint has been overlooked. No: record no action required.
2.6 Are there any other concerns about the person's physical health?	Make a note of any other concerns about physical health. This should include any health-related observations about the person's physical appearance (for example, weight, pallor, jaundice, gait). As with recent injuries, both negative and positive signs are relevant. Yes: refer the person to the GP at reception. No: note 'Nil'.
2.7 Additional questions for women	
Ask the woman if she has reason to think she is pregnant.	Yes: refer the person to the GP at reception and to a midwife. No: record response.
Ask if she would like a pregnancy test.	Yes: if requested, provide a pregnancy test. Record the outcome and if positive make an appointment for the person to see the GP. No: record response.
2.8 Independent living and diet	
Ask the person if they need help to live independently.	Yes: note any needs. Liaise with the prison disability lead in reception about: • the location of the person's cell • further disability assessments the prison may need to carry out. No: record response.
Ask if they use any equipment or aids (for example, walking stick, hearing aid, glasses).	Yes: remind prison staff that all special equipment and aids the person uses should follow them from reception to their cell. No: record response.
Ask if they need a special medical diet.	Yes: note the medical diet the person needs and send a request to catering. No: record response.
2.9 Past or future medical appointments	
Ask the person if they have seen a doctor or other healthcare professional in the past few months, and if so what this was	Yes: note details of any recent medical contact. Arrange a contact letter to get further information from the person's doctor. Note any ongoing treatment the

for.	person needs and make appointments with relevant clinics, specialist nurses, GP or other healthcare staff. No: record no action required.
Ask if they have any outstanding medical appointments, who they are with, and the dates.	Yes: note future appointment dates. Ask healthcare administrative staff to manage these appointments or arrange for new dates and referral letters to be sent if the person's current hospital is out of the local area. No: record no action required.
3 Alcohol and drug use	
3.1 Ask the person if they drink alcohol, and if so: • how much they normally drink • how much they drank in the week before coming into custody.	Urgently refer the person to the GP at reception or the drug services team if: • they drink more than 15 units of alcohol daily or • they are showing signs of withdrawal. No: record response.
3.2 Type and frequency of drug use	
Ask the person if they have used drugs in the last month. If yes, ask about frequency of use, and last use of, for example: • heroin • methadone • benzodiazepines • amphetamine • cocaine or crack • novel psychoactive substances.	Ask about use of different drugs including those listed. Yes: refer the person to drug services if there are concerns about their immediate clinical management and they need immediate support. Take into account whether: • they have taken drugs intravenously • they have a positive urine test for drugs • their answers suggest that they use drugs more than once a week. Refer the person to the GP at reception if there are any physical health concerns. No: record response.
3.3 Intravenous drugs	
Ask the person if they have taken any drugs intravenously.	Yes: check injection sites. Refer the person to drug services if there are concerns about their immediate clinical management and they need immediate support. Refer the person to the GP at reception if there are any physical health concerns. No: record response.

3.4 Prescription drugs	
Ask the person if they have used prescription or over-the-counter medicines in the past month that: • were not prescribed or recommended for them, or • for purposes or at doses that were not prescribed.	Yes: refer the person to drug services if there are concerns about their immediate clinical management and they need immediate support. Refer the person to the GP at reception if there are any physical health concerns. No: record response.
If yes, ask what this medicine was and how they used it (frequency and dose).	
4 Mental health	
4.1 Previous contact with mental health services	
Ask the person if they have ever seen a health professional or service about a mental health problem (including a psychiatrist, GP, psychologist, counsellor, community mental health team or learning disability team). If yes, ask: • who they saw • the nature of the problem.	Yes: consider referring the person for mental health assessment by the prison mental health in-reach team) if they have received care for mental health problems. Refer the person to the GP at reception. If the person has been in contact with learning disability services refer them to the GP in reception No: record response.
Ask the person if they have ever been admitted to a psychiatric hospital. If yes, ask them: • the date of their most recent discharge • the name of the hospital • the name of their consultant.	Yes: refer the person for mental health assessment by the prison mental health in-reach team if they have received inpatient care for mental health problems. Refer the person to the GP at reception. No: record response.
4.2 Medicine for mental health problems	
Ask the person if they have ever been prescribed medicine for any mental health problems. If yes, ask: • what the medicine was • when they received it • what the current dose is (if they are still taking it).	Yes: consider referring the person for mental health assessment if they have received medicine for mental health problems. Refer the person to the GP at reception. No: record response.
5 Self-harm and suicide	
5.1 History of self-harm or suicide attempts	
Ask the person if they have ever tried to harm themselves. If yes, ask: • whether this was inside or outside prison • what the most recent incident was • what the most serious incident was.	Yes: consider referring the person for a mental health assessment if they have ever tried to harm themselves. No: record response.
Ask the person if they:	Yes: refer the person for an urgent

• have a history of previous suicide attempts • are currently thinking about or planning to harm themselves or attempt suicide.	mental health assessment. Open an Assessment, Care in Custody and Teamwork (ACCT) plan if there are: • serious concerns raised in response to questions about self-harm, including thoughts, intentions, or plans • a history of previous suicide attempts. Refer the person to the GP at reception. No: record response.

Identification throughout the care pathway and second stage health assessment in prisons

1.3.6 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 physical health problem with associated functional impairment
- concerns have been raised by other agencies about the person's abilities to participate in the criminal justice process[1].

1.3.7 When using the CMHS-M or CMHS-W with a transgender person, use the measure that is in line with their preferred gender identity.

1.3.8 If a man scores 6 or more on the CMHS-M, or a woman scores 4 or more on the CMHS-W, or there is other evidence supporting the likelihood of mental health problems, practitioners should:

[1] This recommendation applies both throughout the care pathway and to second stage health assessment in prisons. Consultation on this recommendation (in the context of second stage health assessment in prisons) has already happened as part of the consultation on the physical health in prisons guideline.

- conduct a further assessment if they are competent to perform assessments of mental health problems, **or**
- refer the person to an appropriately trained professional for further assessment if they are not competent to perform such assessments themselves[2].

Carrying out a mental health assessment

1.3.9 Service providers should ensure that a practitioner who is competent and has experience of working with people in contact with the criminal justice system who have mental health problems, undertakes the mental health assessment and where necessary coordinates the input of other professionals into the assessment.

1.3.10 If there are concerns about a person's mental capacity, practitioners should:

- perform a mental capacity assessment if they are competent to do this (or refer the person to a practitioner who is)
- consider involving an advocate to support the person.

1.3.11 All practitioners should discuss rights to confidentiality with people and explain:

- what the assessment is for, and how the outcome of the assessment may be used
- how consent for sharing information with named family members, carers and other services should be sought
- that the assessor may have a legal or ethical duty to disclose information relating the safety of the person or others, or to the security of the institution.

[2] This recommendation applies both throughout the care pathway and to second stage health assessment in prisons. Consultation on this recommendation (in the context of second stage health assessment in prisons) has already happened as part of the consultation on the physical health in prisons guideline.

1.3.12 All practitioners should ensure assessment is a collaborative process that:

- involves negotiation with the person, as early as possible in the assessment process, about how information about them will be shared with others involved in their care
- makes the most of the contribution of everyone involved, including the person, those providing care or legal advice, and families and carers
- engages the person in an informed discussion of treatment, support and care options
- allows for the discussion of the person's concerns about the assessment process.

1.3.13 Ensure all practitioners carrying out mental health assessments are competent to assess common presenting problems, with an understanding of the context and setting in which they are undertaken. They should:

- tailor the content, structure and pace of an assessment to the person’s needs and adjust the assessment as new information emerges
- take into account the person’s understanding of the problem
- have knowledge and awareness of diagnostic classification systems and their limitations
- appraise the reliability and validity of all available health and criminal justice systems records
- identify and take into account the reasons for any significant differences between the assessor’s views and those of the person, and other agencies involved in their care
- use validated tools relevant to the disorders or problems being assessed

- take into account the views of practitioners from other services involved in the person's care.

1.3.14 All practitioners carrying out mental health assessment should take into account the following when conducting an assessment of suspected mental health problems for people in contact with the criminal justice system:

- the nature and severity of the presenting problems (including substance misuse) and their development and history
- coexisting mental health problems
- coexisting physical health problems
- social and personal circumstances
- social care, educational and occupational needs
- people's strengths that may help engagement with interventions
- previous care, support and treatment, including how the person responded to these
- offending history, and how this may interact with mental health problems.

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
- discuss mental health problems and treatment options in a way that gives rise to hope and optimism by explaining that change is possible and attainable
- be aware that people may have negative expectations based on earlier experiences with mental health services, the criminal justice system, or other relevant services.

1.3.16 All practitioners should share the outcomes of an assessment, in accordance with local policies and legislation, with:

- the person and when possible with family members and carers
- all staff involved in the direct development and implementation of the plan
- other staff or agencies (as needed) not directly involved in the development and implementation of the plan who could support the effective implementation and delivery of the plan.

Reviewing the assessment

1.3.17 Practitioners should review and update assessments:

- if new information is available about the person's mental health problem
- if there are significant differences between the views of the person and the views of the family, carers or staff that cannot be resolved through discussion
- when major legal or life events occur
- when the person is transferred between, or out of, criminal justice services
- if a person experiences a significant change in care or support (for example, stopping an Assessment, Care in Custody and Teamwork [ACCT] plan).

1.3.18 When updating assessments, practitioners should consider:

- reviewing demographic, psychological, social, personal historical and criminological factors
- assessing multiple areas of need, including social and personal circumstances, physical health, occupational rehabilitation, education and previous and current care and support
- developing an increased understanding of the function of the offending behaviour and its relationship with mental health problems
- covering any areas not fully explored by the initial assessment.

1.4 Risk assessment and management

1.4.1 Undertake a risk assessment for all people in contact with the criminal justice system when a mental health problem occurs or is suspected.

1.4.2 All practitioners should include the following in risk assessments for people in contact with the criminal justice system:

- risk to self, including self-harm, suicide, self-neglect, risk to own health and degree of vulnerability to exploitation or victimisation
- risk to others that is linked to mental health problems, including aggression, violence and sexual offending and predation
- causal and maintaining factors
- the likelihood, imminence and severity of the risk
- the impact of their social and physical environment
- protective factors that may reduce risk.

1.4.3 During risk assessment the practitioner undertaking the assessment should explain to the person that their behaviours may need to be monitored. For example, behaviours that may indicate a risk to self or others, or if monitoring will help the person to identify, anticipate and prevent high-risk situations.

1.4.4 The practitioner undertaking the assessment should develop a risk management plan for a person when indicated by their risk assessment. This should:

- integrate with or be consistent with the mental health assessment and plan
- take an individualised approach to each person and recognise that risk levels may change over time
- set out the interventions to reduce risk at the individual, service or environmental level

- take into account any legal or statutory responsibilities which apply in the setting in which they are used
- be shared with appropriate parties (including families and carers) and services
- be reviewed regularly by those responsible for implementing the plan and adjusted if risk levels change.

1.4.5 All practitioners should ensure that management of the risks of self-harm and suicide, the risk of harm to others, the risk of exploitation by others and the risk of self-neglect is:

- informed by the assessments and interventions in relevant NICE guidance for the relevant mental health disorders, including the NICE guidelines on self-harm in over 8s: short-term management and prevention of recurrence and self-harm in over 8s: long-term management
- implemented in line with agreed protocols for safeguarding and appropriate adults
- implemented in line with agreed protocols in police custody, prisoner escort services, prison, community settings and probation service providers
- integrated with and recorded in the relevant information systems (for example, the ACCT procedure in prisons, the Offender Assessment and Sentence Management (OASys), and SystmOne and Multi Agency Risk Assessment Conference (MARAC) and multi-agency public protection arrangements (MAPPA).

1.5 Care planning

1.5.1 Develop a mental health plan of care in collaboration with the person and, when possible, their family, carers and advocates. All practitioners developing the plan, should ensure it is integrated with care plans from other services, and includes:

- a profile of the person's needs, identifying agreed goals and the means to progress towards goals
- identification of the roles and responsibilities of those practitioners involved in delivering the plan
- a clear strategy to access all identified interventions and services
- agreed outcome measures and timescale to evaluate and review the plan
- a risk management and a crisis plan if developed
- an agreed process for communicating the plan to all relevant agencies, the person, and their families and carers.

1.5.2 Give people the opportunity to discuss the outcomes and implications of their assessment and the content of their plan of care with the practitioner undertaking the assessment.

1.5.3 When developing or implementing a plan of care all practitioners should take into account:

- the ability of the person to take in and remember information
- the need to provide extra information and support to help with the understanding and implementation of the plan of care
- the need for any adjustment to the social or physical environment
- the need to adjust the structure, content, duration or frequency of any intervention
- the need for any prompts or cognitive aids to help with delivery of the intervention.

1.6 Psychological interventions

Delivering psychological interventions for mental health problems

1.6.1 Refer to relevant NICE guidance for the psychological treatment of mental health problems for adults in contact with the criminal justice system, taking into account:

- the need to modify the delivery of psychological interventions in the criminal justice system
- the need to ensure continuity of the psychological intervention (for example, transfer between prison settings or on release from prison).

1.6.2 Be aware that many people in contact with the criminal justice system (including people with a diagnosis of personality disorder) may have difficulties with:

- accurately interpreting and controlling emotions
- impulse control (for example, difficulty planning, seeking high levels of stimulation, ambivalent about consequences of their negative actions)
- experiencing themselves as having a lack of autonomy (for example, seeing their actions as pointless, having difficulties in setting and achieving goals)
- having an unstable sense of self that varies depending on context or is influenced by the people they interact with
- social functioning (for example, relating to, cooperating with, and forming relationships with others, difficulties understanding their own and others' needs)
- occupational functioning.

Personality disorder

1.6.3 Providers of services should ensure staff are able to identify common features and behaviours associated with personality

disorders and use these to inform the development of programmes of care.

1.6.4 Practitioners should ensure interventions for people with a diagnosis of personality disorder or associated problems are supportive, facilitate learning and develop new behaviours and coping strategies in the following areas:

- problem solving
- emotion regulation and impulse control
- managing interpersonal relationships
- self-harm
- medicine management (including reducing polypharmacy).

1.6.5 Practitioners should be aware when delivering interventions for people with mental health problems that having a personality disorder or an associated problem may reduce the effectiveness of interventions. Think about:

- providing additional support.
- adjusting the duration and intensity of psychological interventions if standard protocols have not worked
- delivering complex interventions in a multidisciplinary context.

1.6.6 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.

Specific psychological interventions

1.6.7 Practitioners should consider using contingency management to reduce drug misuse and promote engagement with services for people with substance misuse problems.

1.6.8 Practitioners delivering contingency management programmes should:

- agree with the person the behaviour that is the target of change
- provide incentives in a timely and consistent manner
- confirm the person understands the relationship between the treatment goal and the incentive schedule
- make incentives reinforcing and supportive of a healthy and drug-free lifestyle.

1.6.9 Practitioners should consider referral to a therapeutic community specifically for substance misuse for people in prison with a minimum 18-month sentence who have an established pattern of drug misuse.

1.6.10 When setting up therapeutic community programmes in prison settings in a separate wing of a prison for people with substance misuse problems, aim to:

- include up to 50 prisoners in the programme
- provide treatment for between 12 and 18 months, made up of:
  - twice-weekly group therapy sessions (mean group size of 8)
  - daily (5 days only) community meeting for all wing residents
  - daily (5 days only) social activity groups for all wing residents
  - a once-weekly individual review meeting (20 minutes).

1.6.11 Consider psychological interventions for paraphilias only when delivered as part of a research programme.

1.7 Pharmacological interventions

1.7.1 Refer to relevant NICE guidance for pharmacological interventions for mental health problems in adults in contact with the criminal justice system. Take into account:

- risks associated with in-possession medicines
- administration times for medication
- availability of medicines in the first 48 hours of transfer to prison

- availability of medicines after release from prison.

1.7.2 Refer to NICE's guidance on attention deficit hyperactivity disorder (ADHD) when prescribing pharmacological interventions for this condition.

1.7.3 Review all medicines prescribed for sleep problems and the management of chronic pain to:

- establish the best course of treatment (seek specialist advice if needed)
- assess the risk of diversion or misuse of medicines.

1.8 Organisation of services

Service structures and delivery

1.8.1 Commissioners and providers of criminal justice services and healthcare services should consider developing systems for police custody and court custody that provide prompt access to the following:

- the effective identification and recognition of mental health problems
- a comprehensive mental health assessment
- advice on immediate care and management.

1.8.2 Providers of criminal justice services and healthcare services should consider diverting people from standard courts to dedicated drug courts if the offence is linked to substance misuse and was non-violent.

1.8.3 Commissioners and providers of criminal justice services and healthcare services should consider establishing joint working arrangements between healthcare, social care and police services

for managing urgent and emergency mental health presentations in the community (for example, street triage). Include:

- joint training for police, healthcare and social care staff
- agreed protocols for joint working developed and reviewed by a multi-agency group
- agreed protocols for effective communication within and between agencies
- agreed referral pathways for urgent and emergency care and routine care.

1.8.4 Commissioners and providers of criminal justice services and healthcare services should ensure effective identification, assessment, coordination and delivery of care for all people with a mental health problem in contact with the criminal justice system (including the National Probation Service or Community Rehabilitation Company). In particular, ensure that:

- all people with a severe or complex mental health problem have a designated care coordinator
- during transitions between services care plans are shared and agreed between all services
- effective protocols are in place to support routine data sharing between health and criminal justice agencies to reduce unnecessary duplication of assessments.

1.9 Staff training

1.9.1 Commissioners and providers of criminal justice services and healthcare services should provide all staff working in the criminal justice system, who provide direct care or supervision, a comprehensive induction, covering:

- the purpose of the service in which they work, and the role and availability of other related local services, including pathways for referral
- the roles, responsibilities and processes of criminal justice, health and social care staff
- legislation and local policies for sharing information with others involved in the person's care
- protocols for dealing with mental health problems in the criminal justice system (for example, in-possession medicines, side effects, withdrawal)
- the importance of clear communication, including avoiding acronyms and using consistent terminology.

1.9.2 Commissioners and providers of criminal justice services and healthcare services should educate all staff about:

- the stigma and discrimination associated with mental health problems and associated behaviours, such as self-harm
- the need to avoid judgemental attitudes
- and the need to avoid using inappropriate terminology.

1.9.3 Provide multidisciplinary and multi-agency training to increase consistency, understanding of ways of working, and promotion of positive working relationships for all staff who work in the criminal justice system on:

- the prevalence of mental health problems in the criminal justice system, and why such problems may bring people into contact with the criminal justice system
- the main features of commonly occurring mental health problems seen in the criminal justice system (for example, substance misuse, neurodevelopmental disorders, acquired cognitive impairment, personality disorder, depression, anxiety disorders, psychosis, post-traumatic stress disorder [PTSD]),

and the impact these may have on behaviour and compliance with rules and statutory requirements

- recognising and responding to mental health problems and communication problems that arise from, or are related to, physical health problems.

1.9.4 Give all staff involved in direct care, training and supervision to support them in:

- dealing with critical incidents, including emergency life support
- managing stress associated with working in the criminal justice system and how this may affect their interactions with people and their own mental health and wellbeing
- the recognition, assessment, treatment, and management of self-harm and suicide
- de-escalation methods to minimise the use of restrictive interventions
- recognition of changes in behaviour, taking into account that these may indicate the onset of, or changes to, mental health problems
- knowledge of effective interventions for mental health problems
- developing and maintaining safe, boundaries and constructive relationships
- delivering interventions within the constraints of the criminal justice system (for example, jail craft training, formulation skills).

Terms used in this guideline

Acquired cognitive impairment

Any cognitive impairment that develops after birth, including traumatic brain injury, stroke, and neurodegenerative disorders such as dementia.

Appropriate adult

Is responsible for protecting (or 'safeguarding') the rights and welfare of a child or 'mentally vulnerable' adult who is either detained by police or is interviewed under caution voluntarily. The role was created alongside the Police and Criminal Evidence Act (PACE) 1984.

Carer

A person who provides unpaid support to someone who is ill, having trouble coping or who has disabilities.

Care worker

A person who provides paid support to someone who is ill, having trouble coping or who has disabilities, in a variety of settings (including residential homes, supported living settings and day services).

Contingency management

A set of techniques that focus on the use of reinforcement to change certain specified behaviours. These may include promoting abstinence from drugs (for example, cocaine), reduction in drug misuse (for example, illicit drug use by people receiving methadone maintenance treatment), and improving adherence to interventions that can improve physical health outcomes.

Jail craft

Learned, knowledgeable work depending on experience and fine judgements in a prison setting – often learned by new prison officers through shadowing and being mentored by senior officers.

Multidisciplinary team

A group of experts from different disciplines who each provide specific support to a person, working as a team.

Programme of care

This is developed from a comprehensive assessment of a person's needs and sets out how those needs might be met, who is responsible for meeting those needs, and how the programme of care will be evaluated and reviewed.

Street triage

Schemes involving mental health professionals providing on-the-spot support to police officers who are dealing with people with possible mental health problems.

You can also see this guideline in the NICE pathway on [pathway title].

To find out what NICE has said on topics related to this guideline, see our web page on [add and link topic page titles or titles].

Putting this guideline into practice

[This section will be finalised after consultation]

NICE has produced tools and resources [link to tools and resources tab] to help you put this guideline into practice.

[Optional paragraph if issues raised] Some issues were highlighted that might need specific thought when implementing the recommendations. These were raised during the development of this guideline. They are:

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

[Clinical topics only] Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their

work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. Raise awareness through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. Identify a lead with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. Carry out a baseline assessment against the recommendations to find out whether there are gaps in current service provision.

4. Think about what data you need to measure improvement and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. Develop an action plan, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes

may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. For very big changes include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. Implement the action plan with oversight from the lead and the project group. Big projects may also need project management support.

8. Review and monitor how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

Context

Mental health problems are very common among people in contact with criminal justice system, ranging from 39% in police custody up to 90% in prison. There is also evidence that certain mental disorders like personality disorders and psychotic disorders were more prevalent in the prison population than the general population. Moreover, it is reported that certain subgroups like females, black and minority ethnic groups and those older than 50 years and groups with comorbid disorders are over-represented in prisoners with mental health disorders.

The underlying mechanisms between crime and mental illness are still not yet well understood. There are some suggestions that pre-existing social factors,

for instance homelessness, may be associated with increased offending and in other areas like substance misuse, the urge to use illicit drugs may drive to commit crime. In some cases, the links may relate to either poor adaptive functioning or the consequence of offending and contact with the Criminal Justice System upon mental health.

Currently, NHS is responsible for healthcare provision including mental healthcare for people in contact with the criminal justice system, apart from police and court custody. There is also joint care pilot scheme between the criminal justice system and NHS funded by Department of Health, such as 'street triage' schemes. However, identifying the mental health problems in police custody is complicated by the lack of standard assessment and training and education. In addition, there is lack of clarity on appropriate signposting and prompt access to a mental healthcare.

This guideline covers recognition, assessment, treatment and prevention of mental health problems in adults who are in contact with the criminal justice system. Mental health problems include common mental health problems, severe mental illness, paraphilias, neurodevelopmental disorders and acquired cognitive impairment. Moreover, there are recommendations on care planning and pathways and organisation and structure of services as well as training for health, social care and criminal justice professionals and practitioners.

This guideline covers only settings in criminal justice system (police and court custody, liaison, diversion and street triage services as well as community rehabilitation or probation services).

People in contact with the criminal justice system have many needs as individuals and related to criminal involvement. This guideline only addresses mental health needs of people in contact with criminal justice system.

Recommendations for research

The guideline committee has made the following recommendations for research. The committee's full set of research recommendations is detailed in the full guideline.

1 Psychological and pharmacological interventions for people with paraphilic disorders

What is the clinical, cost-effectiveness and safety of psychological and pharmacological interventions both in and out of the prison among people with paraphilic disorders?

Why this is important

The limited evidence for pharmacological interventions (for example, medroxyprogesterone acetate) provides no clear evidence of benefit in people with paraphilias. A randomised trial with adequate sample size is required to examine the effectiveness of medroxyprogesterone acetate in these populations.

There is insufficient evidence on the use of psychological interventions for people with paraphilias in the criminal justice system. Individual patient data analysis of paedophiles who have been treated should be conducted to inform treatment and future research. Psychological interventions paraphilias (such as sex offender treatment programme) should be tested in large randomised controlled trials in criminal justice populations. This research could have a significant impact upon updates of this guideline.

Important outcomes could include:

- offending and re-offending rates
- effect on mental health problems
- cost-effectiveness
- health-related quality of life.

When designing the trials, consideration should be given to timing, intensity and duration of interventions in the context of the criminal justice system.

2 Structured clinical management interventions in community rehabilitation centres and national probation services

What is the effectiveness of a structured clinical or case management to improve mental health outcomes using interventions within community rehabilitation centres and national probation services?

Why this is important

Many individuals in contact with the CJs in particularly those managed by community rehabilitation companies have significant personality problems and interpersonal difficulties. Evidence from people with such problems in general mental health services suggest that structure mental health services may be of benefit in improving mental health outcomes. 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. The comparison should be against standard CRC care. The trail should consider both clinical outcomes (as detailed below) and cost-effectiveness. .

Important outcomes could include:

- offending and re-offending rates
- mental health outcomes
- cost-effectiveness
- health-related quality of life.

3 Interventions for coordination and delivery of care to improve access and uptake

What models for the coordination and delivery of care for people in contact with the criminal justice provide for the most effective and efficient coordination of care and improve access and uptake of services?

Why this is important

There is low quality evidence for a range of systems for the delivery and coordination of care in the criminal justice system (for example drug or mental health courts, and case management). However, there is clear evidence of poor engagement, uptake and retention in treatment for people with mental health problems in contact with the criminal justice system. A number of models for example, case management and collaborative care have shown benefit for people with common and sever mental health problems in routine healthcare settings. A programme of research and development is required which will (a) develop and test in small feasibility studies different models of care coordination for the delivery of care and (b) test those models which have shown promise in the feasibility studies in large scale randomised clinical trials in the criminal justice system

Important outcomes could include:

- improved access and uptake of services
- improved mental health outcomes
- reductions in offending and reoffending.

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4 Tools for case identification for mental health problems and populations common in the criminal justice system

What are the reliable and valid tools to identify cognitive impairment among people in contact with the criminal justice system (focusing on people with trauma, neurodevelopmental disorders and acquired cognitive impairment as well as veterans and older people)?

Why this is important

There is limited evidence that interventions can reduce the cognitive or functional impairments associated with acquired cognitive impairment. Acquired cognitive impairment is common in criminal justice population. Moreover, people with acquired cognitive impairment have high risk of self-

harm. Acquired cognitive impairment may arise as result of a traumatic brain injury, or a stroke. Experts in this area have suggested that early identification of deficits and prompt management strategies could be important in ameliorating the long-term impact of acquired cognitive impairment. However, there is lack of evidence on reliable and valid case identification tools and methods. It is important that research is developed to assist the staff in criminal justice pathway to facilitate identification of acquired cognitive impairment and support better understanding and management of acquired cognitive impairment.

5 Identification of factors associated with suicide

How could suicide in the criminal justice system be prevented successfully?

Why this is important

There is high prevalence of suicide attempts among people in contact with criminal justice system. While considering interventions on the prevention of self-harm among these population, it is important to examine the factors related to successful suicide. A retrospective analysis of observational studies of suicidal attempts and completed suicides using suicide as a definitive and measurable outcome should be performed to identify the prognostic factors for successful prevention.