Appendices on separate files:

Appendix A: Scope for the development of the clinical guideline

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

SCOPE

A.1 Guideline title

Mental health of adults in contact with the criminal justice system: identification and management of mental health problems and integration of care for adults in contact with the criminal justice system

A.1.1 Short title

Mental health of adults in contact with the criminal justice system

A.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 contact with the criminal justice system.

A.3 Need for the guideline

A.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.

c. 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.

d. 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).

e. 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.

f. 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.

g. 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.

h. Illicit drug use is high, with an estimated 12% of adults serving community sentences thought to have substantial or severe levels of drug misuse, and estimates of drug misuse and dependence on reception into prison range from 10–48% for male prisoners and 30–60% for female prisoners.

i. 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.

j. Sexual offenders comprise 13% of the prison population.

k. Estimates for the prevalence of learning disabilities among people in police custody range from 0.5–9%, while an estimated 7% of the prison population have a learning disability compared to 2% of the general population.

l. 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.

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

n. 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 in England and Wales. 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.

o. The prison population is ageing and there is an increasing incidence of mental health problems in older prisoners, including dementia and depression.

A.3.2 Current practice

a. Current healthcare provision, including mental healthcare, for people in contact with the criminal justice system is the responsibility of the NHS, with the exception of police custody and court custody.

b. The first contact with the criminal justice system for most people is with the police. 'Street triage' schemes, funded by the Department of Health and managed by police forces in partnership with local NHS organisations, are being developed in some locations. These schemes involve mental health professionals providing on-the-spot support to police officers who are dealing with people with possible mental health problems (including people who come into contact with the police without having committed an offence).

c. People who have only brief contact with the criminal justice system, for example through street triage schemes or on-the-spot fines, pose particular problems for recognising mental health problems and appropriate signposting.

d. Currently, the custody officer has responsibility for identifying mental health needs, assessing risk, and determining fitness for detention and interview for people in police custody (although legal responsibility for commissioning of custodial health services is expected to move to NHS England by April 2015). Identifying mental health problems in people in police custody is complicated by:

e. the high number of people being detained who are intoxicated on arrival at the police station

f. the lack of a standard mental health assessment

g. the lack of a national standard for police training in mental health

h. a reliance on self-reporting

i. barriers to disclosure including stigma, previous negative experiences and the custody suite environment.

j. 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.

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

l. a lack of trained professionals to undertake the assessment

m. the settings for the assessment (custody suites) being unsuitable

n. frequent transfer of people between different custodial settings

o. the lack of common assessment and effective information transfer systems across the criminal justice system.

p. Police and court liaison and diversion schemes, mostly funded by health services, are being developed in some locations. The functions of these schemes include:

q. improving identification of mental health problems

r. making transfer to hospital (when appropriate) easier

s. assessing people appearing in court to help with case completion options

t. signposting and referring to appropriate services

u. From April 2013, NHS England became responsible for commissioning all health services (with the exception of some emergency care, ambulance services and out-of-hours services) for people in prisons (including youth offender institutions) in England.

v. Prisoners receive a brief health reception screen on arrival in prison, intended to identify immediate needs. A subsequent, more in-depth health assessment is

supposed to be done outside of the time-constrained reception environment. However, the implementation of health screening, in particular the longer and more detailed post-reception assessment, is variable and often does not happen. Because of this, identification of mental health problems, particularly depression and anxiety disorders, is poor.

w. Learning disabilities also often go unrecognised. For example, the prison reception health screen does not assess learning disabilities. Specialist services are provided by some prisons for offenders with learning disabilities and learning difficulties. However, availability of adapted management programmes remains limited.

x. For adults in the prison service, mental healthcare is provided by a range of primary care services, specialist mental health services and drug and alcohol services, with variable levels of integration.

y. Mental health in-reach teams were originally set up to treat people with severe mental illness in prison by providing equivalent specialist mental health services to those provided by community-based mental health teams. However, the focus of these teams has been extended to all people with mental health problems in prison, including providing services for prisoners with personality disorders or with primary mental health needs. This wider scope, together with a lack of resources, has restricted the role of in-reach teams to assessment and liaison or support, rather than face-to-face therapeutic intervention.

z. As well as 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.

aa. Delivering effective treatment options in prison may be limited by the restrictive nature of the prison environment and the fact that the Mental Health Act does not apply to the prison population (with the exception of sections 47 and 48 for the transfer of prisoners to and from hospital). Prisoners who would be sectioned if they were in the community would be transferred to NHS inpatient facilities. However, there are often long delays in transfers going ahead.

bb. People with comorbid alcohol or drug misuse and mental health problems often 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.

cc. The care of individuals in the community and in contact with probation and community rehabilitation companies is the responsibility of generic NHS services. Responsibilities for providing social care for prisoners assessed as being in need (including arrangements for people upon their release from prison and people residing in approved premises) are outlined by the Care Act 2014. There are considerable difficulties arranging effective community-based care for people in contact with the criminal justice system. For example, referral to a mental health service or adequate support for substance misuse is often not put in place before release from prison and there are many barriers to acceptance into community services.

dd. Rehabilitation and resettlement into the community is also complicated by the lifetime of social exclusion experienced by many prisoners. For example, 50% of sentenced prisoners are not registered with a GP before entering prison. There are also considerable difficulties in finding a GP willing to accept prisoners after release.

A.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.

A.4.1 Population

A.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:
b. in police custody
c. in court custody
d. in contact with liaison, diversion and street triage services
e. remanded on bail
f. remanded in prison
g. who have been convicted and are serving a prison or community sentence
h. released from prison on licence
i. released from prison and in contact with a community rehabilitation company (CRC) or the probation service.
j. '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:
k. people with neurodevelopmental disorders (including learning disabilities)
l. women
m. older adults (aged 50 years and over)
n. young black men
o. young adults that have transitioned from juvenile services.

A.4.1.2 Groups that will not be covered

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

a. people who are cared for in hospital, except for providing guidance on managing transitions between criminal justice system settings and hospital
b. people in immigration removal centres
c. children and young people (aged under 18 years)
d. people who are in contact with the criminal justice system solely as a result of being a witness or victim.

A.4.2 Setting

a. The guideline will cover the care and shared care provided or commissioned by health and social care services, for people in contact with the criminal justice system.

A.4.3 Management

A.4.3.1 Key issues that will be covered

When there is existing NICE guidance for the assessment, treatment or management of a mental health problem, the primary source for the evidence in this guideline will be drawn from the relevant guidance. A key concern for this guideline will be reviewing evidence relevant to the criminal justice system to identify any modifications needed to existing recommendations or to the current structure and systems for the delivery of health and social care services in the criminal justice system, in order to support implementation of existing

guidance. When there is no existing NICE guidance a new review will be carried out for this guideline.

Identification and assessment

a. recognising people who have a mental health problem (including formal recognition tools)
b. assessing mental health problems (including formal assessment tools).

Interventions and their adaptation to the criminal justice system

a. interventions to promote mental health and wellbeing, including environmental adaptations, and individual and population-based psychoeducational interventions
b. pharmacological interventions for the care and treatment of mental health problems (including adaptation to the prison environment)
c. psychological and social interventions for the care and treatment of mental health problems (including adaptation to the prison environment).

The organisation and provision of services for people with mental health problems in contact with the criminal justice system

a. care planning and pathways, and organisation and structure of services, which promote:

    i. appropriate access to services
    ii. positive experience of services
    iii. care coordination
    iv. transitions between services
    v. discharge from services

Training or education needed to enable health, social care and criminal justice professionals and practitioners to provide good-quality services.

A.4.3.2 Issues that will not be covered

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

A.4.4 Main outcomes

a. Mental health outcomes
b. Offending and re-offending
c. Service use
d. Adaptive functioning (for example, employment status both within and outside of prison, development of daily living and interpersonal skills and quality of life)
e. Rates of self-injury in service users
f. Experience of care

A.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 carried out 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 contact with the criminal justice system. 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 contact with the criminal justice system if appropriate cost data are available. Further detail on the methods can be found in 'The guidelines manual' (see ‘Further information’).

A.4.6 Status

A.4.6.1 Scope

This is the final draft of the scope.

A.4.6.2 Timing

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

A.5 Related NICE guidance

A.5.1 Published guidance

A.5.1.1 NICE guidance to be incorporated

This guideline will incorporate the following NICE guidance: TBC

A.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).
- Medicines adherence. NICE clinical guideline 76 (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).

A.5.2 Guidance under development

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

- Antenatal and postnatal mental health (update). NICE clinical guideline. Publication expected December 2014.
- Medicines optimisation. NICE clinical guideline. Publication expected March 2015.
- Violence and aggression. NICE clinical guideline. Publication expected April 2015.
- Challenging behaviour and learning disabilities. NICE clinical guideline. Publication expected May 2015.
- Transition from children's to adult services. NICE clinical guideline expected February 2016.
- Transition between inpatient mental health settings and community and care home settings. NICE clinical guideline expected August 2016.
- Dual diagnosis. NICE clinical guideline. Publication expected September 2016.
- Physical health in prisons. NICE clinical guideline. Publication expected November 2016.
- Depression in adults (update). NICE clinical guideline. Publication expected May 2017.

A.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.

Appendix B: Declarations of interests by Guideline Committee members

With a range of practical experience relevant to mental health of adults in contact with the criminal justice system in the GC, members were appointed because of their understanding and expertise of the identification and management of mental health problems of people in contact with the criminal justice system and support for their families/carers, including: scientific issues; health research; the delivery and receipt of healthcare, along with the work of the healthcare industry; and the role of professional organisations and organisations for adults with mental health problems in contact with the criminal justice system and their families/carers.

To minimise and manage any potential conflicts of interest, and to avoid any public concern that commercial or other financial interests have affected the work of the GC and influenced guidance, members of the GC must declare as a matter of public record any interests held by themselves or their families which fall under specified categories (see below). These categories include any relationships they have with the healthcare industries, professional organisations and organisations for mental health of adults in contact with the criminal justice system and their families/carers.

Individuals invited to join the GC were asked to declare their interests before being appointed. To allow the management of any potential conflicts of interest that might arise during the development of the guideline, GC members were also asked to declare their interests at each GC meeting throughout the guideline development process. The interests of all the members of the GC are listed below, including interests declared prior to appointment and during the guideline development process.

B.1 Categories of interest

- Paid employment
- Personal pecuniary interest: financial payments or other benefits from either the manufacturer or the owner of the product or service under consideration in this guideline, or the industry or sector from which the product or service comes. This includes holding a directorship or other paid position; carrying out consultancy or fee paid work; having shareholdings or other beneficial interests; receiving expenses and hospitality over and above what would be reasonably expected to attend meetings and conferences.
- Personal family interest: financial payments or other benefits from the healthcare industry that were received by a member of your family.
- Non-personal pecuniary interest: financial payments or other benefits received by the GC member's organisation or department, but where the GC member has not personally received payment, including fellowships and other support provided by the healthcare industry. This includes a grant or fellowship or other payment to sponsor a post, or contribute to the running costs of the department; commissioning of research or other work; contracts with, or grants from, NICE.
- Personal non-pecuniary interest: these include, but are not limited to, clear opinions or public statements you have made about individuals with mental health problems in contact with the criminal justice system, holding office in a professional organisation or advocacy group with a direct interest in the identification and management of mental health problems of people in contact with the criminal justice system, other reputational risks relevant to the identification and management of mental health problems of people in contact with the criminal justice system.

Guideline Development Group – declarations of interest	
Vikki Baker	
Employment	Joint Service Director, Consultant Clinical Psychologist, Resettle
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	Involvement in the procurement of a housing provider for men with personality disorder
Personal non-pecuniary interest	None
Non-personal non-pecuniary interest	None
Action taken	None
Annie Bartlett	
Employment	Reader and Honorary Consultant in Forensic Psychiatry SGUL and CNWL FT; Clinical Director (Jt) Offender Care CNWL FT
Personal pecuniary interest	Received Department of Health funding for 1 year looking at secure care for Addicts
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	Non-executive Board Member of Phoenix Futures
Non-personal non-pecuniary interest	None
Action taken	None
Diana Binding	
Employment	Assistant Chief Executive – Gwent; Wales Community Rehabilitation Service (CRC)
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Non-personal non-pecuniary interest	None
Action taken	None
Richard Byng	
Employment	Professor of Primary Care Research, Primary Care Group, Plymouth University Peninsula Schools of Medicine and Dentistry; Deputy Director, Peninsula CLAHRC for the south west; General Practitioner, Mount Gould Primary Care Centre and GP with Special Interest in Mental Health (Honorary, Plymouth Community Healthcare and The Zone, Plymouth)
Personal pecuniary interest	Ongoing programme with publications for offender health Publication of Realist Review of Collaborative Care for mental health of offenders
Personal family interest	None
Non-personal pecuniary interest	NIHR funded programme grant evolving collaborative care for prison leavers
Personal non-pecuniary interest	None
Action taken	None
Steffan Davies	

Guideline Development Group – declarations of interest	
Employment	Consultant Forensic Psychiatrist, Offender Health Services, Northamptonshire Healthcare NHS Foundation Trust
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Stephen Habgood	
Employment	Retired senior governor
Personal pecuniary interest	Director of a company that sells fitness products to improve treatment of back and hip pain
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	NHS working group looking at family involvement in NHS investigations into homicide and suicide Chairman of the national charity, PAPYRUS Prevention of Young Suicide NICE's standing advisory committee for safe staffing as a topic specialist committee member for 'Safe staffing for mental health inpatients'.
Action taken	None
Kay Isaacs	
Employment	Manager Criminal Justice Mental Health Team Abertawe Bro Morgannwg University Health Board
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Nick Kosky	
Employment	Medical Director & Consultant Psychiatrist, Dorset Healthcare University Foundation Trust, Forston Clinic
Personal pecuniary interest	Author of (draft) book on the Problem with Diagnoses
Personal family interest	None
Non-personal pecuniary interest	Appointed to project group for Centre for Mental Health and Howard League for Penal Reform on reducing deaths in detention
Personal non-pecuniary interest	None
Action taken	None
Sunil Lad	
Employment	Principal Counselling Psychologist Offender Health, Northamptonshire Healthcare Foundation Trust
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	The organisation now manages healthcare in a Category A prison

Guideline Development Group – declarations of interest	
Personal non-pecuniary interest	None
Action taken	None
Naomi Lumsdaine	
Employment	Human Rights lawyer at the Equality and Human Rights Commission
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Kerry Manson	
Employment	Clinical Psychologist
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	Hosting 'engage project' at HMP Liverpool
Personal non-pecuniary interest	None
Action taken	None
Tony O'Connell	
Employment	Detective Constable, Dorset Police
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Leroy Simpson	
Employment	Service User
Personal pecuniary interest	Board member of Revolving Doors Agency
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Nicole Stanbury	
Employment	Service User
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Julia Tabreham	
Employment	Carer represenative
Personal pecuniary interest	Non-executive director of Nottingham University Hospital NHS Trust Non-executive Director of the Parlimentary and Health Service Ombudsman

Guideline Development Group – declarations of interest	
	Delivering a pilot Health and Social care passport for NoMs Former Chief Executive of Carers Federation (retired)
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	Member of Restore Support Network
Action taken	None
Action Taken	None
Jenny Talbot	
Employment	Director, Care not Custody, Prison Reform Trust
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Mark Warren	
Employment	Service Manager, Adult Mental Health, Hywel Dda University Health Board, Brynmair Clinic, Llaneli, SA15 3HH
Personal pecuniary interest	Chair of the Royal College of Nursing Forum in Criminal Justice Settings Former Forensic Liaison Practitioner, CWM TAF University Health Board, Wales
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Geoffrey White	
Employment	Prison Officer
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Joanne White	
Employment	CQC Inspector (Hospitals) Northeast Region
Personal pecuniary interest	None
Personal family interest	None
Non-personal pecuniary interest	None
Personal non-pecuniary interest	None
Action taken	None
Professor Steve Pilling	
Employment	Director, NGA
Personal pecuniary interest	None
Personal family interest	None

Guideline Development Group – declarations of interest	
Non-personal pecuniary interest	Co. applicant of trial of MBT in Probation Services in England
Personal non-pecuniary interest	None
Action taken	None

Appendix C: Special advisors to the Guideline Committee

Those who acted as advisors on specialist topics or have contributed to the process by meeting the Guideline Committee:

Huw Williams, Exeter University

Appendix D: Stakeholders who submitted comments in response to the consultation draft of the guideline

Adult Secure Services Clinical Reference Group (Armed Forces and their Families and Health and Justice Commissioning Manager)

Adult Secure Services Clinical Reference Group (Lead for Reducing Restrictive Practice)

Association of Directors of Adult Social Services

Association of Directors of Public Health

Centre for Mental Health

College of Mental Health Pharmacy (CMHP)

College of Occupational Therapists

Foundation for People with Learning Disabilities

Inclusion London

Janssen Cilag ltd

Joint comment update between Northumbria Police and Northumberland Tyne and Wear NHS Foundation Trust

Medicines and technologies programme (MTP)

Mental Health Foundation

Nacro

National Offender Management Service

Newcastle University

NICE Physical Health of People in Prisons GC

NICE-Quality Standards

Northumberland Tyne and Wear NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust

Prison Reform Trust

Prisons and Probation Ombudsman

Public Health England

RECOOP

Rethink Mental Illness

Revolving Doors Agency

Royal College of General Practitioners

Royal College of Nursing

Royal College of Psychiatrists

Shire Pharmaceutical limited Ireland

The British Psychological Society

The Disabilities Trust

The Magistrates' Association

Together for Mental Wellbeing

Youth Justice Board

Appendix E: Researchers contacted to request information about unpublished or soon-to-be published studies

National Offender Management Service (NoMs)

Appendix F: Analytical framework, review questions and protocols

1.1 Experience of care

Item No.	Item [Prospero field No.]	Details
	Guideline details	
1.	Guideline*	Mental health of adults in contact with the criminal justice system
2.	Guideline chapter*	Experience of care
3.	Topic Group (if used)	
4.	Sub-section lead*	
5.	Review team lead*	Odette Megnin-Viggars
6.	Objective of review*	To review experiences of care for adults with mental health problems in contact with the criminal justice system, from the perspective of practitioners, service users, and family or carers
	Review title and timescale	
7.	Review title*	Service user, family and carer, and practitioner experiences of care for adults with mental health problems in contact with the criminal justice system
8.	Anticipated or actual start date	
9.	Anticipated completion date	
10	Stage of review at time of registration	**Started** / **Completed** Preliminary searches ☐ ☐ Piloting of the study selection process ☐ ☐ Formal screening of search results against eligibility criteria ☐ ☐ Data extraction ☐ ☐ Risk of bias (quality) assessment ☐ ☐ Data analysis ☐ ☐

		Prospective meta-analysis ☐ ☐ Provide any other relevant information about the stage of the review here (e.g. Funded proposal, final protocol not yet finalised). ☐
	Review methods	
11	Review question(s)*	RQ 1.1: What factors support or hinder practitioners in their delivery of assessment, intervention or management for adults with mental health problems in contact with the criminal justice system? RQ 1.2: What factors improve or diminish access to, or experience of, services for adults in contact with the criminal justice system and their family or carers? Consider:- • stigma and barriers to disclosure • involvement in decisions and respect for preferences • individualised intervention and management • attention to physical and environmental needs RQ 1.3: What factors improve or diminish uptake of and engagement with intervention and services for adults in contact with the criminal justice system?
12	Sub-question(s)	Where possible, consideration should be given to the specific needs of:- • people with neurodevelopmental disorders (including learning disabilities) • women • older adults (aged 50 years and over) • young black men • young adults that have transitioned from juvenile services
13	Searches*	**Mainstream databases:** CENTRAL, Embase, MEDLINE, PsycINFO **Topic specific databases:** **None**

		Other resources of evidence: • Reference lists of included studies • Citation tracking for included papers in Scopus and Web of Knowledge (WoK) • Calls for evidence from stakeholders • Contacting authors of relevant works for 'sibling' studies • "Related articles" searching in PubMed • PROSPERO (http://www.crd.york.ac.uk/Prospero/) • Conference abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Dissertation titles/abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Non-English language papers (with English abstracts) will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in an English language journal. [Note: inclusion criteria restricted to UK setting] *The number of citations that might relate to relevant trials that haven't been included will be recorded. Note. Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline.
14	Condition or domain being studied*	Mental health problems in adults in contact with the criminal justice system 'Mental health problems' includes: common mental health problems; severe mental illness; personality disorders; drug and alcohol problems; paraphilias; neurodevelopmental disorders; acquired cognitive impairment Contact with the criminal justice system includes people: in police custody; in court custody; in contact with liaison,

		diversion and street triage services; remanded on bail; remanded in prison; who have been convicted and are serving a prison or community sentence; released from prison on licence; released from prison and in contact with a community rehabilitation company (CRC) or the probation service.
15	Perspective*	Practitioners, service users, and family or carers **Excluded:** • 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
16	Phenomenon of interest*	• Factors or attributes (at the individual-, practitioner- or service- level) that can enhance or inhibit access to services • Factors or attributes (at the individual-, practitioner- or service- level) that can enhance or inhibit delivery of services • Factors or attributes (at the individual-, practitioner- or service- level) that can enhance or inhibit uptake of and engagement with intervention and services • Actions by services that could improve or diminish the experience of care for example:- ▪ Form, frequency, and content of interactions with service users, families or carers ▪ Sharing information with and receiving information from service users, families or carers ▪ Planning of care with service users, families or carers • Experience of specific recognition or assessment tools, or specific interventions, from the perspective of practitioners, service users, family or carers **Excluded:** • The provision of financial and practical support (for example direct payments) is outside the scope of this guideline and will not be included.
17	Comparison*	None
18	Types of study to be included initially*	Systematic reviews of qualitative studies and primary qualitative research

		Excluded: Surveys, case studies, autobiographical account, commentary, editorial, vignettes, books, policy and guidance, and non-empirical research
19	Setting	Care and shared care provided or commissioned by health and social care services in the UK, for people in contact with the criminal justice system **Excluded:** • Non-UK studies • Pre-2000 studies • People who are cared for in hospital, except for providing guidance on managing transitions between criminal justice system settings and hospital • People in immigration removal centres
20	Evaluation	• Experience of assessment received • Experience of care received • Experience of access to care • Experience of engagement with care • Experience of and/or views on care planning, delivery and/or management **Excluded:** • Experiences of disorder or criminal justice system with no explicit implications for management, planning and/or delivery of care • Qualitative measures of perceived intervention effectiveness where a quantitative approach would have been more appropriate
21	Data extraction (selection and coding)*	Citations from each search will be downloaded into EndNote and duplicates removed. Records will then be screened independently by two reviewers against the eligibility criteria of the review (if there is disagreement, resolution will be by discussion or a third reviewer). Initially 10% of references will be double-screened. If inter-rater agreement is good (percentage agreement =>90%) then the remaining references will be screened by one reviewer. The unfiltered search results will be saved and retained for future potential re-analysis. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). Eligibility will be confirmed by at least one member of the Guideline Development Group (GDG). Two researchers will extract data into the study database, comparing a sample of each other's work (10%) for reliability. Discrepancies or difficulties with coding will

		be resolved through discussion between reviewers or with members of the GDG. Data to be extracted: Study characteristics: RQ, N, mental health problem, CJS setting, offence (if appropriate), length of sentence (if appropriate), demographics of service user and family/carer/practitioner (age, sex, ethnicity), treatment details, data collection method, data analysis method Data extraction (for thematic meta-synthesis): RQ addressed, population, point on care pathway, overarching theme from the NICE Service User Experience in Adult Mental Health (NICE, 2011; NCCMH, 2012) matrix, intervention/service, practitioner, type of experience, emotional valence of experience, theme, sub-theme, author quote to support theme, participant quote to support theme
22	Risk of bias (quality) assessment*	The Critical Appraisal Skills Programme CASP (2013) checklist (available from http://www.casp-uk.net/) will be completed for each study
23	Strategy for data synthesis*	If existing reviews are found, the review team with advice from the GDG will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GDG agree that a systematic review appropriately addresses a review question we will assess if any additional studies, conducted or published since the review was conducted, could affect the conclusions of the previous review. If new studies could change the conclusions, we will conduct a new analysis to update the review. If new studies could not change the conclusions of an existing review, the GDG will use the existing review to inform their recommendations. If primary qualitative studies are included, qualitative data synthesis will be guided by a “best fit” framework synthesis approach (Carroll et al., 2011). The distinguishing characteristic of this type of approach, and the aspect in which it differs from other methods of qualitative synthesis such as meta-ethnography (Campbell et al., 2003) is that it is primarily deductive involving a priori theme identification and framework construction against which data from included studies can be mapped. This review will use the thematic framework identified and developed by the Service User Experience in Adult Mental Health guidance (NICE, 2011; NCCMH, 2012) as a starting point to systematically index and organise all relevant themes and sub-themes within an Excel-based matrix. A secondary

		thematic analysis will then be used to inductively identify additional themes in cyclical stages (Carroll et al., 2011).
24	Analysis of subgroups or subsets	N/A
	Further information	
	Existing reviews utilised in this review:*	
25	• Updated	
26	• Not updated	

1.2 Recognition and assessment

Item No.	Item [Prospero field No.]	Details
	PROSPERO: Reg. No.	CRD##########
	Guideline details	
1.	Guideline*	Mental health of adults in contact with the criminal justice system
2.	Guideline chapter*	Recognition and assessment
3.	Topic Group (if used)	
4.	Sub-section lead*	
5.	Review team lead*	
6.	Objective of review*	• To estimate the diagnostic accuracy of brief recognition tools that assess need for further assessment of adults in contact with the criminal justice system with a suspected mental health problem • To estimate the diagnostic accuracy of formal assessment tools • To identify the key components of a comprehensive assessment
	Review title and timescale	
7.	Review title [1]*	The recognition and assessment of mental health problems in adults in contact with the criminal justice system
8.	Anticipated or actual start date [3]	
9.	Anticipated completion date [4]	
10	Stage of review at time of registration [5]	**Started** **Completed** Preliminary searches ☐ ☐ Piloting of the study selection process ☐ ☐ Formal screening of search results against eligibility criteria ☐ ☐ Data extraction ☐ ☐ Risk of bias (quality) assessment ☐ ☐

		Data analysis ☐ ☐ Prospective meta-analysis ☐ ☐ Provide any other relevant information about the stage of the review here (e.g. Funded proposal, final protocol not yet finalised). ☐
	Review team details	
11	Named contact [6]	Odette Megnin-Viggars
12	Named contact email [7]	omegnin@rcpsych.ac.uk
13	Named contact address [8]	NCCMH Royal College of Psychiatrists, 3rd Floor, 21 Prescot Street London E1 8BB
14	Named contact phone number [9]	020 3701 2645
15	Review team members and their organisational affiliations [10]	Dr. Odette Megnin-Viggars NCCMH
16	Organisational affiliation of the review [11]	National Collaborating Centre for Mental Health
17	Funding sources/ sponsors [12]	National Institute for Health and Care Excellence
18	Conflicts of interest [13]	⊙ None known ○ Yes
19	Collaborators [14]	Title/First name/Last name/Organisation details
	Review methods	
20	Review question(s) [15]*	RQ 2.1: What are the most appropriate tools for the recognition of mental health problems, or what modifications are needed to recognition tools recommended in existing NICE guidance, for adults: • in contact with the police? • in police custody? • for the court process?

		• at reception into prison? • at subsequent time points in prison? • in the community (serving a community sentence, released from prison on licence or released from prison and in contact with a community rehabilitation company [CRC] or the probation service)? RQ 2.2: What are the most appropriate tools to support or assist in the assessment of mental health problems, or what modifications are needed to assessment tools recommended in existing NICE guidance, for adults: • in contact with the police? • in police custody? • for the court process? • at reception into prison? • at subsequent time points in prison? • in the community (serving a community sentence, released from prison on licence or released from prison and in contact with a community rehabilitation company [CRC] or the probation service)? RQ 2.3: What are the most appropriate tools to support or assist in risk assessment, for adults with mental health problems: • in contact with the police? • in police custody? • for the court process? • at reception into prison? • at subsequent time points in prison? • in the community (serving a community sentence, released from prison on licence or released from prison and in contact with a community rehabilitation company [CRC] or the probation service)? RQ 2.4: What are the key components of, and the most appropriate structure for a comprehensive assessment of mental health problems for adults: • in police custody? • for the court process? • at reception into prison? • at subsequent time points in prison? • in the community (serving a community sentence, released from prison on licence or released from prison and in contact with a community rehabilitation company [CRC] or the probation service)?

21	Sub-question(s)	Where possible, consideration should be given to the specific needs of:- • people with neurodevelopmental disorders (including learning disabilities) • women • older adults (aged 50 years and over) • young black men • young adults that have transitioned from juvenile services
22	Searches [16]*	**Mainstream databases:** CENTRAL, Embase, MEDLINE, PsycINFO **Topic specific databases:** None **Other resources of evidence:** • Reference lists of included studies • Citation tracking for included papers in Scopus and Web of Knowledge (WoK) • Calls for evidence from stakeholders • Contacting authors of relevant works for 'sibling' studies • "Related articles" searching in PubMed • PROSPERO (http://www.crd.york.ac.uk/Prospero/) • Conference abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Dissertation titles/abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Non-English language papers (with English abstracts) will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in an English language journal. *The number of citations that might relate to relevant trials that haven't been included will be recorded. Note. Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission

		to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline.
23	Condition or domain being studied [18]*	Mental health problems in adults in contact with the criminal justice system 'Mental health problems' includes: common mental health problems; severe mental illness; personality disorders; drug and alcohol problems; paraphilias; neurodevelopmental disorders; acquired cognitive impairment Contact with the criminal justice system includes people: in police custody; in court custody; in contact with liaison, diversion and street triage services; remanded on bail; remanded in prison; who have been convicted and are serving a prison or community sentence; released from prison on licence; released from prison and in contact with a community rehabilitation company (CRC) or the probation service.
24	Participants/ population [19]*	Included: Adults (aged 18 and over) with, or at risk of developing, a mental health problem who are in contact with the criminal justice system Excluded: • people who are cared for in hospital, except for providing guidance on managing transitions between criminal justice system settings and hospital • people in immigration removal centres • 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.
25	Intervention(s), exposure(s) [20]*	RQ 2.1-2.3: Included: Any formal recognition and assessment tools considered appropriate and suitable for use Index test: Recognition or assessment tool RQ 2.1: Included:

		• 6-Item Cognitive Impairment Test (6-CIT) • Abbreviated Mental test (AMT) • Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) • Alcohol Use Disorders Inventory Test (AUDIT) • Amritsar Depression Inventory (ADI) • Anxiety and Depression Detector • Autism-Spectrum Quotient (AQ-10 or AQ-20 or AQ-50) • Autism Behavior Checklist (ABC) • Autism Screening Questionnaire (ASQ) now known as the Social Communication Questionnaire (SCQ) • Autonomic Nervous System Questionnaire (ANS) • Beck Anxiety Inventory (BAI) • Beck Depression Inventory (BDI) and BDI – short form • Binge Eating Scale (BES) • Brief DSMPTSD–III–R and DSMPTSD–IV • Brief Jail Mental Health Screen (BJMHS) or Brief Jail Mental Health Screen - Revised (BJMHS-R) • Bulimic Investigatory Test, Edinburgh (BITE) • CAGE questionnaire and CAGE questionnaire adapted to include drugs (CAGE-AID) • Caribbean Culture-Specific Screen for emotional distress (CCSS) • Center for Epidemiological Studies Depression Scale (CES-D) • Chemical Use Abuse and Dependency (CUAD) • Clock-drawing test • Co-occurring Disorders Screening Instruments (CODSI) – any mental disorder and severe mental disorder • Confusion Assessment Method, short or long version (CAM) • Correctional Mental Health Screen for Men (CMHS-M) or Correctional Mental Health Screen for Women (CMHS-W) • Dartmouth Assessment of Lifestyle Instrument (DALI) • Davidson Trauma Scale (DTS) • Delirium Rating Scale (DRS) or Delirium Rating Scale-Revised-98 (DRS-R-98) • Disaster-Related Psychological Screening Test (DRPST) • Distress Thermometer • Don Grubin prison reception health screening tool • Drug Abuse Screening Test (DAST-10) • Drug Use Disorders Identification Test (DUDIT) • Eating Attitudes Test (EAT-12 or EAT-26) • Eating Disorder Diagnostic Scale (EDDS) • Eating Disorder Examination Questionnaire (EDE-Q) • Eating Disorders Screen for Primary Care (ESP) • Eating Disturbance Scale (EDS-5)

		• Edinburgh Postnatal Depression Scale (EPDS) • England Mental Health Screen (EMHS) • General Health Questionnaire (GHQ-12 or GHQ-28 or GHQ-30) • General Practitioner Assessment of Cognition (GPCOG) • Generalized Anxiety Disorder scale (the GAD) • Geriatric Depression Scale (GDS) and short form (GDS-15) • Global appraisal of individual needs Short Screener version 1 (GSS) • Hamilton Anxiety Rating Scale (HAM-A) • Hamilton Rating Scale for Depression (HRSD), also called the Hamilton Depression Rating Scale (HDRS/HAM-D) • Health Screening of People in Police Custody (HELP-PC) • Hospital Anxiety and Depression Scale (HADS) • Impact of Event Scale (IES) • Jail Screening Assessment Tool (JSAT) • Kessler-6 or Kessler-10 (K6 or K10) • Mental Disability/Suicide Intake Screen (MDSIS) • Mental Health Screen for Adults (MHS-A) • Mental Health Screening Form (MHSF) • Michigan Alcoholism Screening Test (MAST) • Millon Clinical Multiaxial Inventory-III (MCMI-III) • Mini Mental State Examination (MMSE) • Mini Social Phobia Inventory (Mini-SPIN) • Mood Disorder Questionnaire (MDQ) • National Strategy for Police Information Systems (NSPIS) custody risk assessment • New York State brief screening tool (NYS BST) • Newcastle Mental Test Score • Paddington Alcohol Test • Panic and Agoraphobia Scale (PAS) • Panic Disorder Severity Scale, self-report (PDSS-SR) • Patient Health Questionnaire (PHQ-2 or PHQ-8 or PHQ-9) • Penn Inventory • Personality Assessment Screener (PAS) • Pervasive Developmental Disorder in Mental Retardation Scale (PDD-MRS) • Post-traumatic Stress Disorder Questionnaire (PTSD–Q) • Posttraumatic Stress Symptom Scale – Self-Report version (PSS–SR) and Post-traumatic Diagnostic Scale (PDS) • Prisoner Intake Screening Procedure (PISP) • PTSD Checklist – Civilian version (PCL–C) • Referral Decision Scale (RDS) • Richmond Agitation Sedation Scale (RASS) • Risk Behaviors Related to Eating Disorders (RiBED-8)

		• SCOFF questionnaire • Screen for Post-traumatic Stress Symptoms (SPTSS) • Screening Instrument for Psychosis (PS) • Self-Rating Inventory for Post-traumatic Stress Disorder (SRIP) • Self-Rating Scale for Post-traumatic Stress Disorder (SRS–PTSD) • Seven-minute screen • Sheehan Disability Scale (SDS) • Sheehan Patient-Related Anxiety Scale (SPRAS) • Single Alcohol Screening Question (SASQ) • Social Communication Questionnaire (SCQ) • Social Phobia Questionnaire (SPQ) • Social Phobia module of the Structured Clinical Interview for DSM-IV (SCID-SP) – screening questions • SPAN test • Symptom Checklist 90 (SCL-90) or Symptom Checklist 90-Revised (SCL-90-R) • T-ACE Screening Tool • Trauma Screening Questionnaire (TSQ) • TWEAK alcohol screening test • 'Whooley questions' • Zung Self Rated Depression Scale RQ 2.2: Included: • Aberrant behaviour checklist (ABC) • Addenbrooke's Cognitive Examination (ACE) • Adult Asperger Assessment (AAA) • Alcohol Problems Questionnaire (APQ) • Alcohol Use Disorders Inventory Test (AUDIT) • Alzheimer's Disease Assessment Scale cognitive subscale (ADAS-cog) • Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) • Asperger Syndrome (and high-functioning autism) Diagnostic Interview (ASDI) • Autism-Diagnostic Interview – Revised (ADI-R) • Autism Diagnostic Observation Schedule (ADOS) • Autism Spectrum Disorders Diagnosis Scale for Intellectually Disabled Adults (ASD-DA) • Behavior Summarized Evaluation – Revised (BSE-R) • Behaviour Problem Inventory (BPI-01) or Behaviour Problem Inventory - Short Form (BPI-S) • Cambridge Cognitive Examination – Revised (CAMCOG-R) • Challenging Behaviour Interview (CBI) • Childhood Autism Rating Scale (CARS)

		• Clinical Institute Withdrawal Assessment for Alcohol scale, revised (CIWA-Ar) • Developmental Behaviour Checklist for adults (DBC-A) • Developmental, Dimensional and Diagnostic Interview (3di) • Diagnostic Interview for Social and Communication Disorders (DISCO) • Eating Disorder Inventory (EDI) • Functional Analysis Screening Tool (FAST) • Leeds Dependence Questionnaire (LDQ) • Middlesex Elderly Assessment of Mental State (MEAMS) • Modified Overt Aggression Scale (MOAS) • Movie for the Assessment of Social Cognition (MASC) • Pervasive Developmental Disorders Rating Scale (PDDRS) • Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) • Ritvo Autism and Asperger's Diagnostic Scale (RAADS) or Ritvo Autism and Asperger's Diagnostic Scale – Revised (RAADS-R) • Severity of Alcohol Dependence Questionnaire (SADQ) • Social Responsiveness Scale (SRS) RQ 2.3: Included: • Adult Suicide Ideation Questionnaire (ASIQ) • Beck Depression Inventory (BDI) • Beck Hopelessness Scale (BHS) • Brøset-Violence Checklist (BVC) • Dynamic Appraisal of Situational Aggression – Inpatient Version (DASA-IV) • Edinburgh Risk of Repetition Scale (ERRS) • Global Clinical Assessment (GCA) • Hamilton Depression Rating Scale (HDRS) • Health Screening of People in Police Custody (HELP-PC) • Historical, Clinical, Risk Management-20 (HCR-20) • Level of Supervision Inventory (LSI) • Manchester Self-harm Rule (MSHR) • National Strategy for Police Information Systems (NSPIS) custody risk assessment • Offender Group Reconviction Scale (OGRS) • Psychopathy Checklist (PCL), Psychopathy Checklist-Revised (PCL-R) or Psychopathy Checklist-Screening Version (PCL-SV) • Reasons for Living Inventory (RFL) • Risk Assessment Management and Audit Systems (RAMAS)

		• Scale for Suicide Ideation (SSI) • Suicide Assessment Scale (SUAS) • Suicide Behaviours Questionnaire – Revised (SBQ-R) • Suicide Checklist (SCL) • Suicide Concerns for Offenders in Prison Environment (SCOPE) • Suicide Intent Scale (SIS) • Suicide Potential Scale • Suicide Probability Scale (SPS) • Violence Risk Assessment Guide (VRAG) RQ 2.1-2.2: Excluded: N/A RQ 2.3: Excluded: Risk assessment tools measuring risk of offending or reoffending where the offending behaviour is not linked to the mental health problem RQ 2.4: Key components of, and the most appropriate structure for a comprehensive assessment of mental health problems for adults in contact with the criminal justice system
26	Comparator(s)/ control [21]*	RQ 2.1-2.3: Included: Gold standard RQ 2.1-2.2: Reference test: Diagnosis Statistical Manual (DSM) or International Classification of Diseases (ICD) diagnosis Excluded: N/A RQ 2.4: N/A
27	Types of study to be included initially [22]*	RQ 2.1-2.3: Included: Systematic reviews of diagnostic test accuracy studies, diagnostic cross-sectional studies (including cohort studies, case-control studies and nested case-control studies) Excluded: N/A RQ 2.4: N/A; GDG consensus-based

28	Context [23]*	Included: Care and shared care provided or commissioned by health and social care services, for people in contact with the criminal justice system in any Organisation for Economic Co-operation and Development (OECD) country Excluded: Studies from non-OECD countries
29	Primary/Critical outcomes [24]*	RQ 2.1-2.3: • Sensitivity: the proportion of true positives of all cases diagnosed with autism in the population • Specificity: the proportion of true negatives of all cases not-diagnosed with autism in the population • Reliability (for instance, inter-rater or test-retest reliability or internal consistency) • Validity (for instance, criterion or construct validity) RQ 2.4: Key components of, and the most appropriate structure for a comprehensive assessment of mental health problems for adults in contact with the criminal justice system. Consider:- • the nature and content of the interview and observation • formal diagnostic methods/ psychological tools for the assessment of mental health problems • the assessment of risk to self and others • the assessment of need of self and others • the setting(s) in which the assessment takes place • the role of any informants • gathering of independent and accurate information from informants
30	Secondary/Important, but not critical outcomes [25]*	RQ 2.1 & 2.2: • Positive Predictive Value (PPV): the proportion of patients with positive test results who are correctly diagnosed. • Negative Predictive Value (NPV): the proportion of patients with negative test results who are correctly diagnosed. • Area under the Curve (AUC): are constructed by plotting the true positive rate as a function of the false positive rate for each threshold. RQ 2.4: N/A
31	Data extraction (selection and coding) [26]*	Citations from each search will be downloaded into EndNote and duplicates removed. Records will then be screened independently by two reviewers against the eligibility criteria of the review (if there is disagreement, resolution will be by discussion or a third reviewer). Initially 10% of references will be double-screened. If inter-rater agreement is good (percentage agreement =>90%) then

		the remaining references will be screened by one reviewer. The unfiltered search results will be saved and retained for future potential re-analysis. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). Eligibility will be confirmed by at least one member of the Guideline Development Group (GDG). Two researchers will extract data into the study database, comparing a sample of each other's work (10%) for reliability. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or with members of the GDG. Data to be extracted: Study characteristics: RQ addressed, study design, country, N, age, recruitment location, target condition, index test, no. of items, cut-off, reference standard, CJS setting Outcomes: Sensitivity, specificity, number of 'cases', N, PPV, NPV, TP, FP, FN, TN, PLR, NLR, prevalence, AUR (mean), AUR (sd)
32	Risk of bias (quality) assessment [27]*	The quality of individual studies will be assessed using the QUADAS-2 quality checklist (available from: http://www.bris.ac.uk/media-library/sites/quadas/migrated/documents/quadas2.pdf)
33	Strategy for data synthesis [28]*	RQ 2.1-2.3: If existing reviews are found, the review team with advice from the GDG will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GDG agree that a systematic review appropriately addresses a review question we will assess if any additional studies, conducted or published since the review was conducted, could affect the conclusions of the previous review. If new studies could change the conclusions, we will conduct a new analysis to update the review. If new studies could not change the conclusions of an existing review, the GDG will use the existing review to inform their recommendations. Review Manager 5 will be used to summarise diagnostic accuracy data from each study using forest plots and summary ROC plots. Where appropriate (where more than two studies report comparable data), a bivariate diagnostic accuracy meta-analysis will be conducted using Metadisc (Zamora et al., 2006, publically available at

		http://www.hrc.es/investigacion/metadisc_en.htm), in order to obtain pooled estimates of sensitivity and specificity using a random effects model. Alternatively, a narrative synthesis will be used. RQ 2.4: The GDG will use a consensus-based approach to identify the key components of an effective assessment
34	Analysis of subgroups or subsets [29] (including sensitivity analyses)	Heterogeneity is usually much greater in meta-analyses of diagnostic accuracy studies compared with RCTs. Therefore, a higher threshold for acceptable heterogeneity in such meta-analyses is required. Where substantial heterogeneity exists, sensitivity analyses will be considered, including: • Excluding case-control (from cohort) studies • Excluding non-UK studies
	General information	
35	Type of review [30]	Diagnostic
36	Dissemination plans [35]	This review is being conducted for the NICE guideline on Mental health of adults in contact with the criminal justice system. Further information about the guideline and plans for implementation can be found on the NICE website: http://guidance.nice.org.uk The review findings will be included in the full guideline developed by the National Collaborating Centre for Mental Health: http://www.nccmh.org.uk/
37	Details of any existing review of the same topic by the same authors [37]*	
38	Review status [38]	Ongoing
	Further information (not needed for Prospero registration)	
	Existing reviews utilised in this review:*	
39	• Updated	
40	• Not updated	

1.3 Interventions and their adaptations to the criminal justice system

Item No.	Item [Prospero field No.]	Details
	PROSPERO: Reg. No.	CRD##########
	Guideline details	
41	Guideline*	Mental health of adults in contact with the criminal justice system
42	Guideline chapter*	Interventions and their adaptation to the criminal justice system
43	Topic Group (if used)	
44	Sub-section lead*	
45	Review team lead*	
46	Objective of review*	To review the evidence for interventions to promote mental health and wellbeing, and for the care and treatment of mental health problems, in adults in contact with the criminal justice system
	Review title and timescale	
47	Review title [1]*	Interventions to promote mental health and wellbeing, and for the care and treatment of mental health problems, in adults in contact with the criminal justice system
48	Anticipated or actual start date [3]	
49	Anticipated completion date [4]	
50	Stage of review at time of registration [5]	**Started** / **Completed** Preliminary searches ☐ ☐ Piloting of the study selection process ☐ ☐ Formal screening of search results against eligibility criteria ☐ ☐ Data extraction ☐ ☐ Risk of bias (quality) assessment ☐ ☐ Data analysis ☐ ☐

		Prospective meta-analysis ☐ ☐ Provide any other relevant information about the stage of the review here (e.g. Funded proposal, final protocol not yet finalised). ☐
	Review team details	
51	Named contact [6]	Odette Megnin-Viggars
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54	Named contact phone number [9]	020 3701 2645
55	Review team members and their organisational affiliations [10]	Dr. Odette Megnin-Viggars NCCMH
56	Organisational affiliation of the review [11]	National Collaborating Centre for Mental Health
57	Funding sources/ sponsors [12]	National Institute for Health and Care Excellence
58	Conflicts of interest [13]	⊙ None known ○ Yes
59	Collaborators [14]	Title/First name/Last name/Organisation details
	Review methods	
60	Review question(s) [15]*	RQ 3.1: 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 who have: • alcohol-use disorders? • antenatal or postnatal mental health problems [for women]? • antisocial personality disorder?

		• attention deficit hyperactivity disorder? • autism? • bipolar disorder? • borderline personality disorder? • challenging behaviour or mental health problems [for adults with learning disabilities]? • delirium? • dementia? • depression (with or without a coexisting chronic physical health problem)? • eating disorders? • generalised anxiety disorder and panic disorder (with or without agoraphobia)? • obsessive-compulsive disorder and body dysmorphic disorder? • post-traumatic stress disorder? • psychosis (with or without coexisting substance misuse) or schizophrenia? • self-harmed (self-harming)? • social anxiety disorder? • substance misuse disorders? • violent and aggressive behaviour [for adults with mental disorders]? RQ 3.2: For adults with a paraphilic disorder who are in contact with the criminal justice system, what are the benefits and harms of psychological, social or pharmacological interventions aimed at reducing or preventing the expression of paraphilic behaviour, or preventing or reducing sexual offending or reoffending? RQ 3.3: For adults with acquired cognitive impairment who are in contact with the criminal justice system, what are the benefits and harms of psychological, social or pharmacological interventions aimed at rehabilitation? RQ 3.4: For adults with a personality disorder (other than antisocial or borderline personality disorder) who are in contact with the criminal justice system, what are the benefits and harms of psychological, social or pharmacological interventions aimed at reducing personality disorder symptomatology, or preventing or reducing offending or reoffending? RQ 3.5: What are the most effective interventions to promote mental health and wellbeing in adults in contact with the criminal justice system (including environmental

		adaptations and individual- and population-based psychoeducational interventions)?
61	Sub-question(s)	Where possible, consideration should be given to the specific needs of:- • people with neurodevelopmental disorders (including learning disabilities) • women • older adults (aged 50 years and over) • young black men • young adults that have transitioned from juvenile services
62	Searches [16]*	**Mainstream databases:** CENTRAL, Embase, MEDLINE, PsycINFO **Topic specific databases:** None **Other resources of evidence:** • Reference lists of included studies • Citation tracking for included papers in Scopus and Web of Knowledge (WoK) • Calls for evidence from stakeholders • Contacting authors of relevant works for 'sibling' studies • "Related articles" searching in PubMed • PROSPERO (http://www.crd.york.ac.uk/Prospero/) • Conference abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Dissertation titles/abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Non-English language papers (with English abstracts) will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in an English language journal. *The number of citations that might relate to relevant trials that haven't been included will be recorded.

		Note. Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline.
63	Condition or domain being studied [18]*	Mental health problems in adults in contact with the criminal justice system 'Mental health problems' includes: common mental health problems; severe mental illness; personality disorders; drug and alcohol problems; paraphilias; neurodevelopmental disorders; acquired cognitive impairment Contact with the criminal justice system includes people: in police custody; in court custody; in contact with liaison, diversion and street triage services; remanded on bail; remanded in prison; who have been convicted and are serving a prison or community sentence; released from prison on licence; released from prison and in contact with a community rehabilitation company (CRC) or the probation service.
64	Participants/ population [19]*	Included: Adults (aged 18 and over) with, or at risk of developing, a mental health problem who are in contact with the criminal justice system Excluded: • people who are cared for in hospital, except for providing guidance on managing transitions between criminal justice system settings and hospital • people in immigration removal centres • 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.
65	Intervention(s), exposure(s) [20]*	Included: • Psychological and social interventions • Pharmacological interventions • Combined psychological or social and pharmacological interventions • Support and education interventions aimed at promoting mental health and wellbeing (including

		environmental adaptations and individual- and population-based psychoeducational interventions) RQ 3.1: Included: • Psychological and social interventions: ○ adherence therapy ○ anger/aggression management (Controlling Anger and Learning to Manage it [CALM]) ○ animal-assisted therapy ○ arts-based therapies (art, drama, music or dance therapy) ○ behavioural therapies (applied behaviour analysis, aversion therapy, behavioural activation, behavioural self-control training, cue exposure, contingency management, systematic desensitisation) ○ biofeedback ○ breathing training ○ cognitive analytic therapy (CAT) ○ cognitive behavioural therapies (CBT) ○ cognitive bias modification ○ cognitive rehabilitation ○ cognitive remediation therapy (CRT) or cognitive enhancement therapy (CET) ○ cognitive stimulation (reality orientation) ○ cognitive therapy ○ counselling (directive or non-directive) ○ couples therapy ○ debriefing ○ dialectical behaviour therapy (DBT) ○ dietary counselling ○ eye movement desensitisation and reprocessing (EMDR) ○ facilitated self-help ○ family therapy and family interventions ○ harm minimisation/reduction strategies (replacement therapy, positive emotion technique) ○ home visits ○ humanistic therapy ○ hypnotherapy ○ interpersonal psychotherapy (IPT) ○ interpersonal and social rhythm therapy (IPSRT) ○ life review ○ mindfulness-based cognitive therapy (MBCT) ○ meditation ○ memory training (procedural memory stimulation) ○ mother-infant relationship interventions

		○ motivational techniques (motivational interviewing, motivational enhancement therapy) ○ multimodal treatment ○ narrative exposure therapy (NET) ○ neurolinguistic programming (NLP) ○ panic control therapy ○ peer-mediated support and support groups ○ problem-solving skills training ○ psychodynamic psychotherapy ○ psychoeducational interventions, including psychologically (CBT or IPT)-informed psychoeducation (Building Skills for Recovery [BSR]; FOCUS substance misuse programme; Low Intensity Alcohol Programme [LIAP]; Medium Alcohol Requirement Intervention [MARI]; Offender Substance Abuse Programme [OSAP]; Prison - Addressing Substance Related Offending [P-ASRO]) ○ rational emotive behaviour therapy ○ relaxation training (applied relaxation, progressive muscle relaxation, Jacobsonian relaxation) ○ reminiscence ○ self-help ○ social network and environment-based therapies (social behaviour and network therapy [SBNT], community reinforcement approach, social systems interventions) ○ social skills training ○ solution focused (brief) therapy (SFBT) ○ supportive therapy ○ therapeutic communities (democratic therapeutic communities [DTC]; Prison Partnership Therapeutic Community Programme [PPTCP]) ○ trauma incident reduction (TIR) ○ twelve-step facilitation (TSF) (Prison Partnership Twelve Step Programme [PPTSP]) ○ validation therapy ○ vocational interventions (pre-vocational training [sheltered workshop], supported employment) • Pharmacological interventions: ○ acetylcholinesterase inhibitors (donepezil, galantamine, rivastigmine) ○ alcohol deterrent compounds (disulfiram) ○ alpha-adrenergic agonists (clonidine, lofexidine) ○ antialcoholic agents (acamprosate calcium) ○ anticonvulsants (carbamazepine, gabapentin, lamotrigine, levetiracetam, phenytoin, pregabalin, topiramate, valproate)

		○ antidepressants (atypical antidepressants [bupropion], monoamine oxidase inhibitors [MAOIs], selective serotonin reuptake inhibitors [SSRIs], serotonin–norepinephrine reuptake inhibitors [SNRIs], tricyclic antidepressants [TCAs]) ○ antiemetics (ondansteron) ○ antihistamines (cyproheptadine, hydroxyzine, trimeprazine) ○ anti-inflammatory drugs (indomethacin) ○ antipsychotics (amisulpride, aripiprazole, asenapine, benperidol, chlorpromazine, clozapine, flupentixol, fluphenazine, haloperidol, levomepromazine/methotrimeprazine, lurasidone, olanzapine, paliperidone, pericyazine, perphenazine, pimozide, pipotiazine, prochlorperazine, promazine, quetiapine, risperidone, sertindole, sulpiride, trifluoperazine, ziprasidone, zotepine, zuclopenthixol) ○ anxiolytics (benzodiazepines [alprazolam, bromazepam, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, lorazepam, oxazepam], beta-blockers [atenolol, pindolol, practolol, propranolol, oxprenolol], busiprone, meprobamate) ○ cognitive enhancers (D-cycloserine, ergoloid mesylates, memantine, nicergoline) ○ 5HT3 antagonists (odansetron) ○ GABA-B agonists (baclofen) ○ hypnotics (benzodiazepines [flurazepam, nitrazepam, loprazolam, lormetazepam, temazepam], non-benzodiazepines [zaleplon, zolpidem, zopiclone], chloral and derivatives, clomethiazole [chlormethiazole], antihistamines [diphenhydramine, promethazine]) ○ mood stabilisers (lithium) ○ N-methyl-D-aspartate (NMDA)-receptor antagonists (memantine) ○ norepinephrine (noradrenaline) reuptake inhibitors (atomoxetine) ○ opioid antagonists (naltrexone) ○ opioid maintenance treatment (methadone, buprenorphine, nalmefene, naltrexone) ○ rapid tranquillisation (antipsychotics [aripiprazole, chlorpromazine, haloperidol, loxapine, olanzapine, quetiapine, risperidone], benzodiazepines, antihistamines) ○ stimulants (dexamfetamine, methylphenidate) ○ other substances (antiandrogens, botulinum toxin, folate [folacin, folic acid], ginkgo biloba, hydrocortisone, inositol, kava (also

		known as kava kava), kudzu root, nimodipine, omega-3 fatty acids, oxytocin, ritanserin, St John's wort, sage [salvia officinalis, salvia lavendulafolia], triptans, tryptophan, valerian, vitamin E, vitamin B12, zinc) • Physical interventions: o acupuncture o aromatherapy o bright light therapy o deep brain stimulation o electroconvulsive therapy (ECT) o exercise or physical activity o hydration intervention o massage o nasogastric feeding o neurosurgery (stereotactic anterior capsulotomy/cingulotomy) o reactive strategies (physical restraint, mechanical restraint, modifications to the environment, personal and institutional alarms, de-escalation methods, confinement, and containment and seclusion) o sensory interventions (multi-sensory stimulation, Snoezelen) o thoracic sympathectomy o total parenteral nutrition (TPN) o transcranial magnetic stimulation (TMS) or repetitive TMS (rTMS) o vagus nerve stimulation (VNS) RQ 3.2: Included: • Psychological and social interventions: o behavioural interventions (aversion therapy, imaginal desensitisation, covert sensitisation or olfactory conditioning) o cognitive analytic therapy (CAT) o CBT (group or individual) o milieu therapy o motivational interviewing o multisystemic therapy o psychodynamic or psychoanalytic psychotherapy o psychoeducational interventions, including psychologically (CBT or IPT)-informed psychoeducation (Sex Offender Treatment Programmes [SOTP]) o reintegration programmes (circles of support and accountability) o schema therapy

		○ therapeutic communities • Pharmacological interventions: ○ antiandrogen hormone therapy (cyproterone acetate, medroxyprogesterone acetate) ○ antidepressants (SSRIs) ○ antipsychotic medication (benperidol) ○ gonadotropin-releasing hormone agonists (triptorelin) RQ 3.4: Included: • Psychological and social interventions: ○ therapeutic communities (democratic therapeutic communities) Excluded: N/A
66	Comparator(s)/ control [21]*	Included: • Treatment as usual • No treatment • Waitlist control • Placebo (including attention control) • Any alternative management strategy Excluded: N/A
67	Types of study to be included initially [22]*	Included: Systematic reviews of RCTs and RCTs (including crossover randomised trials if data from the first phase is available) If no existing systematic reviews address the review question, then in the first instance only RCTs will be included. If the RCT evidence is limited either in terms of numbers of RCTs (≤5), or numbers of included participants (≤100), the range of included studies will be expanded to include non-randomised studies. Preference will be given to quasi-randomised controlled trials (for example, allocation by alternation or date of birth), controlled non-randomised studies and large cohort studies. If little evidence meets the above criteria, then before-and-after studies will be considered cautiously.

		Excluded: Case series or case reports
68	Context [23]*	Included: Care and shared care provided or commissioned by health and social care services, for people in contact with the criminal justice system in any Organisation for Economic Co-operation and Development (OECD) country Excluded: Studies from non-OECD countries
69	Primary/Critical outcomes [24]*	• Mental health outcomes • Offending and reoffending • Service utilisation • Adaptive functioning (for example, employment status, development of daily living and interpersonal skills, and quality of life) • Rates of self-injury
70	Secondary/Important, but not critical outcomes [25]*	
71	Data extraction (selection and coding) [26]*	Citations from each search will be downloaded into EndNote and duplicates removed. Records will then be screened independently by two reviewers against the eligibility criteria of the review (if there is disagreement, resolution will be by discussion or a third reviewer). Initially 10% of references will be double-screened. If inter-rater agreement is good (percentage agreement =>90%) then the remaining references will be screened by one reviewer. The unfiltered search results will be saved and retained for future potential re-analysis. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). Eligibility will be confirmed by at least one member of the Guideline Development Group (GDG). Two researchers will extract data into the study database, comparing a sample of each other's work (10%) for reliability. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or with members of the GDG. Data to be extracted: Study characteristics: RQ addressed, study design, country, N, inclusion/exclusion criteria, mental health problem, CJS setting, offence (if appropriate), length of sentence (if appropriate), demographics (age, sex, ethnicity, IQ), risk of bias (selection bias, performance bias, detection bias, attrition bias, other bias)

		Comparisons: For both experimental and control interventions: Intervention, format, group size (if applicable), intensity/dose, frequency, duration (of treatment and follow-up), intervention setting, intervention administrator Outcomes: Outcome name, outcome measure, rater, direction of scale, time point (for instance, weeks post-randomisation), phase, outcome data (for instance, mean, SD, N, events)
72	Risk of bias (quality) assessment [27]*	The quality of individual studies will be assessed using the appropriate NICE quality assessment checklist. Where possible, the quality of evidence for each outcome will be assessed using the GRADE approach.
73	Strategy for data synthesis [28]*	If existing reviews are found, the review team with advice from the GDG will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GDG agree that a systematic review appropriately addresses a review question we will assess if any additional studies, conducted or published since the review was conducted, could affect the conclusions of the previous review. If new studies could change the conclusions, we will conduct a new analysis to update the review. If new studies could not change the conclusions of an existing review, the GDG will use the existing review to inform their recommendations. If RCTs are included, meta-analysis using a random-effects model will be used to combine results from similar studies. If this is not possible, a narrative synthesis will be used. Repeated observations on participants: If studies report results for several periods of follow-up (e.g. 4 weeks, 12 weeks and 26 weeks post treatment) the longest follow-up from each study will be utilised in analyses. If the GDG feel that periods of follow-up are sufficiently distanced by time, we will consider defining several different outcomes, based on different periods of follow-up, to perform separate analyses (for example, short-term, medium-term and long-term follow-up). Method of dealing with missing data Because imputation of missing data in order to perform a full ITT analysis is controversial, only the results for

		available participants will be analysed in meta-analysis. However, for dichotomous outcomes a sensitivity analyses will be carried out whereby missing data will be imputed according to worst case scenario. Outcomes from the sensitivity analysis will only be presented if the ITT analysis differs significantly from the available case analysis.
74	Analysis of subgroups or subsets [29] (including sensitivity analyses)	Where substantial heterogeneity exists, sensitivity analyses will be considered, including: • Excluding RCTs with <10 participants per arm
	General information	
75	Type of review [30]	Intervention
76	Dissemination plans [35]	This review is being conducted for the NICE guideline on Mental health of adults in contact with the criminal justice system. Further information about the guideline and plans for implementation can be found on the NICE website: http://guidance.nice.org.uk The review findings will be included in the full guideline developed by the National Collaborating Centre for Mental Health: http://www.nccmh.org.uk/
77	Details of any existing review of the same topic by the same authors [37]*	
78	Review status [38]	Ongoing
	Further information (not needed for Prospero registration)	
	Existing reviews utilised in this review:*	
79	• Updated	
80	• Not updated	

1.4 Organisation and provision of services

Item No.	Item [Prospero field No.]	Details
	PROSPERO: Reg. No.	CRD##########
	Guideline details	
81	Guideline*	Mental health of adults in contact with the criminal justice system
82	Guideline chapter*	Organisation and provision of services
83	Topic Group (if used)	
84	Sub-section lead*	
85	Review team lead*	
86	Objective of review*	To review the evidence for the structure and systems for the delivery of health and social care services for adults with mental health problems who are in contact with the criminal justice system
	Review title and timescale	
87	Review title [1]*	Organisation and provision of services for the assessment, intervention and management of mental health problems in adults in contact with the criminal justice system
88	Anticipated or actual start date [3]	
89	Anticipated completion date [4]	
90	Stage of review at time of registration [5]	**Started** **Completed** Preliminary searches ☐ ☐ Piloting of the study selection process ☐ ☐ Formal screening of search results against eligibility criteria ☐ ☐ Data extraction ☐ ☐ Risk of bias (quality) assessment ☐ ☐ Data analysis ☐ ☐ Prospective meta-analysis ☐ ☐

		Provide any other relevant information about the stage of the review here (e.g. Funded proposal, final protocol not yet finalised).
	Review team details	
91	Named contact [6]	Odette Megnin-Viggars
92	Named contact email [7]	omegnin@rcpsych.ac.uk
93	Named contact address [8]	NCCMH Royal College of Psychiatrists, 3rd Floor, 21 Prescot Street London E1 8BB
94	Named contact phone number [9]	020 3701 2645
95	Review team members and their organisational affiliations [10]	Dr. Odette Megnin-Viggars NCCMH
96	Organisational affiliation of the review [11]	National Collaborating Centre for Mental Health
97	Funding sources/ sponsors [12]	National Institute for Health and Care Excellence
98	Conflicts of interest [13]	⊙ None known ○ Yes
99	Collaborators [14]	Title/First name/Last name/Organisation details
	Review methods	
10	Review question(s) [15]*	RQ 4.1: What are the most effective care plans and pathways, and organisation and structure of services, for the assessment, intervention and management of mental health problems in people in contact with the criminal justice system to promote: • appropriate access to services? • positive experience of services? • positive mental health outcomes? • integrated multi-agency care? • successful transition between services? • successful discharge from services?

10	Sub-question(s)	Where possible, consideration should be given to the specific needs of:- • people with neurodevelopmental disorders (including learning disabilities) • women • older adults (aged 50 years and over) • young black men • young adults that have transitioned from juvenile services
10	Searches [16]*	**Mainstream databases:** CENTRAL (date range), Embase (date range), MEDLINE (date range), PsycINFO (date range) Topic specific databases: [add]None Other resources of evidence: [amend as appropriate]: • Reference lists of included studies • Citation tracking for included papers in Scopus and Web of Knowledge (WoK) • Calls for evidence from stakeholders • Contacting authors of relevant works for 'sibling' studies • "Related articles" searching in PubMed • PROSPERO (http://www.crd.york.ac.uk/Prospero/) • Conference abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Dissertation titles/abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Non-English language papers (with English abstracts) will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in an English language journal. *The number of citations that might relate to relevant trials that haven't been included will be recorded. Note. Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of

		unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline.
10	Condition or domain being studied [18]*	Mental health problems in adults in contact with the criminal justice system 'Mental health problems' includes: common mental health problems; severe mental illness; personality disorders; drug and alcohol problems; paraphilias; neurodevelopmental disorders; acquired cognitive impairment Contact with the criminal justice system includes people: in police custody; in court custody; in contact with liaison, diversion and street triage services; remanded on bail; remanded in prison; who have been convicted and are serving a prison or community sentence; released from prison on licence; released from prison and in contact with a community rehabilitation company (CRC) or the probation service.
10	Participants/ population [19]*	Included: Adults (aged 18 and over) with, or at risk of developing, a mental health problem who are in contact with the criminal justice system Excluded: • people who are cared for in hospital, except for providing guidance on managing transitions between criminal justice system settings and hospital • people in immigration removal centres • 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.
10	Intervention(s), exposure(s) [20]*	Included: Any service delivery model, including: • Assertive Community Treatment (ACT) • case management (including intensive case management) • CARAT (Counselling, Assessment, Referral, Advice and Throughcare) • collaborative care • Dangerous and Severe Personality Disorder (DSPD) programme • Drug Arrest Referral Schemes (DARS)

		• Drug Interventions Programme (DIP) • Drug Rehabilitation Requirements (DRRs) • Drug Treatment and Testing Orders (DTTO) • Integrated Drug Treatment System (IDTS) • mental health courts • prison/court liaison and diversion programmes • Psychologically Informed Planned Environments (PIPEs) • re-entry programmes • street triage Excluded: N/A
10	Comparator(s)/ control [21]*	Included: • Treatment as usual • No treatment • Waitlist control • Placebo (including attention control) • Any alternative service delivery model Excluded: N/A
10	Types of study to be included initially [22]*	Included: Systematic reviews of RCTs and RCTs (including crossover randomised trials if data from the first phase is available) If no existing systematic reviews address the review question, then in the first instance only RCTs will be included. If the RCT evidence is limited either in terms of numbers of RCTs (≤5), or numbers of included participants (≤100), the range of included studies will be expanded to include non-randomised studies. Preference will be given to quasi-randomised controlled trials (for example, allocation by alternation or date of birth), controlled non-randomised studies and large cohort studies. If little evidence meets the above criteria, then before-and-after studies will be considered cautiously. Excluded: Case series or case reports
10	Context [23]*	Included: Care and shared care provided or commissioned by health and social care services, for people in contact with the criminal justice system in any Organisation for Economic Co-operation and Development (OECD) country

		Excluded: Studies from non-OECD countries
10	Primary/Critical outcomes [24]*	• Mental health outcomes • Offending and reoffending • Service utilisation • Access to services • Adaptive functioning (for example, employment status, development of daily living and interpersonal skills, and quality of life) • Rates of self-injury • Satisfaction
11	Secondary/Important, but not critical outcomes [25]*	
11	Data extraction (selection and coding) [26]*	Citations from each search will be downloaded into EndNote and duplicates removed. Records will then be screened independently by two reviewers against the eligibility criteria of the review (if there is disagreement, resolution will be by discussion or a third reviewer). Initially 10% of references will be double-screened. If inter-rater agreement is good (percentage agreement =>90%) then the remaining references will be screened by one reviewer. The unfiltered search results will be saved and retained for future potential re-analysis. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). Eligibility will be confirmed by at least one member of the Guideline Development Group (GDG). Two researchers will extract data into the study database, comparing a sample of each other's work (10%) for reliability. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or with members of the GDG. Data to be extracted: Study characteristics: RQ addressed, study design, country, N, inclusion/exclusion criteria, mental health problem, CJS setting, offence (if appropriate), length of sentence (if appropriate), demographics (age, sex, ethnicity, IQ), risk of bias (selection bias, performance bias, detection bias, attrition bias, other bias) Comparisons: For both experimental and control conditions: Service delivery model or control condition, group size (if applicable), intensity/dose, frequency, duration, setting

		Outcomes: Outcome name, outcome measure, rater, direction of scale, time point (for instance, weeks post-randomisation), phase, outcome data (for instance, mean, SD, N, events)
11	Risk of bias (quality) assessment [27]*	The quality of individual studies will be assessed using the appropriate NICE quality assessment checklist. Where possible, the quality of evidence for each outcome will be assessed using the GRADE approach.
11	Strategy for data synthesis [28]*	If existing reviews are found, the review team with advice from the GDG will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GDG agree that a systematic review appropriately addresses a review question, we will search for studies conducted or published since the review was conducted, and the GDG will assess if any additional studies could affect the conclusions of the previous review. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GDG will use the existing review to inform their recommendations. If RCTs are included, meta-analysis using a random-effects model will be used to combine results from similar studies. If this is not possible, a narrative synthesis will be used. Repeated observations on participants: If studies reports results for several periods of follow-up (e.g. 4 weeks, 12 weeks and 26 weeks post treatment) the longest follow-up from each study shall be utilised in analyses. If the GDG feel that periods of follow-up are sufficiently distanced by time, we shall consider defining several different outcomes, based on different periods of follow-up, and to perform separate analyses (e.g. short-term, medium-term and long-term follow-up). Method of dealing with missing data Because imputation of missing data in order to perform a full ITT analysis is controversial, only the results for available participants will be analysed in meta-analysis. However, for dichotomous outcomes a sensitivity analyses will be carried out whereby missing data will be imputed according to worst case scenario. Outcomes from the sensitivity analysis will only be presented if the ITT

		analysis differs significantly from the available case analysis.
11	Analysis of subgroups or subsets [29] (including sensitivity analyses)	Where substantial heterogeneity exists, sensitivity analyses will be considered, including: • Excluding RCTs with <10 participants per arm
	General information	
11	Type of review [30]	Service delivery
11	Dissemination plans [35]	This review is being conducted for the NICE guideline on Mental health of adults in contact with the criminal justice system. Further information about the guideline and plans for implementation can be found on the NICE website: http://guidance.nice.org.uk The review findings will be included in the full guideline developed by the National Collaborating Centre for Mental Health: http://www.nccmh.org.uk/
11	Details of any existing review of the same topic by the same authors [37]*	
11	Review status [38]	Ongoing
	Further information (not needed for Prospero registration)	
	Existing reviews utilised in this review:*	
11	• Updated	
12	• Not updated	

1.5 Staff training and education

Item No.	Item [Prospero field No.]	Details
	PROSPERO: Reg. No.	CRD##########
	Guideline details	
12	Guideline*	Mental health of adults in contact with the criminal justice system
12	Guideline chapter*	Staff training or education
12	Topic Group (if used)	
12	Sub-section lead*	
12	Review team lead*	
12	Objective of review*	To review the evidence for support, training and supervision programmes for health, social care or criminal justice practitioners to improve the assessment, intervention and management of adults with mental health problems in contact with the criminal justice system
	Review title and timescale	
12	Review title [1]*	Support, training and supervision programmes for health, social care or criminal justice practitioners to improve the assessment, intervention and management of adults with mental health problems in contact with the criminal justice system
12	Anticipated or actual start date [3]	
12	Anticipated completion date [4]	
13	Stage of review at time of registration [5]	**Started** **Completed** Preliminary searches ☐ ☐ Piloting of the study selection process ☐ ☐ Formal screening of search results against eligibility criteria ☐ ☐ Data extraction ☐ ☐ Risk of bias (quality) assessment ☐ ☐ Data analysis ☐ ☐

		Prospective meta-analysis ☐ ☐ Provide any other relevant information about the stage of the review here (e.g. Funded proposal, final protocol not yet finalised). ☐
	Review team details	
13	Named contact [6]	Odette Megnin-Viggars
13	Named contact email [7]	omegnin@rcpsych.ac.uk
13	Named contact address [8]	NCCMH Royal College of Psychiatrists, 3rd Floor, 21 Prescot Street London E1 8BB
13	Named contact phone number [9]	020 3701 2645
13	Review team members and their organisational affiliations [10]	Dr. Odette Megnin-Viggars NCCMH
13	Organisational affiliation of the review [11]	National Collaborating Centre for Mental Health
13	Funding sources/ sponsors [12]	National Institute for Health and Care Excellence
13	Conflicts of interest [13]	⊙ None known ○ Yes
13	Collaborators [14]	Title/First name/Last name/Organisation details
	Review methods	
14	Review question(s) [15]*	RQ 5.1: What are the most effective support, training and education, and supervision programmes for health, social care or criminal justice practitioners to improve awareness, recognition, assessment, intervention and management of mental health problems in adults in contact with the criminal justice system?
14	Sub-question(s)	Where possible, consideration should be given to the specific needs of:-

		• people with neurodevelopmental disorders (including learning disabilities) • women • older adults (aged 50 years and over) • young black men • young adults that have transitioned from juvenile services
14	Searches [16]*	**Mainstream databases:** CENTRAL (date range), Embase (date range), MEDLINE (date range), PsycINFO (date range) Topic specific databases: [add]None Other resources of evidence: [amend as appropriate]: • Reference lists of included studies • Citation tracking for included papers in Scopus and Web of Knowledge (WoK) • Calls for evidence from stakeholders • Contacting authors of relevant works for 'sibling' studies • "Related articles" searching in PubMed • PROSPERO (http://www.crd.york.ac.uk/Prospero/) • Conference abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Dissertation titles/abstracts will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in full • Non-English language papers (with English abstracts) will be assessed for eligibility and potentially eligible studies will be checked to determine if they have been published in an English language journal. *The number of citations that might relate to relevant trials that haven't been included will be recorded. Note. Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that

		summary data from the study and the study's characteristics will be published in the full guideline.
14	Condition or domain being studied [18]*	Mental health problems in adults in contact with the criminal justice system 'Mental health problems' includes: common mental health problems; severe mental illness; personality disorders; drug and alcohol problems; paraphilias; neurodevelopmental disorders; acquired cognitive impairment Contact with the criminal justice system includes people: in police custody; in court custody; in contact with liaison, diversion and street triage services; remanded on bail; remanded in prison; who have been convicted and are serving a prison or community sentence; released from prison on licence; released from prison and in contact with a community rehabilitation company (CRC) or the probation service.
14	Participants/ population [19]*	Included: Adults (aged 18 and over) with, or at risk of developing, a mental health problem who are in contact with the criminal justice system Excluded: • people who are cared for in hospital, except for providing guidance on managing transitions between criminal justice system settings and hospital • people in immigration removal centres • 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.
14	Intervention(s), exposure(s) [20]*	Included: Any staff support, training or supervision programme, including: • Applied Suicide Intervention Skills Training (ASIST) Excluded: N/A
14	Comparator(s)/ control [21]*	Included: • Treatment as usual • No treatment • Waitlist control • Placebo (including attention control)

		• Any alternative staff training or education programme Excluded: N/A
14	Types of study to be included initially [22]*	Included: Systematic reviews of RCTs and RCTs (including crossover randomised trials if data from the first phase is available) If no existing systematic reviews address the review question, then in the first instance only RCTs will be included. If the RCT evidence is limited either in terms of numbers of RCTs (≤5), or numbers of included participants (≤100), the range of included studies will be expanded to include non-randomised studies. Preference will be given to quasi-randomised controlled trials (for example, allocation by alternation or date of birth), controlled non-randomised studies and large cohort studies. If little evidence meets the above criteria, then before-and-after studies will be considered cautiously. Excluded: Case series or case reports
14	Context [23]*	Included: Care and shared care provided or commissioned by health and social care services, for people in contact with the criminal justice system in any Organisation for Economic Co-operation and Development (OECD) country Excluded: Studies from non-OECD countries
14	Primary/Critical outcomes [24]*	• Mental health outcomes • Offending and reoffending • Service utilisation • Adaptive functioning (for example, employment status, development of daily living and interpersonal skills, and quality of life) • Rates of self-injury • Satisfaction
15	Secondary/Important, but not critical outcomes [25]*	

15	Data extraction (selection and coding) [26]*	Citations from each search will be downloaded into EndNote and duplicates removed. Records will then be screened independently by two reviewers against the eligibility criteria of the review (if there is disagreement, resolution will be by discussion or a third reviewer). Initially 10% of references will be double-screened. If inter-rater agreement is good (percentage agreement =>90%) then the remaining references will be screened by one reviewer. The unfiltered search results will be saved and retained for future potential re-analysis. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). Eligibility will be confirmed by at least one member of the Guideline Development Group (GDG). Two researchers will extract data into the study database, comparing a sample of each other's work (10%) for reliability. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or with members of the GDG. Data to be extracted: Study characteristics: RQ addressed, study design, country, N, inclusion/exclusion criteria, mental health problem, CJS setting, offence (if appropriate), length of sentence (if appropriate), demographics (age, sex, ethnicity, IQ), risk of bias (selection bias, performance bias, detection bias, attrition bias, other bias) Comparisons: For both experimental and control conditions: Staff training or education programme or control condition, group size (if applicable), intensity/dose, frequency, duration, setting Outcomes: Outcome name, outcome measure, rater, direction of scale, time point (for instance, weeks post-randomisation), phase, outcome data (for instance, mean, SD, N, events)
15	Risk of bias (quality) assessment [27]*	The quality of individual studies will be assessed using the appropriate NICE quality assessment checklist. Where possible, the quality of evidence for each outcome will be assessed using the GRADE approach.
15	Strategy for data synthesis [28]*	If existing reviews are found, the review team with advice from the GDG will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GDG agree that a systematic review appropriately

		addresses a review question, we will search for studies conducted or published since the review was conducted, and the GDG will assess if any additional studies could affect the conclusions of the previous review. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies could not change the conclusions of an existing review, the GDG will use the existing review to inform their recommendations. If RCTs are included, meta-analysis using a random-effects model will be used to combine results from similar studies. If this is not possible, a narrative synthesis will be used. Repeated observations on participants: If studies reports results for several periods of follow-up (e.g. 4 weeks, 12 weeks and 26 weeks post treatment) the longest follow-up from each study shall be utilised in analyses. If the GDG feel that periods of follow-up are sufficiently distanced by time, we shall consider defining several different outcomes, based on different periods of follow-up, and to perform separate analyses (e.g. short-term, medium-term and long-term follow-up). Method of dealing with missing data Because imputation of missing data in order to perform a full ITT analysis is controversial, only the results for available participants will be analysed in meta-analysis. However, for dichotomous outcomes a sensitivity analyses will be carried out whereby missing data will be imputed according to worst case scenario. Outcomes from the sensitivity analysis will only be presented if the ITT analysis differs significantly from the available case analysis
15	Analysis of subgroups or subsets [29] (including sensitivity analyses)	Where substantial heterogeneity exists, sensitivity analyses will be considered, including: • Excluding RCTs with <10 participants per arm
	General information	
15	Type of review [30]	Intervention
15	Dissemination plans [35]	This review is being conducted for the NICE guideline on Mental health of adults in contact with the criminal justice system. Further information about the guideline and plans for implementation can be found on the NICE website: http://guidance.nice.org.uk

		The review findings will be included in the full guideline developed by the National Collaborating Centre for Mental Health: http://www.nccmh.org.uk/
15	Details of any existing review of the same topic by the same authors [37]*	
15	Review status [38]	Ongoing
	Further information (not needed for Prospero registration)	
	Existing reviews utilised in this review:*	
15	• Updated	
16	• Not updated	

Appendix G: Research recommendations

The Guideline Committee has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

1. What staff training models improve identification of mental health problems and clinical outcomes for adults in contact with the criminal justice system?

Why this is important

There is limited evidence on the effective models for the training and supervision of practitioners working in the criminal justice system which could best support the identification of mental health problems in the criminal justice system. A series of experimental studies are required to assess the best methods to improve the recognition of the full range of mental health problems. These studies should be of adequate size and cover the full range of health, social and criminal justice staff.

There is insufficient evidence to determine the best methods to deliver effective training to improve the identification of mental health problems in the criminal justice system. Lack of adequate training leads to under-recognition and consequently sub-optimal treatment. Programmes need to be designed and evaluated which are specially developed with the needs of those working in the criminal justice system in mind. There is good evidence that the provision of training alone is unlikely to bring about substantial changes in staff behaviours without adequate service style change and the provision of high quality supervision. The nature of service style changes and the supervision training should also be evaluated.

Important outcomes could include:

- staff competence
- improved recognition of mental health problems
- improved access to and uptake of mental health interventions.

Criterion	Explanation
Population	Staff working in the health, social and criminal justice systems
Intervention	Training and associated supervision, and service style changes
Comparators	No training or different models of training
Outcomes	• Improved recognition of mental health problems • Improved access to and uptake of mental health interventions • Staff competence
Study design	Cluster randomised trial; Stepped wedge randomised trial
Timeframe	Development or adaptation of tools and methods and training model(s) (12 months); feasibility studies (9 months); full trial and follow up (24 months)

2. 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)?

Acquired cognitive impairment is common in criminal justice system populations and may be associated with poor social, occupational and interpersonal functioning. Also, people with acquired cognitive impairment have high risk of self-harm which is particularly prevalent in the prison population. Acquired cognitive impairment may arise as a result of, for example, traumatic brain injury, a stroke or other neurological conditions. Experts in this area have suggested that early identification of deficits and the implementation of effective management strategies could be important in limiting the long-term impact of acquired cognitive impairment. However, there is a lack of evidence on reliable and valid case identification tools and methods. It is important that research is developed to assist staff in the criminal justice pathway to help identify acquired cognitive impairment and support better understanding and management of acquired cognitive impairment.

Criterion	Explanation
Population	People in contact with the criminal justice system who have acquired cognitive impairment
Intervention	Methods and tools to identify acquired cognitive impairment
Comparators	Gold standard diagnostic assessment of acquired cognitive impairment
Outcomes	Improved recognition of cognitive impairment (sensitivity and specificity of the measures)
Study design	The measures should be tested in representative populations against the gold standard in different settings (for example prison, court and community settings)
Timeframe	Development or adaptation of tools and methods and training in administration of tools (12 months); assessment of tools against gold standard (9 months per population)

3. What is the prevalence of mental health problems and associated social problems for those in contact with the criminal justice system?

It is widely recognised that the people in contact with the criminal justice system have a high prevalence of a whole range of mental health problems and associated problems including unstable housing, long-standing unemployment, a lack of supportive social networks and debt. What is not clear, however, is how the mental and social functioning of this group of people has changed since the last major epidemiological study in the late 1990s. In order to plan for the effective mental health care of people in the criminal justice system, it is important to have a greater understanding of the prevalence of mental health problems and social functioning of this group of people. There are a number of factors which have changed since the last epidemiological study; these include a larger prison population, changing patterns of substance misuse, an aging prison population, changes in probation practice and sentencing policy as well as broader changes in society such as changes in mental health care and social care practice. A series of epidemiological studies of representative criminal justice system populations should be undertaken to address the above problems

Criterion	Explanation
Population	People in contact with the criminal justice system including those in contact with the prison, the courts, the probation service and CRCs and other criminal justice community services
Intervention	N/A because this is a descriptive study
Comparators	N/A because this is a descriptive study
Outcomes	• Personal characteristics (e.g. age, gender, relationship status, ethnicity) • Social status (e.g. housing, employment, education,

Criterion	Explanation
	• Diagnosis including drug and alcohol misuse, cognitive and neurodevelopmental problems • Personal and social functioning • Current and past contact with the criminal justice system
Study design	A series of large-scale cross sectional epidemiological studies of representative populations of those in contact with (a) the prison service (b) the courts (c) the probation service and CRCs and (d) other criminal justice community services
Timeframe	4 years

4. What factors are associated with suicide attempts and completed suicides?

There is high prevalence of suicide attempts among people in contact with criminal justice system. When developing interventions to prevent self-harm among these populations, it is important to identify and understand 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.

Criterion	Explanation
Population	People in contact with the criminal justice system
Prognostic factors	These will include factors known to be associated with suicide in the general population (e.g. mental health problems, drug and alcohol misuse and previous suicide attempts) as well as specific factors in the criminal justice population (e.g. type of offence)
Outcomes	Suicide and attempted suicide
Study design	Systematic review of observational studies
Timeframe	12 months

5. What is the effectiveness of structured clinical (case) management in improving mental health outcomes using interventions within probation service providers?

Many people in contact with the community-based criminal justice services, have significant mental health problems, in particular, personality problems and interpersonal difficulties. Evidence from studies of people with such problems in general mental health services suggests that structured organisation and delivery of mental health interventions (structured clinical management) may be of benefit in improving mental health outcomes. A programme of research is needed which would first refine and develop structured clinical management for use in the community rehabilitation companies (CRCs) and the National Probation Service (NPS) and then test this in large scale randomised control trials in both CRCs and the NPS. The comparison should be against standard CRC and NPS care. The trial should consider both clinical outcomes and cost-effectiveness.

Important outcomes could include:

- mental health outcomes
- offending and re-offending rates
- service utilisation
- cost-effectiveness
- broader measures of social functioning

Criterion	Explanation
Population	People with mental health problems in contact with the criminal justice system
Intervention	Structured clinical management
Comparators	Standard community rehabilitation company or national probation service care
Outcomes	• Offending and re-offending rates • Mental health outcomes • Cost-effectiveness • Health-related quality of life
Study design	Large-scale randomised controlled trials
Timeframe	Development and refinement of structured clinical management for use in criminal justice system (12 months); 2 feasibility studies (9 months); 2 multi-centre randomised trials and follow up (36 months)

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

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

There is also insufficient evidence on the effectiveness of psychological interventions for people with paraphilias in the criminal justice system. An individual patient data analysis of existing large scale data sets of paedophiles who have been treated in the criminal justice system should be conducted to inform the choice of treatment and the design of any future research. Psychological interventions for 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
- mental health problems
- cost-effectiveness
- service utilisation

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

Criterion	Explanation
Population	People with paraphilic disorders in the criminal justice system
Interventions	a) Pharmacological interventions (medroxyprogesterone acetate) b) Psychological interventions (specifically developed for the treatment of paraphilias
Comparators	Standard care for paraphilias in the criminal justice system
Outcomes	• Offending and re-offending rates • Mental health problems • Service utilisation • Cost-effectiveness
Study design	a) IPD review of existing psychological interventions for paraphilias in the criminal justice system

Criterion	Explanation
	b) Randomised controlled trials
Timeframe	a) Medroxyprogesterone acetate; (a) feasibility studies (9 months); (b) multi-centre randomised trial and follow up (48 months) b) Psychological interventions: (a) IPD review of existing psychological interventions (9 months), (b) Development and refinement of psychological interventions for use in the CJS (12 months), (c) feasibility studies (9 months), (d) multi-centre randomised trials and follow up (36 months)

7. What interventions are clinically effective and cost-effective for the remediation of difficulties associated with acquired brain injuries (including TBI) in adults with mental health problems within the criminal justice system?

Acquired brain injuries are common in adults in contact with the criminal justice system and are associated with an increased prevalence of mental health problems including increased suicidal risk and an increased risk of re-offending. Recognition of ACI is poor and there is currently no effective intervention used in the criminal justice system to address the problems presented by ACI. This leads to poor management in the criminal justice system and poor longer term outcomes in terms of mental health and offending. There is limited evidence on effective models to remediate the consequences of ACI in the general population but no evidence for remediative interventions in the adult criminal justice population. A programme of research and development is required which will (a) develop novel interventions for remediation specially to address the type of ACI commonly seen in the adult criminal justice system population (b) test these interventions in small pilot studies and (c) if the pilot studies show promise test the interventions in large scale randomised clinical trials in the criminal justice system.

Important outcomes could include:

- Improved adaptive functioning
- Improved cognitive performance
- Improved mental health
- Reductions in offending
- Service utilisation

Criterion	Explanation
Population	Adults with acquired brain injuries who are in contact with the criminal justice system
Intervention	Cognitive remediation programmes
Comparators	Standard care
Outcomes	• Improved adaptive functioning • Improved cognitive performance • Improved mental health • Reductions in offending • Service utilisation
Study design	(a) systematic review of existing cognitive remediation programmes (b) Development and refinement of cognitive remediation programmes for use in the criminal justice system (c) Multi-centre randomised trial(s)
Timeframe	Systematic review of existing cognitive remediation programmes (9 months), development and refinement of cognitive remediation programmes for use in criminal justice system (12 months), feasibility studies (9 months) and multi-centre randomised trials and follow up (36 months)

8. What psychosocial interventions are clinically and cost-effective for people with a personality disorder (other than ASPD or PBD) within the criminal justice system?

Personality disorders are common in adults in contact with the criminal justice system and are associated with an increased risk of re-offending, increased self-harm and suicidality and increased drug and alcohol misuse. Personality disorder may also contribute to significant management problems in the criminal justice system, these management problems may in part arise because the disorders are not recognised and potentially effective interventions are not made available. There are effective treatments for antisocial and borderline personality disorders and, in particular, antisocial personality disorder are available in the criminal justice system. However, although other types of personality disorder are also present in the criminal justice population there is very limited evidence to guide effective treatment for these problems. A programme of research and development is required which will (a) develop interventions for personality disorder (other than ASPD or PBD) within the criminal justice system specially for use in the adult criminal justice system population (b) test these interventions in a series of pilot studies and (c) if the pilot studies show promise, test the interventions in large scale randomised clinical trials in the criminal justice system

Important outcomes could include:

- Remission of the disorder
- Improved interpersonal performance
- Improved mental health
- Reductions in offending
- Service utilisation
- Cost effectiveness

Criterion	Explanation
Population	Adults in contact with the criminal justice system who have a personality disorder (other than ASPD or PBD)
Intervention	Psychological interventions specifically designed for personality disorder
Comparators	Standard care
Outcomes	• Remission of the disorder • Improved interpersonal performance • Improved mental health • Reductions in offending • Service utilisation • Cost effectiveness
Study design	(a) systematic review of psychological interventions for personality disorders (other than ASPD and BPD) (b) Development and refinement of psychological interventions for personality disorders for use in the criminal justice system (c) Multi-centre randomised trial(s)
Timeframe	Systematic review of psychological interventions for personality disorders (12 months), development and refinement of psychological interventions for personality disorders for use in the criminal justice system (12 months), feasibility studies (9 months) and multi-centre randomised trials and follow up (36 months)

9. 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?

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 severe mental health problems in routine healthcare settings. A programme of research and development is needed, which will first develop and test different models of care coordination for the delivery of care in small feasibility studies and then test those models that have shown promise in the feasibility studies in large scale randomised clinical trials in the criminal justice system.

Important outcomes could include:

- improved mental health outcomes
- improved access and uptake of services
- reductions in offending and re-offending
- cost-effectiveness

Criterion	Explanation
Population	People with mental health problems in contact with the criminal justice system
Intervention	Models for the delivery of and coordination of care
Comparators	Standard care
Outcomes	• Improved mental health outcomes • Improved access and uptake of services • Reductions in offending and reoffending • Cost-effectiveness
Study design	(a) systematic review of the care coordination and delivery systems for people with mental health problems in the criminal justice system (b) Development and refinement of the care coordination and delivery systems for use in the criminal justice system (c) Multi-centre randomised trial(s)
Timeframe	Systematic review of care coordination and delivery systems (12 months), development and refinement of care coordination and delivery systems (12 months), feasibility studies (9 months) and multi-centre randomised trials and follow up (36 months)

10. What is the best setting for treating people who have acute or significant ongoing psychotic illness within the prison system?

It is recognised that there is often a substantial delay in transferring patients with acute psychosis to a non-custodial hospital setting (currently identified as the preferred setting for such treatment). Currently approximately 1,000 prisoners per year are transferred to a hospital setting with an objective that this transfer be achieved within 14 days. However, this target is often not met and in certain circumstances and in some prisons, alternatives to hospital provision have had to evolve due to necessity. These include treatment in healthcare wings and segregation units. There are significant clinical concerns surrounding this practice and it warrants proper study to determine its feasibility, efficacy and safety.

Criterion	Explanation
Population	People with acute mental illness in prison requiring intensive specialist care
Intervention	Comprehensive and intensive acute ‘hospital like’ care for those with a severe mental illness delivered in a prison setting

Criterion	Explanation
Comparators	Standard care provided in a non-prison setting
Outcomes	• Time to transfer to appropriate care • Improved mental health outcomes • Safety and harms • Service utilisation • Cost-effectiveness
Study design	a) A systematic review of acute care models for severely mental ill people in the prison system b) Development of a service model for the effective delivery of acute care in a prison (c) Multi-centre randomised trial(s)
Timeframe	Systematic review of delivery systems (12 months), development and refinement of service model (12 months), feasibility studies (9 months) and multi-centre cluster randomised trial and follow up (36 months)