NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Mental health of adults in contact with the criminal justice system

Output: Prioritised quality improvement areas for development.

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for the mental health of adults in contact with the criminal justice system. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Mental health of adults in contact with the criminal justice system (2017) NICE guidance NG66. (Update not yet scheduled)

2 Overview

2.1 Focus of quality standard

This quality standard will cover the assessment, diagnosis and management of mental health conditions in adults (aged 18 and over) who are in contact with the criminal justice system.

2.2 Criminal justice system and mental health

The UK spends around £15bn per year[1] on the criminal justice system which comprises police, court and prison custody, street triage and liaison and diversion services, and probation services. The financial costs of crime are significant, and the personal and social costs often devastating for the people affected.

Mental health problems include common mental health problems, severe mental illness, paraphilias, neurodevelopmental disorders and acquired cognitive impairment. Mental health problems are common among people in contact with the criminal justice system, with the number of people affected ranging from 39% in police custody to 90% in prison. There is also evidence that certain mental disorders, like personality disorders and psychotic disorders, are more prevalent in the prison

[1] Revolving Doors Agency (2017) Rebalancing Act

population than the general population. Certain groups who are in prison like women, black, Asian and minority ethnic groups, people older than 50 years and people with comorbid disorders are more likely to have mental health disorders.

The underlying mechanisms between crime and mental illness are still not yet well understood. There are some suggestions that pre-existing social factors, for example homelessness, may be associated with increased offending. In other areas, such as substance misuse, the urge to use illicit drugs may drive people to commit crimes such as theft. In some cases, the links may relate to either poor adaptive functioning or the consequence that offending and being in contact with the criminal justice system have upon mental health.

2.3 Incidence and prevalence

The population in contact with the criminal justice system is far larger than the prison population. In 2014-15, 1.7 million people in England had contact with police forces resulting in a record on the police national computer. Among this population many people experience significant health problems (including physical and mental health and substance misuse) which are often complicated by social problems. Prison receptions amounted to roughly 90,000 people in the 12 months ending December 2015 and almost 140,000 people were referred to probation in the same year. At any one time, the proportion of offenders supervised by probation services outnumbers those serving a custodial sentence by around 3 to 1[2].

Continuing care is key throughout an individual's journey through the criminal justice system and back into the community. Forty-six per cent of all prisoners re-offend within a year of release, costing up to £13 billion a year. Seventy-four percent of people sentenced to custody are sentenced to less than 12 months which means they will be released within 6 months and forty-three percent are sentenced for less than 6 months which means they will be released within 3 months. Services need to address their particular health and care needs to make a significant impact and so improve health, change lives and reduce health inequalities.[3]

The use of community sentences, which can include requirements such as mental health treatment, alcohol misuse treatment and drug misuse treatment, reduced by approximately 45% between 2005 - 2015[4].

2.4 Criminal justice system mental health management

Mental health services for adults in contact with the criminal justice system are commissioned by NHS England, clinical commissioning groups and local authorities. Providers are community providers, primary care, secondary care and

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[2] Revolving Doors Agency (2017) Rebalancing Act
[3] NHS England (2016) Strategic Direction for Health Services in the justice system: 2016-2020
[4] Revolving Doors Agency (2017) Rebalancing Act

prisons[5].There is a joint care pilot scheme between the criminal justice system and NHS funded by the Department of Health, with initiatives such as 'street triage' schemes. However, identifying mental health problems in police custody is complicated by the lack of training, education and a standard assessment. There is also a lack of clarity on appropriate signposting and prompt access to mental healthcare.

Liaison and Diversion[6] services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. The service can support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.

Integrated offender management[7] is a locally led cross-agency response to the crime and reoffending threats faced by communities. It works through managing the most persistent and problematic offenders identified jointly by partner agencies working together.

The Five Year Forward View for mental health[8] notes that the Ministry of Justice, Home Office, Department of Health, NHS England and Public Health England should work together to support those in the criminal justice system experiencing mental health problems by expanding liaison and diversion schemes nationally, increasing support for blue light services, and for the 90 per cent of people in prison with mental health problems, drug or alcohol problems.

See appendix 1 for the associated care pathway from NICE guideline NG66.

2.5 National outcome frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

[5] NHS England (2016) Strategic Direction for Health Services in the justice system: 2016-2020
[6] NHS England (2017) About liaison and diversion webpage
[7] Revolving Doors Agency (2017) Rebalancing Act
[8] NHS England (2016) Mental health task force five year forward view

Table 1 Public health outcomes framework for England, 2016–2019

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.07 Proportion of people in prison aged 18 or over who have a mental illness 1.13 Levels of offending and re-offending 1.15 Statutory homelessness
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.10 Self-harm 2.15 Drug and alcohol treatment completion and drug misuse deaths 2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 Adult social care outcomes framework 2015–16

Domain	Overarching and outcome measures
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support *Placeholder 3E The effectiveness of integrated care* ***Outcome measures*** **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual** This information can be taken from the Adult Social Care Survey and used for analysis at the local level.
4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	***Overarching measure*** 4A The proportion of people who use services who feel safe** ***Outcome measures*** **People are free from physical and emotional abuse, harassment, neglect and self-harm** 4B The proportion of people who use services who say that those services have made them feel safe and secure
Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 3 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Improvement areas*** **Reducing premature mortality in people with mental illness** 1.5 i Excess under 75 mortality rate in adults with serious mental illness* *ii Excess under 75 mortality rate in adults with common mental illness** *iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services***
2 Enhancing quality of life for people with long-term conditions	***Improvement areas*** **Enhancing quality of life for people with mental illness** 2.5 *ii Health-related quality of life for people with mental illness*** **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions***
4 Ensuring that people have a positive experience of care	**Improving experience of healthcare for people with mental illness** *4.7 Patient experience of community mental health services* **Improving people's experience of integrated care** *4.9 People's experience of integrated care***
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

3 Summary of suggestions

3.1 Responses

In total 16 stakeholders and 5 specialist committee members responded to the 2-week engagement exercise 12 May – 26 May 2017.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

NHS Improvement's patient safety division submitted comments during stakeholder engagement, which can be found in full in appendix 4.

Full details of all the suggestions provided are given in appendix 4 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Initial assessment • Assessment for specific conditions • Content of assessment • Patient involvement and reasonable adjustments	HW, IL, NCD, NHS/HMPPS, RCGP, SCMs, UKADHD.
Identification and assessment throughout the care pathway • Liaison and diversion • Identification of support needs • Comorbidities and physical health	ADPH, CC, IL, PHE, RCPsych, RDA, RCN, SCM.
Risk assessment and management, and care planning • Accurate risk assessment and management • Integrated services and information sharing • Self-harm and suicide risk in prison • Specialist teams, pathways and services for mental health	ADPH, CC, CPNHSFT, NHS/HMPPS, NCD, PHE, RCGP, RCN, RCPsych, RDA, SCMs.
Psychological interventions • Personality disorder • Delivery of psychological treatment	RCPsych, SCMs.
Staff training • Key non-clinical professionals	CC, CPNHSFT, NCD, NHS/HMPPS, PHE, RCGP, RCN, RCPsych, SCM.
Additional areas • Second-stage health assessment • Smoke free prisons • Accommodation on release • Brain injury • Equality and diversity • Enabling environments framework • Personality disorder service • Built environment • Forensic outreach	ASH, ADPH, CC, HW, NCD, NHS/HMPPS, PHE, RCPsych, RDA, SCMs.
ASH, Action on Smoking and Health ADPH, Association of Directors of Public Health CC, Cambridge Constabulary CPNHSFT, Cambridgeshire and Peterborough NHS Foundation Trust HW, Headway – the Brain Injury Association IL, Inclusion London NCD, Deputy National Clinical Director and Adult Clinical Reference Group NHSE, NHS England NHSI, NHS Improvement Patient Safety Team NHS/HMPPS, Joint response NHS/ Her Majesty's Prison and Probation Service PHE, Public Health England RDA, Revolving Doors Agency RCGP, Royal College of General Practitioners RCN, Royal College of Nursing RCPsych, Royal College of Psychiatrists SCM, Specialist Committee Member UKADHD, UK Adult ADHD Network	

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 605 papers were identified for the mental health of adults in contact with the criminal justice system. In addition, 41 papers were suggested by stakeholders at topic engagement and 7 papers internally at project scoping.

Of these papers, 10 have been included in this report and are included in the current practice sections where relevant. Appendix 3 outlines the search process.

4 Suggested improvement areas

4.1 Initial assessment

4.1.1 Summary of suggestions

Assessment for specific conditions

Stakeholders suggested that mental health disorders often go unrecognised in the criminal justice system which can then delay access to appropriate support and treatment. Stakeholders highlighted autism, schizophrenia, ADHD and dementia in particular.

Content of assessment

Stakeholders suggested mental health assessment should obtain, evaluate and integrate information from a variety of sources. It may also be beneficial to measure and record people's accommodation prior to admission to prison. Stakeholders also suggested that a valid assessment tool could be used.

Patient involvement and reasonable adjustments

Stakeholders commented that involving service users in their care is a key priority for service development. Patient involvement is particularly important for people who require reasonable adjustments to be made such as people with significant physical and cognitive impairments and those who require mental health support.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Assessment for specific conditions	**Using this guideline together with other NICE guidelines** NICE NG66 Recommendation 1.1.2 **Principles of assessment** NICE NG66 Recommendation 1.2.3 **First-stage health assessment at reception into prison** NICE NG66 Recommendation 1.3.5
Content of assessment	**Using this guideline together with other NICE guidelines** NICE NG66 Recommendation 1.1.3

Patient involvement and reasonable adjustments	**Principles of assessment** NICE NG66 Recommendations 1.2.1 and 1.2.3 **Carrying out a mental health assessment** NICE NG66 Recommendation 1.3.12 **Care planning** NICE NG66 Recommendation 1.5.1

Using this guideline together with other NICE guidelines

NICE NG66 – Recommendations 1.1.2 and 1.1.3

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

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

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

- person escort record (PER)
- pre-sentence report
- all medical records
- custody reports
- Assessment, Care in Custody and Teamwork (ACCT) document
- reports from other relevant services, including liaison and diversion, substance misuse services, social service or housing services and youth offending services
- Offender Assessment System (OASys) or other assessment tools.

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

Principles of assessment

NICE NG66 – Recommendations 1.2.1 and 1.2.3

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

- the person's wishes
- the nature and quality of family relationships, including any safeguarding issues
- any statutory or legal considerations that may limit family and carer involvement
- the requirements of the Care Act 2014.

1.2.3 When assessing a person, make reasonable adjustments to the assessment that take into account any suspected neurodevelopmental disorders (including learning disabilities), cognitive impairments, or physical health problems or disabilities. Seek advice or involve specialists if needed.

First-stage health assessment at reception into prison

NICE NG66 – Recommendation 1.3.5

Recommendations 1.3.3 to 1.3.5 cover what happens when a person first arrives into prison, and are taken from the NICE guideline on physical health of people in prison. They refer to the first-stage health assessment, which is a combined physical and mental health assessment. A second-stage mental health assessment in prison should normally be done within 7 days.

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

- physical health
- alcohol use
- substance misuse
- mental health
- self-harm and suicide risk.

Carrying out a mental health assessment

NICE NG66 – Recommendation 1.3.12

All practitioners should ensure mental health assessment is a collaborative process that:

- involves negotiation with the person, as early as possible in the assessment process, about how information about them will be shared with others involved in their care
- makes the most of the contribution of everyone involved, including the person, those providing care or legal advice and family members and carers

- engages the person in an informed discussion of treatment, support and care options
- allows for the discussion of the person's concerns about the assessment process.

Care planning

NICE NG66 – Recommendation 1.5.1

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

- a profile of the person's needs (including physical health needs), identifying agreed goals and the means to progress towards them
- identification of the roles and responsibilities of those practitioners involved in delivering the care plan
- the implications of any mandated treatment programmes, post-release licences and transfer between institutions or agencies, in particular release from prison
- a clear strategy to access all identified interventions and services
- agreed outcome measures and timescale to evaluate and review the plan
- a risk management plan and a crisis plan if developed
- an agreed process for communicating the care plan (such as the Care Programme Approach or Care Treatment Plan) to all relevant agencies, the person, and their families and carers, subject to permission from the person where necessary.

4.1.3 Current UK practice

Assessment for specific conditions

A survey[9] published in 2016 gathered the experiences and views of 394 police officers from England and Wales regarding autism spectrum disorder (ASD). Forty-two percent of officers were satisfied with how they had worked with individuals with ASD. Officers acknowledged the need for adjustments but found organisational and time constraints were barriers. Whilst thirty-seven percent of officers had received training on ASD, a need for training tailored to policing roles was identified. The ASD community who took part in the survey (31 adults with ASD, 49 parents) were generally dissatisfied with their experience of the police.

No published studies on current practice were highlighted for the assessment of schizophrenia, brain injury, ADHD or dementia; these areas are based on stakeholder knowledge and experience.

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[9] Crane et al (2016) Experiences of Autism Spectrum Disorder and Policing in England and Wales: Surveying Police and the Autism Community

Content of assessment

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder knowledge and experience.

Patient experience and reasonable adjustments

The HM Chief Inspector of Prisons annual report 2014/15[10] found that disabled prisoners were not reliably identified, so the needs of many requiring help or reasonable adjustments were not met. The removal of disability liaison officers in many prisons also affected appropriate care provision.

4.1.4 Resource impact

The recommendations related to this section were not considered to have significant resource implications.

[10] HM Chief Inspector of Prisons (2015) Annual Report 2014/15

4.2 Identification and assessment throughout the care pathway

4.2.1 Summary of suggestions

Liaison and diversion

Stakeholders highlighted the need for mental health support in custody as ninety percent of prisoners have a diagnosable mental health problem and prison can be avoided in many cases if people are diverted at an early stage. To avoid inappropriate imprisonment by diversion to mental health provision, appropriate and continuous care should be given during transitions between services.

Identification of support needs

Stakeholders highlighted that delays in recognising mental health problems, learning disabilities and support needs in prison can lead to lack of treatment and poor outcomes. People should have access to mental health practitioners competent in assessing their needs and referring for treatment. A thorough assessment of mental health need should be carried out in a suitable, safe area on reception into prison and people should have regular assessments during their sentence.

Comorbidities and physical health

Stakeholders highlighted that many adults in contact with the criminal justice system have co-existing needs, most commonly mental health and substance misuse, (dual diagnosis) and therefore they require an integrated approach in order to prevent people falling through gaps in services.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the committee’s discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Liaison and diversion	**Service structures and delivery** NICE NG66 Recommendations 1.8.1 and 1.8.2
Identification of support needs	**First-stage health assessment at reception into prison** NICE NG66 Recommendations 1.3.3 and 1.3.5 **Identification and assessment throughout the care pathway (including second-stage health assessment in prisons)** NICE NG66 Recommendations 1.3.6, 1.3.7 and 1.3.8 **Carrying out a mental health assessment** NICE NG66 Recommendations 1.3.9, 1.3.10 and 1.3.14 **Reviewing the mental health assessment** NICE NG66 Recommendation 1.3.17
Comorbidities and physical health	**First-stage health assessment at reception into prison** NICE NG66 Recommendation 1.3.5 **Carrying out a mental health assessment** NICE NG66 Recommendation 1.3.14 **Reviewing the mental health assessment** NICE NG66 Recommendation 1.3.18

First-stage health assessment at reception into prison

NICE NG66 – Recommendations 1.3.3 and 1.3.5

Recommendations 1.3.3 to 1.3.5 cover what happens when a person first arrives into prison, and are taken from the NICE guideline on physical health of people in prison. They refer to the first-stage health assessment, which is a combined physical and mental health assessment. A second-stage mental health assessment in prison should normally be done within 7 days.

1.3.3 At first reception into prison, a healthcare professional (or trained healthcare assistant under the supervision of a registered nurse) should carry out a health assessment for every person. Do this before the person is allocated to their cell. As part of the assessment, identify:

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

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

- physical health
- alcohol use
- substance misuse
- mental health
- self-harm and suicide risk.

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

NICE NG66 – Recommendations 1.3.6, 1.3.7 and 1.3.8

Recommendations 1.3.6 to 1.3.8 apply both throughout the care pathway and to the second-stage health assessment in prisons. In non-prison settings, all staff should think about using the Correctional Mental Health Screen tool (see recommendation 1.3.6).

1.3.6 Consider using the Correctional Mental Health Screen for Men (CMHS-M) or Women (CMHS-W) to identify possible mental health problems if:

- the person's history, presentation or behaviour suggest they may have a mental health problem
- the person's responses to the first-stage health assessment suggest they may have a mental health problem
- the person has a chronic physical health problem with associated functional impairment
- concerns have been raised by other agencies about the person's abilities to participate in the criminal justice process.

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

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

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

Carrying out a mental health assessment

NICE NG66 – Recommendations 1.3.9, 1.3.10 and 1.3.14

1.3.9 Service providers should ensure that competent practitioners who have experience of working with people in contact with the criminal justice system with mental health problems:

- perform the mental health assessment
- coordinate the input of other professionals into the assessment when needed.

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

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

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

- the nature and severity of the presenting mental health problems (including cognitive functioning) and their development and history
- coexisting mental health problems
- coexisting substance misuse problems, including novel psychoactive substances
- coexisting physical health problems
- social and personal circumstances, including personal experience of trauma
- social care, educational and occupational needs
- people's strengths
- available support networks, and the person's capacity to make use of them
- previous care, support and treatment, including how the person responded to these
- offending history and how this may interact with mental health problems.

Reviewing the mental health assessment

NICE NG66 – Recommendations 1.3.17 and 1.3.18

1.3.17 Practitioners should review and update mental health assessments:

- if new information is available about the person's mental health problem
- if there are significant differences between the views of the person and the views of the family, carers or staff that cannot be resolved through discussion
- when major legal or life events occur
- when the person is transferred between, or out of, criminal justice services

- if a person experiences a significant change in care or support, for example, stopping an Assessment, Care in Custody and Teamwork (ACCT) plan
- if a person disengages or does not stick to their treatment plan
- annually, or as required by local policy such as Care Programme Approach or Care Treatment Plan.

1.3.18 When updating mental health assessments, practitioners should consider:

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

Service structures and delivery

NICE NG66 – Recommendations 1.8.1 and 1.8.2

1.8.1 Commissioners and providers of criminal justice services and healthcare services should support the development of liaison and diversion functions for police custody and the courts that provide prompt access to the following:

- the effective identification and recognition of mental health problems
- a comprehensive mental health assessment
- advice on immediate care and management
- appropriate treatment and care (including medication).

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

4.2.3 Current UK practice

Liaison and diversion

The NHS England[11] mental health five year forward view dashboard showed that the proportion of the population with access to liaison and diversion services was 53% in October – December 2016. Liaison and diversion services continue to be rolled out with the aim of covering 100% of the country by 2020/21[12].

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[11] NHS England (2016) Mental health five year forward view
[12] NHS England (2016) Strategic Direction for Health Services in the justice system: 2016-2020

Identification of support needs

The HM Chief Inspector of Prisons annual report 2015/16[13] noted that many detainees in police custody had pre-existing mental health issues of varying severity. Mental health liaison and diversion services in police custody had increased nationally and improved outcomes for detainees, but were still not universally available. Most forces experienced lengthy delays in Mental Health Act assessments, particularly out of hours.

The report noted access to mental health and substance misuse support was good in court custody.

The report noted that a much higher proportion of women in prison than men said they had a problem on arrival with drugs (41% to 25%) or alcohol (30% to 16%). Women were more positive than men about the support they had received.

The report also noted that in male prisons most staff were able to identify and provide good support to the prisoners most at risk. However, not all prisons had a comprehensive safeguarding policy and such prisoners were not always recognised sufficiently well, especially in busy local prisons.

Comorbidities and physical health

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder knowledge and experience.

4.2.4 Resource impact

Experts suggested that liaison and diversion functions for police custody and the courts are becoming current practice. However, in some areas they are not available in every court or police custody suite, or on a daily basis and there may be resource implications to implement this.

The other recommendations related to this section were not considered to have significant resource implications.

[13] HM Chief Inspector of Prisons (2016) Annual Report 2015/16

4.3 Risk assessment and management, and care planning

4.3.1 Summary of suggestions

Accurate risk assessment and management

A stakeholder highlighted that accurate risk assessment and management is key to developing timely interventions for service users. Addressing and assessing risk is relevant throughout the pathway.

Integrated services and information sharing

Stakeholders suggested that multiagency working and information sharing agreements or protocols between criminal justice and health teams is needed to achieve optimal societal and individual benefit. Due to uncertainty, staff may not share information which can impact on service users and contribute to serious further offences. Information sharing agreements will reduce multiple assessments and reviews and build a full picture of risk and harm associated with the person’s mental health. This can ensure all appropriate interventions are explored to improve mental health in the most appropriate setting. Engagement with third sector providers to promote effective transition into the community is also important.

A stakeholder commented that significant substance misuse issues with psycho-social issues often mean service users are treated by mental health and drugs teams with neither taking responsibility. Integrated teams can address the needs of service users and manage public protection issues more effectively. Mainstream and specialist housing provision are also key to pathway planning.

Self-harm and suicide risk in prison

A stakeholder commented that self-harm and suicide have increased in prisons. Effort is put into responding to crises but longer-term interventions in prisons can be neglected. Practitioners need skills in suicide risk assessment and management to reduce the number of suicides of prisoners within the prison estate.

Specialist teams, pathways and services for mental health

A stakeholder felt there is a need for specialist teams and pathways designed for offenders with mental health issues developed jointly with the criminal justice system and health. Offenders with mental health needs often have multiple issues but do not meet the entry criteria to traditional mental health services.

Stakeholders commented that people with mental health problems are at increased risk of suicide following release from prison. Community based mental health services don’t always manage the immediate needs of this group leading to increases in re-offending, suicide and relapse.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Accurate risk assessment and management	**Risk assessment and management** NICE NG66 Recommendations 1.4.1, 1.4.2, 1.4.4, 1.4.5 and 1.4.6
Integrated services and information sharing	**Using this guideline together with other NICE guidelines** NICE NG66 Recommendation 1.1.3 **Risk assessment and management** NICE NG66 Recommendation 1.4.6 **Care planning** NICE NG66 Recommendation 1.5.1 **Service structures and delivery** NICE NG66 Recommendations 1.8.1, 1.8.2, 1.8.3 and 1.8.4
Self-harm and suicide risk in prison	**Risk management plans** NICE CG133 Recommendation 1.4.5 **Staff training** NICE NG66 Recommendation 1.9.4
Specialist teams, pathways and services for mental health	**Care planning** NICE NG66 Recommendation 1.5.1 **Delivering psychological interventions for mental health problems** NICE NG66 Recommendation 1.6.1 **Service structures and delivery** NICE NG66 Recommendations 1.8.1, 1.8.3 and 1.8.4

Using this guideline together with other NICE guidelines

NICE NG66 – Recommendation 1.1.3

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

- person escort record (PER)
- pre-sentence report
- all medical records
- custody reports

- Assessment, Care in Custody and Teamwork (ACCT) document
- reports from other relevant services, including liaison and diversion, substance misuse services, social service or housing services and youth offending services
- Offender Assessment System (OASys) or other assessment tools.

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

Risk assessment and management

NICE NG66 – Recommendations 1.4.1, 1.4.2, 1.4.4, 1.4.5 and 1.4.6

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

1.4.2 All practitioners should take into account the following issues in risk assessments for people in contact with the criminal justice system:

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

1.4.4 If indicated by their risk assessment, the practitioner doing the assessment should develop a risk management plan for a person. This should:

- integrate with or be consistent with the mental health assessment and plan
- take an individualised approach to each person and recognise that risk levels may change over time
- set out the interventions to reduce risk at the individual, service or environmental level
- take into account any legal or statutory responsibilities which apply in the setting in which they are used
- be shared with the person (and their family members or carers if appropriate) and relevant agencies and services subject to permission from the person where necessary
- be reviewed regularly by those responsible for implementing the plan and adjusted if risk levels change.

1.4.5 All practitioners should ensure that any risk management plan is:

- informed by the assessments and interventions in relevant NICE guidance for the relevant mental health disorders, including the NICE guidelines on self-harm in

over 8s: short-term management and prevention of recurrence and self-harm in over 8s: long-term management
- implemented in line with agreed protocols for safeguarding vulnerable people and the provision of appropriate adults
- implemented in line with agreed protocols in police custody, prisoner escort services, prison, community settings and probation service providers.

1.4.6 Ensure that the risk management plan is integrated with, and recorded in, the relevant information systems; for example, the ACCT procedure in prisons, the Offender Assessment System (OASys) and SystmOne and Multi-Agency Risk Assessment Conference (MARAC) and Multi-Agency Public Protection Arrangements (MAPPA).

Risk management plans

NICE CG133 – Recommendation 1.4.5

Update risk management plans regularly for people who continue to be at risk of further self-harm. Monitor changes in risk and specific associated factors for the service user, and evaluate the impact of treatment strategies over time.

Care planning

NICE NG66 – Recommendation 1.5.1

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

- a profile of the person's needs (including physical health needs), identifying agreed goals and the means to progress towards them
- identification of the roles and responsibilities of those practitioners involved in delivering the care plan
- the implications of any mandated treatment programmes, post-release licences and transfer between institutions or agencies, in particular release from prison
- a clear strategy to access all identified interventions and services
- agreed outcome measures and timescale to evaluate and review the plan
- a risk management plan and a crisis plan if developed
- an agreed process for communicating the care plan (such as the Care Programme Approach or Care Treatment Plan) to all relevant agencies, the person, and their families and carers, subject to permission from the person where necessary.

Delivering psychological interventions for mental health problems

NICE NG66 – Recommendation 1.6.1

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

- to modify the delivery of psychological interventions in the criminal justice system
- to ensure continuity of the psychological intervention (for example, transfer between prison settings or on release from prison)
- for staff to be trained and competent in the interventions they are delivering
- for supervision
- for audit using routinely available outcome measures.

Service structures and delivery

NICE NG66 – Recommendations 1.8.1, 1.8.2, 1.8.3 and 1.8.4

1.8.1 Commissioners and providers of criminal justice services and healthcare services should support the development of liaison and diversion functions for police custody and the courts that provide prompt access to the following:

- the effective identification and recognition of mental health problems
- a comprehensive mental health assessment
- advice on immediate care and management
- appropriate treatment and care (including medication).

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

1.8.3 Commissioners and providers of criminal justice services and healthcare services should consider establishing joint working arrangements between healthcare, social care and police services for managing urgent and emergency mental health presentations in the community (for example, street triage). Include:

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

1.8.4 Commissioners and providers of criminal justice services and healthcare services should ensure effective identification, assessment, coordination and delivery of care for all people with a mental health problem in contact with the criminal justice system. This should include people who are transferring from young offender services and those on probation. In particular, ensure that:

- all people with a severe or complex mental health problem have a designated care coordinator
- during transitions between services care plans are shared and agreed between all services
- effective protocols are in place to support routine data sharing and, when necessary, joint plans of care between health services (including primary and secondary care services) and criminal justice agencies to reduce unnecessary assessments and promote effective interventions.

Service structures and delivery

NICE NG66 – Recommendation 1.9.4

Give all staff involved in direct care, training (as part of induction training and continuing professional development) and supervision to support them in:

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

4.3.3 Current UK practice

Accurate risk assessment and management

The HM Chief Inspector of Prisons annual report 2015/16[14] noted that in police custody, care plans should be based on factors identified during risk assessment. Many detainees posed risks of self-harm or suicide, and responses varied across inspected forces. There was generally good awareness of the levels of observation needed but forces sometimes used inappropriate strategies as a first response.

In court custody there was no systematic risk assessment for people arriving. Detainees were often located in cells before a cell sharing risk assessment was completed, and custody staff did not routinely review documents arriving with people

[14] HM Chief Inspector of Prisons (2016) Annual Report 2015/16

that included risk information relevant to their detention in court custody. There was also no pre-release risk assessment to ensure that people were released safely.

The report also noted that in most male prisons, many prisoners either did not have an OASys (offender assessment system) assessment, used as a framework to judge a prisoner's likelihood of reoffending and the risk of harm to others, or had one that was out of date. In some male prisons, the majority of the OASys backlog were cases that were the responsibility of the National Probation Service. These prisoners generally presented the highest risks, and the absence of an OASys assessment prevented their access to effective interventions. The quality of OASys assessments varied considerably in male prisons. The report stated that in female prisons, offender management and public protection arrangements were not good enough.

Integrated services and information sharing

A survey[15] of adult prisoners sentenced to between one month and four years in England and Wales in 2005 and 2006 found that 54% of prisoners had used illegal drugs following release and 68% had been reconvicted within 2 years.

Public Health England[16] reported that, in 2015/16, 63% of the substance misuse interventions received in secure settings were structured psychosocial interventions for drug and alcohol misuse.

No other published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder knowledge and experience.

Self-harm and suicide risk in prison

The NHS England health and justice indicators of performance (HJIP)[17] include the percentage of people in prison at risk of, or presenting with, self-harm injuries or suicidal ideation intentions that have had a completed primary mental health assessment within 12 hours. For January – March 2017, the national monthly average was between 71.9% - 92.3%.

HJIP also include the percentage of prisoners at risk or presenting with self-harm injuries or suicidal ideation that have been referred to in reach mental health teams having had a primary mental health assessment. For January – March 2017, the national monthly average was between 46.4% and 50.4%.

[15] Ministry of Justice (2014) Surveying prisoner crime reduction
[16] Public Health England (2017) Secure setting statistics from the National Drug Treatment Monitoring System
[17] NHS England health and justice indicators of performance 2016/17 quarter 4. Data not published, provided by NHS England.

The Prisons and Probation Ombudsman[18] reported that, of the 557 people who died in prison between 2012 – 2014, 199 deaths were self-inflicted. Those whose deaths were self-inflicted were eight times more likely to have been identified as having thoughts of suicide or self-harm before their death, than those who died from natural causes. They were also considerably more likely to have been diagnosed with a personality or other psychological disorder. At least 17% of those whose death was self-inflicted had been identified with a severe and enduring mental illness (bipolar affective disorder, schizophrenia, or another delusional disorder), compared with only 6% of prisoners who died from natural causes.

Specialist teams, pathways and services for mental health

The Equality and Human Rights Commission[19] reported that 66 non-natural deaths were recorded within 28 days of release from prison between 2010 -15, 44 died from drug overdoses and the others were unclassified. The majority of those who died of a drug overdose did so within 10 days of release. This suggested a lack of continuity of care where, for example, records or referrals for treatment were not passed on or acted upon.

Public Health England[20] reported that the proportion of adults with substance misuse treatment need who successfully engaged in community-based structured treatment within 21 days of release from prison nationally was just over 30% in 2015/16.

4.3.4 Resource impact

The recommendations related to risk assessment and management and care planning may involve costs where training is needed.

Street triage schemes are not widely available and vary in scale. There may be some resource implications for police and mental health teams but savings may also be identified.

Joint working arrangements between healthcare, social care and police services are not widely available across England. Increasing joint working throughout England may have resource implications but may also lead to potential savings.

The identification, assessment, coordination and delivery of care for all people, including those who are transferring from young offender services and those on probation, with a mental health problem in contact with the criminal justice system (including probation service providers) might require additional staff time. However,

[18] Prisons and Probation Ombudsman (2016) Prisoners Mental Health
[19] Equality and Human Rights Commission (2016) Research Report 106: Non-natural deaths following prison and police custody
[20] Public Health England (2017) Secure setting statistics from the National Drug Treatment Monitoring System

organisations may deploy existing community mental health teams and improve access to psychological therapies in a way that encourages engagement.

4.4 Psychological interventions

4.4.1 Summary of suggestions

Personality disorder

Stakeholders commented that personality disorder, and comorbidity with other disorders, is very common in criminal justice settings. People should not be excluded from interventions for comorbid disorders due to a personality disorder diagnosis. Approaches and interventions should be adapted to take personality disorders into account to facilitate rehabilitation activity in prison and reduce levels of conflict.

Delivery of psychological treatment

A stakeholder felt that NICE-compliant psychological treatment should be available, delivered by competent staff with time protected to allow them to deliver the therapy. A stakeholder highlighted that the use of therapeutic communities for substance misuse in prison has better outcomes than current service models.

4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Personality disorder	**Personality disorder** NICE NG66 Recommendations 1.6.3 and 1.6.6
Delivery of psychological treatment	**Delivering psychological interventions for mental health problems** NICE NG66 Recommendation 1.6.1 **Specific psychological interventions** NICE NG66 Recommendations 1.6.9 and 1.6.10

Delivering psychological interventions for mental health problems

NICE NG66 – Recommendation 1.6.1

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

- to modify the delivery of psychological interventions in the criminal justice system

- to ensure continuity of the psychological intervention (for example, transfer between prison settings or on release from prison)
- for staff to be trained and competent in the interventions they are delivering
- for supervision
- for audit using routinely available outcome measures.

Personality disorder

NICE NG66 – Recommendations 1.6.3 and 1.6.6

1.6.3 Providers of services should ensure staff are able to identify common features and behaviours associated with personality disorders and use these to inform the development of programmes of care.

1.6.6. Practitioners should not exclude people with personality disorders from any health or social care service, or intervention for comorbid disorders, as a direct result of their diagnosis.

Specific psychological interventions

NICE NG66 – Recommendations 1.6.9 and 1.6.10

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

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

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

4.4.3 Current UK practice

Personality disorder

No published studies on current practice were highlighted for the treatment of personality disorder; this area is based on stakeholder knowledge and experience.

Delivery of psychological treatment

The NHS England[21] mental health five year forward view dashboard showed that the proportion of mental health patients receiving group therapy in secure and detained settings was 16% in October – December 2016. Thirty-seven percent of mental health patients in secure and detained settings received individual therapy.

The HM Prison and Probation Service website[22] shows that democratic therapeutic communities are provided at 4 male prisons and one female prison in England. There are currently 118 prison establishments in England[23]. Therapeutic communities provide group based therapy within a social climate which promotes positive relationships, personal responsibility and social participation.

4.4.4 Resource impact

There is variation in practice in the delivery of psychological interventions through both primary and secondary mental healthcare in prisons. Fewer prisons have either clinical or counselling psychologists, nurses or state practitioners trained in delivering therapy for mental health problems.

There may be resource implications when developing or converting existing estates to provide appropriate prison wing space. Costs would be for staffing or training, programme supplies and materials, and for equipment to ensure appropriate space is available. Doing this would potentially reduce future re-offending in people who have substance misuse disorders. Potential costs would depend on local needs and services and should be assessed at a local level.

Improving mental health outcomes in the longer term with potential future cost savings to the healthcare system and the criminal justice system.

[21] NHS England (2016) Mental health five year forward view
[22] HM Prison and Probation Service
[23] NHS England Health and Justice Webpage

4.5 Staff training

4.5.1 Summary of suggestions

Key non-clinical professionals

Stakeholders highlighted the importance of training of key non-clinical professionals to carry out initial risk assessments in custody and to understand personality disorders and dual diagnosis. Due to the high levels of mental health issues, staff in contact with service users at any point of the care pathway need to recognise and respond to people with mental health issues therefore basic fundamental training is essential for all. This should reduce delays in referral to mental health teams.

A stakeholder noted that multidisciplinary and multi-agency training should be provided as part of induction training and continuing professional development to staff to increase consistency, understanding of ways of working, and promotion of positive working relationships for all staff who work in the criminal justice system.

4.5.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 9 to help inform the committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Key non-clinical professionals	**Staff training** NICE NG66 Recommendations 1.9.1, 1.9.2, 1.9.3 and 1.9.4

Service structures and delivery

<u>NICE NG66 – Recommendations 1.9.1, 1.9.2, 1.9.3 and 1.9.4</u>

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

- the purpose of the service in which they work, and the role and availability of other related local services, including pathways for referral
- the roles, responsibilities and processes of criminal justice, health and social care staff
- legislation and local policies relevant to their role, for sharing information with others involved in the person's care

- protocols for dealing with mental health problems in the criminal justice system (for example, in-possession medicines, side effects, withdrawal)
- the importance of clear communication, including avoiding acronyms and using consistent terminology.

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

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

1.9.3 Provide multidisciplinary and multi‑agency training (as part of both induction training and continuing professional development) to increase consistency, understanding of ways of working, and promotion of positive working relationships for all staff who work in the criminal justice system on:

- the prevalence of mental health problems in the criminal justice system, and why such problems may bring people into contact with the criminal justice system
- the main features of commonly occurring mental health problems seen in the criminal justice system, and the impact these may have on behaviour and compliance with rules and statutory requirements
- recognising and responding to mental health problems and communication problems that arise from, or are related to, physical health problems.

1.9.4 Give all staff involved in direct care, training (as part of induction training and continuing professional development) and supervision to support them in:

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

4.5.3 Current UK practice

Key non-clinical professionals

The HM Chief Inspector of Prisons annual report 2015/16[24] noted that prison escort and custody officers lacked important training to support their work with detainees, including those with vulnerabilities. Many court custody staff were keen to receive mental health awareness training and felt ill-equipped to deal with detainees with complex needs.

4.5.4 Resource impact

Training already takes place but is not mandatory and varies across the country. Bespoke mental health training for the range of practitioners and clinical issues are rare and not comprehensive. Providing training would involve additional cost but the level would depend on local needs.

[24] HM Chief Inspector of Prisons (2016) Annual Report 2015/16

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 6 July 2017.

Second-stage health assessment

Stakeholders commented that the second-stage health assessment should be completed within 7 days of entering prison to identify any pre-existing or current mental health issues that need to be further assessed or managed during sentence.

The quality standard on the physical health of people in prisons, currently in development, contains a statement on carrying out this assessment within 7 days.

Smoke free prisons

A stakeholder felt the development source guidance (NICE NG66) should include smoking and nicotine withdrawal. As this is a suggested change to the scope of the guideline, it is not within the scope of the quality standards process.

Accommodation on release

Stakeholders felt a lack of safe and appropriate accommodation on release increases the risk of reoffending. This area is not contained within the development source guidance (NICE NG66).

Brain injury

A stakeholder felt research should be carried out to identify how many community-based criminal justice services provide interventions tailored to the needs of someone with a brain injury. They also felt there should be research to identify the scale of the prevalence of brain injury in the criminal justice system, and whether having a brain injury increases the risk of re-offending.

They felt training about brain injury should be distinct from training in mental health and other cognitive disorders and that tools to assist the police to identify brain injury survivors should be promoted.

These areas are not contained within the development source guidance (NICE NG66).

Equality and diversity

A stakeholder commented that there should be a specific focus on the needs of people from black, Asian and minority ethnic groups. There should be provision of culturally sensitive assessments and therapeutic options for this group of people who may find current provision inadequate and insensitive to their cultural contexts and needs.

A stakeholder felt the particular levels and types of need faced by women in contact with the criminal justice system should be met. In addition, female prisons and prison-based mental health services should take a whole-system approach to reducing the risk of suicide.

Equality and diversity considerations are included for all relevant quality statements and recorded in the equality impact assessment.

Enabling environments framework

A stakeholder felt that the Enabling Environments Framework should be used for people in contact with the criminal justice system who have multiple problems including significant interpersonal issues. A stakeholder commented that promoting positive mental health should be embedded in all aspects of the prison. This area is not contained within the development source guidance (NICE NG66).

Personality disorder service

A stakeholder suggested that offender personality disorder service evaluations and standards for the pathway are developmental areas of emergent practice. This area is not contained within the development source guidance (NICE NG66).

Built environment

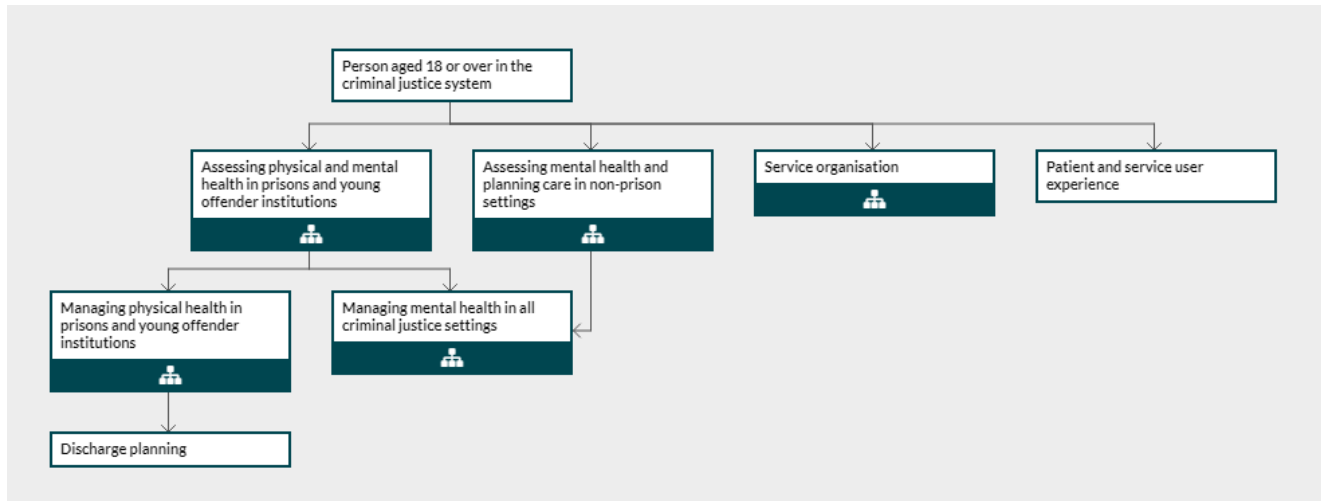
A stakeholder commented that the built environment has a direct and indirect impact on mental health and wellbeing by supporting people to be physically active, having time out of cell and engaging in purposeful activity. This area is not contained within the development source guidance (NICE NG66).

Forensic outreach

A stakeholder felt that the availability of forensic outreach services should be developed and used to support liaison services, particularly for those in contact with community criminal justice teams. This area is not contained within the development source guidance (NICE NG66).

Appendix 1: NICE pathway

Health of people in the criminal justice system overview.



Appendix 2: Recommendation 1.3.5 - Questions for first-stage health assessment

Table 1 Questions for first-stage health assessment

Topic questions	Actions
Prison sentence	
1. Has the person committed murder, manslaughter or another offence with a long sentence?	Yes: refer the person for mental health assessment by the prison mental health in-reach team if necessary. No: record no action needed.
Prescribed medicines	
2. Is the person taking any prescribed medicines (for example, insulin) or over-the-counter medicines (such as creams or drops)? If so: • what are they • what are they for • how do they take them?	Yes: document any current medicines being taken and generate a medicine chart. Refer the person to the prescriber for appropriate medicines to be prescribed, to ensure continuity of medicines. If medicines are being taken, ensure that the next dose has been provided (see recommendations 1.7.10 and 1.7.11). Let the person know that medicines reconciliation will take place before the second-stage health assessment. No: record no action needed.
Physical injuries	
3. Has the person received any physical injuries over the past few days, and if so: • what were they • how were they treated?	Yes: assess severity of injury, any treatment received and record any significant head, abdominal injuries or fractures. Document any bruises or lacerations observed on a body map. In very severe cases, or after GP assessment, the person may need to be transferred to an external hospital. Liaise with prison staff to transfer the person to the hospital emergency department by ambulance. If the person has made any allegations of assault, record negative observations as well (for example, 'no physical evidence of injury'). No: record no action needed.
Other health conditions	
4. Does the person have any of the following:	Ask about each condition listed.

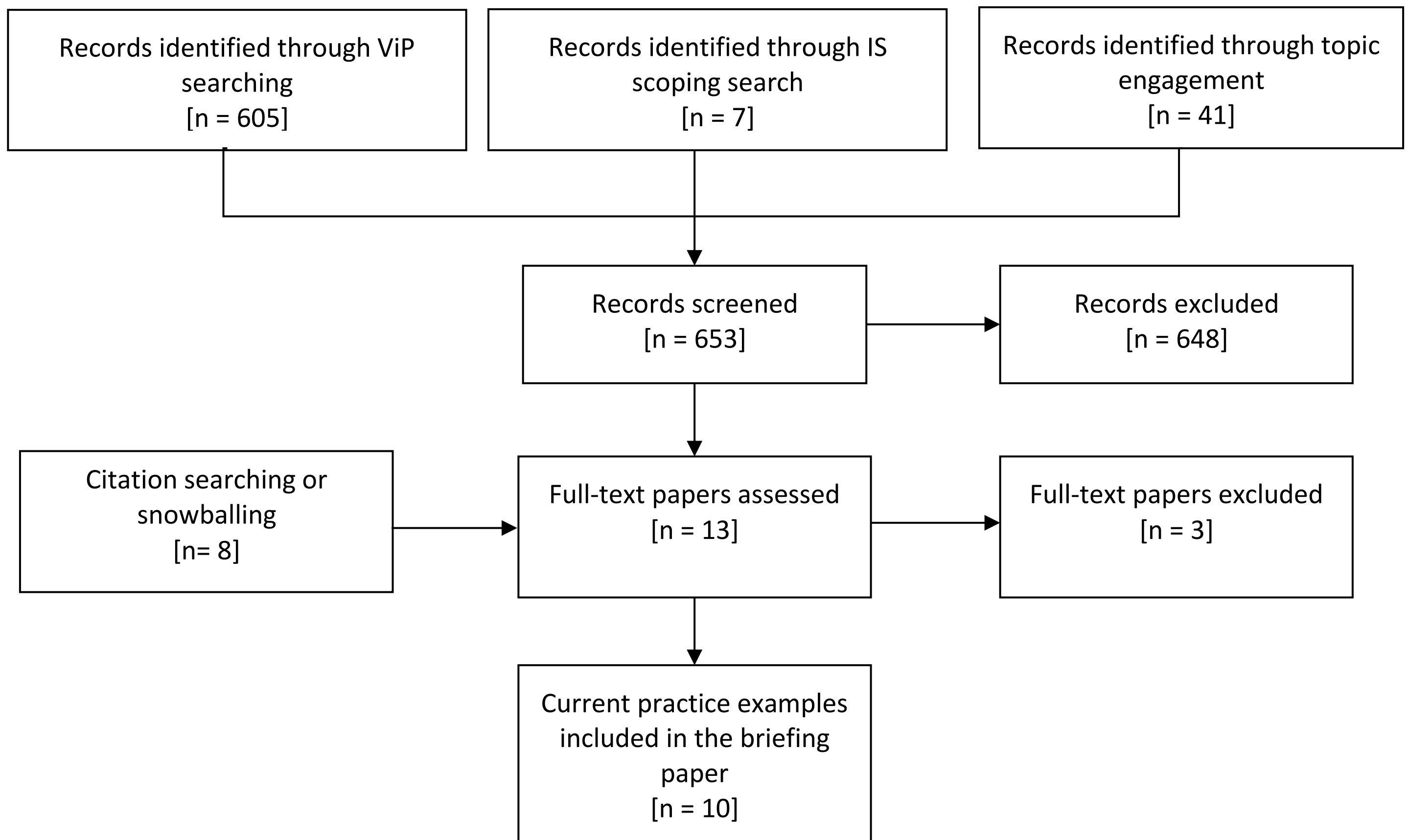
• allergies, asthma, diabetes, epilepsy or history of seizures • chest pain, heart disease • chronic obstructive pulmonary disease • tuberculosis, sickle cell disease • hepatitis B or C virus, HIV, other sexually transmitted infections • learning disabilities • neurodevelopmental disorders • physical disabilities?	Yes: make short notes on any details of the person's condition or management. For example, 'Asthma – on Ventolin 1 puff daily'. Make appointments with relevant clinics or specialist nurses if specific needs have been identified. No: record no action needed.
5. Are there any other health problems the person is aware of that have not been reported?	Yes: record the details and check with the person that no other physical health complaint has been overlooked. No: record no action needed.
6. Are there any other concerns about the person's health?	Yes: make a note of any other concerns about physical health. This should include any health-related observations about the person's physical appearance (for example, weight, pallor, jaundice, gait or frailty). Refer the person to the GP or relevant clinic. No: note 'Nil'.
Additional questions for women	
7. Does the woman have reason to think she is pregnant, or would she like a pregnancy test?	If the woman is pregnant, refer to the GP and midwife. If there is reason to think the woman is pregnant, or would like a pregnancy test: provide a pregnancy test. Record the outcome. If positive, make an appointment for the woman to see the GP and midwife. No: record response.
Living arrangements, mobility and diet	
8. Does the person need help to live independently?	Yes: note any needs. Liaise with the prison disability lead in reception about: • the location of the person's cell • further disability assessments the prison may need to carry out. No: record response.
9. Do they use any equipment or aids (for example, walking stick, hearing aid, glasses, dentures, continence aids or stoma)?	Yes: remind prison staff that all special equipment and aids the person uses should follow them from reception to their cell. No: record response.

10. Do they need a special medical diet?	Yes: confirm the need for a special medical diet. Note the medical diet the person needs and send a request to catering. Refer to appropriate clinic for ongoing monitoring. No: record response.
Past or future medical appointments	
11. Has the person seen a doctor or other healthcare professional in the past few months? If so, what this was for?	Yes: note details of any recent medical contact. Arrange a contact letter to get further information from the person's doctor or specialist clinic. Note any ongoing treatment the person needs and make appointments with relevant clinics, specialist nurses, GP or other healthcare staff. No: record no action needed.
12. Does the person have any outstanding medical appointments? If so, who are they with, and when?	Yes: note future appointment dates. Ask healthcare administrative staff to manage these appointments or arrange for new dates and referral letters to be sent if the person's current hospital is out of the local area. No: record no action needed.
Alcohol and substance misuse	
13. Does the person drink alcohol, and if so: • how much do they normally drink? • how much did they drink in the week before coming into custody?	Urgently refer the person to the GP or an alternative suitable healthcare professional if: • they drink more than 15 units of alcohol daily or • they are showing signs of withdrawal or • they have been given medication for withdrawal in police or court cells. No: record response.
14. Has the person used street drugs in the last month? If so, how frequently? When did they last use: • heroin • methadone • benzodiazepines • amphetamine • cocaine or crack • novel psychoactive substances • cannabis • anabolic steroids • performance and image enhancing drugs?	Yes: refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support. Take into account whether: • they have taken drugs intravenously • they have a positive urine test for drugs • their answers suggest that they use drugs more than once a week • they have been given medication for withdrawal in police or court cells. If the person has used intravenous drugs, check them for injection sites. Refer them to substance misuse services if there are concerns about their immediate clinical

	management and they need immediate support. No: record response.
Problematic use of prescription medicines	
15. Has the person used prescription or over-the-counter medicines in the past month: • that were not prescribed or recommended for them or • for purposes or at doses that were not prescribed? • If so, what was the medicine and how did they use it (frequency and dose)?	Yes: refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support. No: record response.
Mental health	
16. Has the person ever seen a healthcare professional or service about a mental health problem (including a psychiatrist, GP, psychologist, counsellor, community mental health services, alcohol or substance misuse services or learning disability services)? If so, who did they see and what was the nature of the problem?	Yes: refer the person for a mental health assessment if they have previously seen a mental health professional in any service setting. No: record response.
17. Has the person ever been admitted to a psychiatric hospital, and if so: • when was their most recent discharge • what is the name of the hospital • what is the name of their consultant?	Yes: refer the person for a mental health assessment. No: record response.
18. Has the person ever been prescribed medicine for any mental health problems? If so: • what was the medicine • when did they receive it • when did they take the last dose • what is the current dose (if they are still taking it) • when did they stop taking it?	Yes: refer the person for a mental health assessment if they have taken medicine for mental health problems. No: record response
Self-harm and suicide risk	

19. Is the person: • feeling hopeless or • currently thinking about or planning to harm themselves or attempt suicide?	Yes: refer the person for an urgent mental health assessment. Open an Assessment, Care in Custody and Teamwork (ACCT) plan if: • there are serious concerns raised in response to questions about self-harm, including thoughts, intentions or plans, or observations (for example, the patient is very withdrawn or agitated) or • the person has a history of previous suicide attempts. Be aware and record details of the impact of the sentence on the person, changes in legal status and first imprisonment, and the nature of the offence (for example, murder, manslaughter, offence against the person and sexual offences). No: record response.
20. Has the person ever tried to harm themselves, and if so: • do they have a history of suicide attempts • was this inside or outside prison • when was the most recent incident • what was the most serious incident?	Yes: refer the person for a mental health assessment if they have ever tried to harm themselves. No: record response.

Appendix 3: Review flowchart



Appendix 4: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			Initial assessment		
1	SCM1	Assessment and management of people with Autism Spectrum Disorder	Autistic Spectrum Disorder often goes unrecognised and undiagnosed for adults in contact with the Criminal Justice System. This then hinders timely access to the appropriate support and treatment.	Adults with Autistic Spectrum Disorder find difficulty accessing diagnostic services in the general population. Within the Criminal Justice System there is a lack of access to specialist practitioners with diagnostic and treatment skills for ASD. People can fall between Mental Health and learning disability services and there is often a time lag of many months before appropriate services can be out in place. This causes difficulties for service users, whose behaviour can deteriorate away from safe routines and for staff who are not able to understand the nature of the behaviours they encounter.	Evidence shows a prevalence rate of 0.6 to 1.2% in the general population under 25 this rises to 15% of under 25 year olds in custody. House of Commons Justice Committee (2016) The treatment of young adults in the criminal justice system
2	SCM2	Key area for quality improvement 5 NICE guidelines for the treatment of schizophrenia are adhered to in prison settings including the prescription of clozapine in treatment resistant psychosis	NICE guidelines for the treatment of schizophrenia are often not fully adhered to in custodial settings. Clozapine if often not available either for initiation of maintenance treatment and prisoners are often located at great distance from their families to establishments that will provide it.	Suboptimal treatment of schizophrenia (i.e. not in line with NICE guidelines) delivers inferior care and outcomes to patients and increased costs for health, social care and criminal justice services.	
3	Headway – the brain injury association	Key area for quality improvement 1 **Better and earlier identification of brain injury**	It is vital that brain injury is identified at the earliest possible opportunity. This includes arresting officers and, crucially, custody sergeants. In addition, as vulnerable adults, brain injury survivors must have immediate access to an appropriate adult.	Brain injury survivors should be considered as vulnerable adults. A brain injury can affect a person's ability to process, understand, and retain information; it can result in impulsivity and inhibition; it can result in an inability to control anger or emotion. Therefore, detention is often inappropriate for brain injury survivors as it can have a significant detrimental effect on their	Studies report high prevalence of brain injury in offending institutions: https://www.t2a.org.uk/wp-content/uploads/2012/10/Repairing-Shattered-Lives_Report.pdf

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			The disability must be put on record and taken into account in court if the case gets this far. We recommend that custody sergeants ask all detainees if they have a brain injury or have recently sustained a head injury. Police officers should also be aware of the signs to look out for, including visible head injuries, and any erratic or bizarre behaviour, slurred speech, or an inability to comprehend instruction.	psychological wellbeing and lead to miscarriages of justice. According to the National Appropriate Adult Network, police data shows only 3% of adults detained get an appropriate adult (AA). Up to 235,000 mentally vulnerable adults are detained or interviewed without an AA: http://www.appropriateadult.org.uk/index.php/policy/vulnerable-adults	
4	SCM2	Key area for quality improvement 1: Proportion of prisoners screened and diagnosed with ADHD	ADHD is common in criminal justice populations and RCT and follow-up evidence from prisons suggests effective treatment can reduce reoffending	There are wide variations in rates of diagnosis and treatment of ADHD in prisons in England and Wales that do not seem based on epidemiology.	
5	UK Adult ADHD Network	All adults in the criminal justice system should be routinely screened for Attention-Deficit/Hyperactivity Disorder (ADHD), and have access to assessment, diagnosis and treatment where indicated.	ADHD is found in 20-30% of adult offenders (Young et al., 2015). Treatment of ADHD has been found to reduce criminal conviction rates by 30-40% (Lichtenstein and Larsson, 2013); and violent offending on release from prison (Chang et al., 2016). A randomised controlled trial of adult prisoners with ADHD found very large effects on reduction of ADHD symptoms including inattentive, hyperactive and impulsive behaviour (Ginsberg and Lindefors, 2012). Following a successful pilot study at HMYOI Isis, Asherson, Young and colleagues are currently conducting a large randomised controlled trial of stimulant medication on symptoms and behavioural problems related to ADHD in young adult prisoners, funded by the	ADHD is a common childhood onset neurodevelopmental disorder that is associated with the development of conduct disorder in children, and antisocial personality disorder, drug use and crime in adults. Treatment of ADHD has been shown to reduce crime and improve long term outcomes. Yet, ADHD is rarely screened for, diagnosed and treatment in the criminal justice system. The outcomes of offenders treated for ADHD is expected to bring about marked reductions in repeated criminal behaviour, greater integration back into society, and improved educational and occupational outcomes. Currently prison mental health services, as well as those involved in the community treatment of mental health problems in	1. CHANG, Z., LICHTENSTEIN, P., LANGSTROM, N., LARSSON, H. & FAZEL, S. (2016). Association Between Prescription of Major Psychotropic Medications and Violent Reoffending After Prison Release. *JAMA,* 316**,** 1798-1807. 2. GINSBERG, Y. & LINDEFORS, N. (2012). Methylphenidate treatment of adult male prison inmates with attention-deficit hyperactivity disorder: randomised double-blind placebo-controlled trial with open-label extension. *Br J Psychiatry,* 200**,** 68-73. 3. LICHTENSTEIN, P. & LARSSON, H. (2013). Medication for attention deficit-hyperactivity disorder and criminality. *N Engl J Med,* 368**,** 776. 4. YOUNG, S., MOSS, D., SEDGWICK, O., FRIDMAN, M. & HODGKINS, P. (2015). A meta-analysis of the prevalence of

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			National Institute of Health Research (NIHR).	offenders **routinely fail** to diagnose and treat this treatable disorder. Diagnosis and treatment of ADHD among offender populations is recommended by NICE guideline 72 for ADHD (NICE 2008)	attention deficit hyperactivity disorder in incarcerated populations. *Psychol Med,* 45**,** 247-258. 5. YOUNG, S. J., ADAMOU, M., BOLEA, B., GUDJONSSON, G., MULLER, U., PITTS, M., THOME, J. & ASHERSON, P. (2011). The identification and management of ADHD offenders within the criminal justice system: a consensus statement from the UK Adult ADHD Network and criminal justice agencies. *BMC Psychiatry,* 11**,** 32. *"All prisoners were offered screening for ADHD through the specialist Concerta (an ADHD treatment) in adult offenders* ***trial…Some prisoners on the programme to whom we spoke were experiencing some stability of behaviour for the first time in their lives."*** *"There should be efforts to ensure the continued prescribing of medication and* ***ongoing specialist support for prisoners started on the CIAO trial following their release****". Her majesty's Inspectorate of Prisons. http://www.imb.org.uk/wp-content/uploads/2015/01/isis-2013.pdf*
6	Royal College of General Practitioners	Additional developmental areas of emergent practice	Screening and dementia awareness for older patients		
7	Royal College of General Practitioners	Key area for quality improvement 1	Measurement and recording of accommodation prior to prison		https://www.qni.org.uk/wp-content/uploads/2016/09/homelessness_criminal_justice.pdf
8	SCM2	Key area for quality improvement 2 Mental health assessments should obtain, evaluate and integrate information	Whilst rates of mental disorder in CJS populations are high, approaching 100% in prisons, assessments are often brief, lack corroborative information and do not detect many conditions (e.g. neurodevelopmental, PTSD)	Thorough assessment and diagnosis is an essential precursor to effective treatment and management.	

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		from a variety of sources as recommended in 1.1.3			
9	Deputy NCD and adult CRG	ii. Involvement and Co-production The involvement of service users in their care is key priority for service development and a recovery based risk partnership model is a key service outcome.	Service-users highlight that continuity and clarity of care and discharge plans is essential with legal, clinical and recovery outcomes being shared, explicit and followed up. Service users also welcome strength-based service models which focus on building resilience and have clearly defined practitioner roles.		
10	Joint NHS/HMPPS (formerly NOMS) Offender Personality Disorder Team	Involvement and co-production	Particularly for those likely to be diagnosed with 'personality disorder'.		
11	Inclusion London	**Key area for quality improvement 2** **Need for reasonable adjustments** 'Reasonable adjustments'/ necessary support for people with mental health support needs and people with learning difficulties as required by the Equality Act 2010 are needed throughout the judicial and prison services to ensure access to justice and	Disabled people including those with mental health support needs and learning difficulties experience a lack of access to justice and a lack of access to prison services due to a lack of reasonable adjustments so are experiencing discriminatory practices.	• Lack of access to justice • - According to the EHRC: There is a lack of compulsory training for members of the judiciary on disabled people's rights to reasonable adjustments and on UN Convention on the Rights of persons with Disabilities "to ensure equal access to justice." • • - Judges (and magistrates) are ignoring detailed guidance laid out in the Equal Treatment Bench Book Equal Treatment Bench Book (ETBB), according to John Horan Human Rights barrister. • • According to the Prison reform trust:	Equality Act reasonable adjustments legislation at: http://www.legislation.gov.uk/ukpga/2010/15/section/20 See EHRC submission to UN at:: https://www.equalityhumanrights.com/en/our-human-rights-work/monitoring-and-promoting-un-treaties/un-convention-rights-persons-disabilities See the ETBB at: https://www.judiciary.gov.uk/publications/equal-treatment-bench-book/ See Barrister John Horam views at: http://www.disabilitynewsservice.com/disabled-people-denied-access-to-justice-by-

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		access to all prison services including education and visits. - Monitoring is needed to ensure appropriate reasonable adjustments /support is being provided. Examples of a reasonable adjustments for a person with mental health support needs: - Some people with mental health support needs feel confused and find it difficult to concentrate and answer questions in the morning so assessments, interviews, court appearances would need to take place in the afternoon. - giving a person longer to answer questions. Examples of reasonable adjustment for a person with learning difficulties could be: -providing Easy read information about court process and prison routines and services.		• - 'Over two-thirds of prisoners have problems filling in prison forms, which rises to three-quarters for those with learning difficulties. Consequently many miss out on things such as family visits and going to the gym getting the wrong things delivered such as canteen goods. • - 20–30% of offenders have learning difficulties, which interfere with their ability to cope with the criminal justice system'.	failure-of-judges-on-reasonable-adjustments/ See data about people with learning difficulties in the Prison Reform Trust's Bromley Briefings available at: http://www.thebromleytrust.org.uk/files/bromleybriefingsautumn2014.pdf http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Autumn%202016%20Factfile.pdf Information about Easy Read is available at: http://www.easy-read-online.co.uk/media/10612/comm%20basic%20guidelines%20for%20people%20who%20commission%20easy%20read%20info.pdf

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		- Explaining information in plain English - Giving a person longer to answer question.			
12	Royal College of General Practitioners	Additional developmental areas of emergent practice	Patient experience		
			Identification and assessment throughout the care pathway		
13	ADPH	Liaison and diversion – mental health support in custody and mental health treatment requirements	90% of prisoners have a diagnosable mental health problem and prison can be avoided in many cases if people are diverted at any early stage.[25]	Liaison and diversion services currently cover police custody suites and courts in areas representing only 68% of the population in England.[26]	Custody: The Centre for Mental Health recommends that a Diversion and Liaison Team for people with mental health problems who come into contact with the criminal justice system should be established in **every** CCG area in England. These teams should be supported by a national statement of policy and associated implementation guidance. Liaison and diversion services should be commissioned to provide an element of indefinite support, in the form of drop-in support focused on averting crises and reconnecting service users with mainstream services where required. Local NHS commissioners need to ensure that offenders have timely access to psychological therapy services with clear referral routes from liaison and diversion services and from probation. (https://www.centreformentalhealth.org.uk/liaison-and-diversion). Mental Health Treatment Requirements: MHTR is a sentencing option which offers offenders with mental health problems the

[25] Centre for Mental Health, 'Liaison and Diversion', available here: https://www.centreformentalhealth.org.uk/liaison-and-diversion
[26] NHS England, 'Five Year Forward View for Mental Health: One Year On', February 2017, available here: https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf

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					option of a treatment plan that addresses the underlying causes of offending. It is intended for the sentencing of offenders convicted of (an) offence(s) and who have a mental health problem which does not require secure in-patient treatment. The Milton Keynes trial is beginning to show evidence of improved mental health and wellbeing, better coping skills and improved criminal justice outcomes (https://www.magistrates-association.org.uk/news/awards-milton-keynes-pilot-project-offenders)
14	Revolving Doors Agency	There should be vigilance that innovations such as court digitalisation and the increasing use of voluntary attendance (in place of police custody) do not undermine the intent of Liaison and Diversion services.	Liaison and diversion services play an important role in ensuring that mental health and related needs are identified early, in custody or in court.	The Ministry of Justice has set out ambitious plans to reform many aspects of the courts and tribunals systems, including the digital access to justice. This may, in some cases, mean that the opportunities to make an in-person assessment are reduced, and that opportunities to identify, put in place support and, where appropriate, to divert, are missed. Likewise, the increasing use of voluntary attendance, whilst welcome, removes police interviewees from custody suites where L&D has been developed.	We have published a policy blog on the government's response to the Transforming Justice consultation which sets out some of our concerns: http://www.revolving-doors.org.uk/blog/transforming-justice
15	Royal College of Psychiatrists	Is there a multi-disciplinary court liaison and diversion service available in Courts, police stations and to probation services, which links in with local primary and secondary care mental health providers.	NHSE are rolling these out across the country. Availability still patchy. C&D services should help identify mental health need at an earlier stage and help prevent recidivism.	?what evidence exists for benefits of CLD.	

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16	Royal College of Psychiatrists	Initial assessment at reception – numbers of people referred for mental health assessment following initial reception assessment.	?Evidence that delays in recognising mental health problems in prison can lead to lack of treatment, worse outcomes, particularly with respect to longer lengths of illness and increased risk to self and others.	?what evidence exists around reception assessment?	
17	Inclusion London	**Key area for quality improvement 1** **Identification and support** - Health assessments of offenders by a health professional are vital on entry to prison to ensure that mental health support needs are identified and the necessary support given. - Offenders should have regular assessments during their sentence. - Health assessments should be comprehensive to ensure other impairments such as learning difficulties are identified. - The appropriate support/reasonable adjustments needed should be identified in the assessment. This Key area is linked to the one	Offenders with mental health support needs and learning difficulties (or other impairments) are not being identified so the appropriate support is not being provided. Approximately 70% of sentenced prisoners have mental health support needs., with about 60% are likely to have a personality disorder. The percentage of people with learning difficulties in the criminal justice system is about 30%, so many offenders are likely to have both a mental health support need and a learning difficulty.	-According to the Prison Reform Trust nearly one in five of those diagnosed with a mental health problem received no care from a mental health professional in prison. - No mental health referral was made when it should have been in 29% of self-inflicted deaths where mental health needs had already been identified. • -Criminal Justice Joint Inspectors (CJJI) 2015 report says: “In the prisons we visited we were alarmed that there were extremely poor systems for identifying prisoners with learning disabilities”; Also that: “little thought was given to the need to adapt regimes to meet the needs of prisoners with learning disabilities who may find understanding and following prison routines very difficult.”	Please see data on offenders with mental health support needs at: http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth/TroubledInside/QATheBradleyReport http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth http://www.ppo.gov.uk/wp-content/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf Pls see data re number of offenders with learning difficulties at: http://www.hmic.gov.uk/news/news-feed/offenders-with-learning-disabilities/ Please see data re lack of care or referrals of people with mental health support needs at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Autumn%202016%20Factfile.pdf http://www.ppo.gov.uk/wp-content/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf See CJJI report at: http://cdn.basw.co.uk/upload/basw_15142-7.pdf

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		below on reasonable adjustments			
18	SCM3	Key area for quality improvement 1 Ensuring that a thorough assessment of need and mental health need is done by appropriate staff and in an appropriate and safe area on reception into prison	The first 24 hours in prison are a time of high stress and increased risk	To ensure continuity of any treatment being taken in the community prior to reception into prison. To communicate concern for the prisoner. To identify any key individuals (eg other professionals or family members) with whom it might be important to liaise.	
19	Royal College of Psychiatrists	There should be access to mental health practitioners competent in assessing the mental health needs of those in contact with the CJS and either competent in providing suitable mental health care or signposting and referring to the appropriate service.	?evidence of increased self-harm and suicide over past years, related to absence of sufficient mental health service availability.	?What evidence exists	Fazel et al 2011 found that rates of prison suicide did not reflect general population rates and suggested that they were more likely to be related to CJS factors such as availability of prison psychiatric services.
20	Royal College of Psychiatrists	There should be a NICE-compliant management plan encompassing overall care and risk management, developed with and disseminated to all interested parties – evidenced by sign off from individual, involved carers,	Level of mental health input in prison should match that provided in the community, with expectation of a comprehensive care plan which includes a risk assessment and management plan, which would aid communication between different teams within the prison and allow better continuity and follow up outside prison. Recommended by NICE.	?what evidence exists	

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		mental health team and CJS team.			
21	Cambridgeshire Constabulary	improving pathways for people with dual diagnosis			
22	Public Health England	**Dealing with co-morbidities** – alcohol, substance misuse, tobacco dependence and general physical health issues	Many individuals in contact with the CJS have co-existing needs, most commonly mental health and substance misuse. Delivering integrated care can reduce incidences of individuals falling through gaps in services and provide improved consistency of treatment approach to those who are hard to engage. There is an increased vulnerability with people who have used drugs and alcohol to manage their feelings, there is high risk behaviour in not caring whether they live or die, and often the non-compliance with prison rules is seen and not the underlying MH issues. People with mental health issues experience higher premature mortality and this is known to be attributable to the higher prevalence of various physical health conditions among people with mental health problems. These include heart disease, stroke, liver and respiratory diseases, and cancer. In many cases a strong interaction between mental and physical health conditions is the outcome of 'modifiable risk factors'. In particular, those with mental health problems are substantially more likely to smoke, abuse alcohol, have an unhealthy diet and remain physically inactive. Smoking is more prevalent among those with mental health problems in the general population. There is a relationship between offending and having mental health problems which		

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			results in higher smoking prevalence in this population		
23	Revolving Doors Agency	Ensuring that mental health healthcare needs in prison are met, and are adequately coordinated with other services such as substance misuse and resettlement. This includes ensuring that appropriate mental health beds are available in hospital settings to accept prisoners who need them.	There is a substantial degree of unmet needs relating to mental ill health among the prison population.	There is evidence that mental health need is highly prevalent among the prison population, and that this need may not be fully met. Expert opinion and user experience suggests that, while some prisons have made progress in coordination and collaboration, health and social support services in prison are often poorly connected.	Our report Rebalancing Act contains an overview of prevalence of need in various settings, including prison, probation and community: http://www.revolving-doors.org.uk/blog/rebalancing-act HM Inspector of Prisons has highlighted the level of unmet need found during inspections: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/07/HMIP-AR_2015-16_web.pdf A 2002 study of the prevalence of comorbidity of mental ill health and substance misuse among users of community services found that comorbidity was the norm rather than the exception. It would be reasonable to assume that levels of comorbidity among the prison population would be substantially higher, given that prevalence of substance misuse and most forms of mental ill health is markedly higher: http://s3.amazonaws.com/academia.edu.documents/42560918/304.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1496063908&Signature=7a5TPzu%2Fhh3Pn1r9iNXUH96410A%3D&response-content-disposition=inline%3B%20filename%3DCo-morbidity_of_substance_misuse_and_men.pdf
24	Royal College of Nursing	Key area for quality improvement 2 **Improving physical health of prisoners and those who**	There is breadth of evidence to suggest that people with mental have a higher mortality rate. It is essential that people in prisons and/or come in contact with the	People with mental health problems are the most likely to suffer from at least two or more health conditions (DH 2013).	Department of Health - Living Well for Longer: A call to action to reduce avoidable premature mortality: https://www.gov.uk/government/publication

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		come into contact with criminal justice system who have mental health issues	criminal justice systems get the same healthcare and treatment as anyone else. People need to have availability to healthcare resources and staff with the right training to meet their health care needs.	Mental does not have parity of care as physical health. The Prison Reform Trust has the following statistics: "10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%. 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder. 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide."	s/living-well-for-longer-a-call-to-action-to-reduce-avoidable-premature-mortality Pulmonary Rehabilitation in prisons A guide to setting up and delivering a pulmonary rehabilitation programme in prisons - http://oxleas.nhs.uk/long-term-conditions/chronic-obstructive-pulmona-1/pulmonary-rehabilitation-prisons/
			Risk assessment and management, and care planning		
25	SCM4	Risk Assessment and Management	Accurate risk assessment and management is key to developing timely interventions for service users.	Addressing risk is relevant at any point in the pathway and risk shifts, again at any point in the pathway. It is essential that risk is considered for the service users and others.	https://www.nice.org.uk/guidance/indevelopment/gid-qs10022/documents

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26	Deputy NCD and adult CRG	v. Integrated Information Sharing	Agreement/protocols to enable Information to be shared between Criminal Justice and Health. There is incomplete sharing of information in both directions, from the CJS to health and social care and particularly vice versa. A legislative framework such as that in place for MAPPA could enable wider sharing of information where forensic and mental health issues overlap and have a bearing on each other. Staff are unsure what they can and cannot do, and often default to not sharing information which can have a negative impact on service users, and contribute to serious further offences. Service Users highlight poor involvement and clarity of roles between mental health teams and the CJS/ offender managers particularly prior to discharge, which at times can result in unhelpful therapeutic management post discharge with little recognition of their mental health needs or the restrictions applicable to their discharge. There is also a need to engage with third sector providers to promote effective transition into the community. The information sharing needs to be integrated, transparent with clear governance for staff. b) Are there any relevant national audits or reports highlighting current practice that you think it would be helpful for the committee to be made aware of?		https://www.jcpmh.info/wp-content/uploads/jcpmh-bme-guide.pdf

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			Offender Personality Disorder Service Evaluations: The main evaluation of the OPD pathway will report mid 2018; it is examining the provision of a network of services, largely delivered through the CJS to the cohort of offenders who have complex interpersonal and psychological issues (and who might satisfy the criteria to be diagnosed as 'personality disordered'). There are several service evaluations which show positive findings, but these are small scale with limited power, and no controls. The current OPD strategy is attached, as is the current Enabling Environments framework, and a set of slides showing the evidence base for the OPD pathway drawn from across the CJS and mental health. c) Is there anything else happening in the topic area which you think may be of interest to the committee? Standards for the Offender Personality Disorder Pathway: As stated above, joint responsibility between the CJS and Health for the high risk offender group with likely 'personality disorder', calls for a set of standards that the CJS, health and community social care can sign up to; generic mental health standards are helpful but do not necessarily provide an holistic framework. The OPD pathway is currently developing its own standards which draw on both health and criminal justice evidence base. In addition, advice from practitioners suggests that generic mental health standards only go so far when thinking about integrated teams		

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			with many elements and significant multidisciplinary input, with different governance structures and lines of accountability. Use of Enabling Environments Framework (RCPsych) or equivalent will be particularly useful for this client group who have multiple problems including significant interpersonal issues. The EE framework is being widely adopted across prisons and probation approved premises, where there appears to be an impact on behaviour in the secure setting – it is unlikely that this on its own would ameliorate mental health problems and reduce risk of harm, but it should be seen as a basic requirement of any environment that uses psychological and / or interpersonal relationships as a method of treatment. Guidance for commissioners of Mental Health services from Black and minority ethnic communities: Provides useful practice guidance to address specific issues.		
27	SCM4	Organisation of services	Services need to be more responsive to the complex needs of service users.	Significantly services continue to work in silos and are often process driven, there needs to be a more fluid approach to supporting service users in identifying and prioritising collaboratively their needs.	Chapter 7 Health and Justice Objectives 2020/21 https://www.england.nhs.uk/mental-health/taskforce/imp/ https://www.england.nhs.uk/commissioning/health-just/#justice
28	SCM1	Managing the transition between CAMHS and Adult mental health services	To ensure services are available to young people transitioning between systems in order that gains from care and treatment remain.	Transition between young peoples and adult services has been recognised as a point where people can be lost to services. Gains in treatment made as a young person can be lost as adult teams operate different referral criteria and ways of working. This can result in delaying care and treatment resulting in	There is a strong case for a distinct approach to the treatment of young adults in the criminal justice system. Young adults are still developing neurologically up to the age of 25 and have a high prevalence of atypical brain development. Flawed interventions that do not recognise young

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				increased risk of suicide and relapse for young adults	adults' maturity can slow desistance and extend the period of involvement in the system. House of Commons Justice Committee (2016) The treatment of young adults in the criminal justice system
29	Cambridgeshire and Peterborough NHS Foundation Trust		Review the current documentation being used within the transition process from child to adult mental health services, and ensure all staff are competent to deliver care within the transition process including the development of Education, Health and Care Plans.		
30	Cambridgeshire Constabulary	better / clearer framework to share clinical information with non-clinical agencies such as police			
31	Royal College of General Practitioners	Key area for quality improvement 3	Measurement and recording of number of people seeing primary care for CMHPs		https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=59e8d013-dad3-48af-842d-a509de7723c1
32	Royal College of General Practitioners	Key area for quality improvement 4	Measurement of referral and waiting times for IAPT/ psychological therapy and specialist mental health services		Parity with services outside of prison
33	Royal College of General Practitioners	Key area for quality improvement 5	Movement to recovery with IAPT/ psychological therapy		Parity with services outside of prison
34	Royal College of Psychiatrists	Numbers of people referred to mental health services by community CJS services (probation).	Key area where mental health problems could be identified, particularly those related to recidivism. Not sure how effective the links are between mental health services and probation services. These need to be improved. Forensic outreach services (as suggested in NHSE service specifications for MSU/LSU pathways may be the way forward.	This would help to measure need and may help with prevention. People in contact with probation services likely to have high level of mental health need, in common with others in contact with CJS in other settings. Regular contact with a particular individual by probation provides a good opportunity for linking in with mental health services.	

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35	SCM2	Key area for quality improvement 3 The management of self-harm and suicide risk should be in line with NICE guidelines for short-term and long-term management of self-harm – 1.4.5	Rates of self-harm and suicide have increased dramatically over the prison estate. Much effort is put into responding to crises but longer-term interventions tend to be neglected.	Repetitive DSH is often associated with underlying disorders especially emotionally unstable personality disorder and complex trauma. Interventions for these are available and should be delivered as part of the long-term management of DSH and identified as part of short term management	
36	SCM1	Practitioner skills in risk assessment and management of suicidality	To lessen the increasing upward trend in the suicide of prisoners within the England and Wales Prison estate	A recent increase in suicides in custody. Practitioners need to remain skilled in the process of risk assessment and management in order to provide meaningful interventions which support people and ultimately reduce the risk of suicide within custodial settings	NHS England have clearly identified that there is a significant increased risk of suicide for men and women within custodial settings NHS England (2016) Strategic Direction for Health Services in the justice system: 2016-2020
37	ADPH	Mental health support for people when they leave prison	Prisoners have higher levels of mental health needs than the general population. Latest figures indicate that 49% of women and 23% of men in prison are identified as suffering from both anxiety and depression compared to 15% of the general population.[27] Research has indicated that ex-prisoners with common mental health problems are more likely to commit violent offences after their release.[28]	Leaving prison is problematic for those with mental health problems with little continuity of care. The Centre for Mental Health has found that release is an 'overwhelming' time for prisoners and says more needs to be done to help prisoners transition. The risk of suicide in released prisoners is 6.76 times that of the general population.[29]	Follow the Through the Gate model – more information available here: https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiSyv7IkIbUAhWMPRQKHc0LDpMQFggtMAA&url=http%3A%2F%2Fsite.stgilestrust.org.uk%2Fproject%2Fuploads%2Fuser_files%2Ffiles%2FEvaluation%2520into%2520Through%2520the%2520gates%2520full%2520report.ppt&usg=AFQjCNHAXb83KPEZx2gQ97vUIod0_ID4GQ&cad=rja Evidence that is being collected from projects like Engager: https://www.plymouth.ac.uk/research/primarycare/engager
38	Cambridgeshire Constabulary	better use and framework for discharge plans / care			

[27] Prison Reform Trust, 'Self-harm and suicide rising as prisons struggle to meet mental health need', May 2017, available here: http://www.prisonreformtrust.org.uk/PressPolicy/News/vw/1/ItemID/435
[28] http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(15)00234-5/abstract
[29] Jones D and Maynard A. Suicide in recently released prisoners: a systematic review. 2013. *Mental Health Practice.* 17, 3, 20-27.

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		plan approach, particularly when releasing from prison			
39	SCM1	Mental Health Liaison and support for people leaving prison	Improve engagement with community services to lessen the risk of suicide, harm to others and relapse on return to the community	People with mental health problems are at increased risk of suicide following release from prison. Community based mental health services are slow to react to managing immediate needs of this group resulting in missed opportunities to intervene. This can lead to increases in offending, suicide and relapse before services react to the situation	NHS England have clearly identified that there is a significant increased risk of suicide for men and women supervised by probation services in the community NHS England (2016) Strategic Direction for Health Services in the justice system: 2016-2020
40	SCM5	Discharge planning on release from prison	Critical time for mental health, addiction related problems and risk of reoffending	No currently agreed standard and practice highly variable	
41	Royal College of General Practitioners	Key area for quality improvement 2	Discharge planning to include number of people with care plan, number of people registered with GP, number of people whose GP has received care plan		http://www.rcpsych.ac.uk/pdf/Standards%20for%20Prison%20Mental%20Health%20Services%20Publicationhome.pdf
42	Public Health England	**Integrated Care Pathway approach** – pre custody, in custody and post custody, supported by information sharing protocols at key points of transition across the CJS (Criminal Justice System).	Continuity of care across the CJS is of paramount importance, as it is in the community, to ensure people receive the care they require, in the most appropriate place. And they receive on going care and support from the community post custody Information sharing protocols will reduce or eliminate multiple assessments and reviews; build a full picture of risk and harm associated with the individual's mental health; ensure all appropriate interventions are explored to improve mental health in the most appropriate setting; and reduce sending individuals to prison for treatment due to a lack of knowledge of other treatment options.		
43	Deputy NCD and adult CRG	i. A Specialist Service Pathway	Services/teams which can formulate and address both the forensic and mental		

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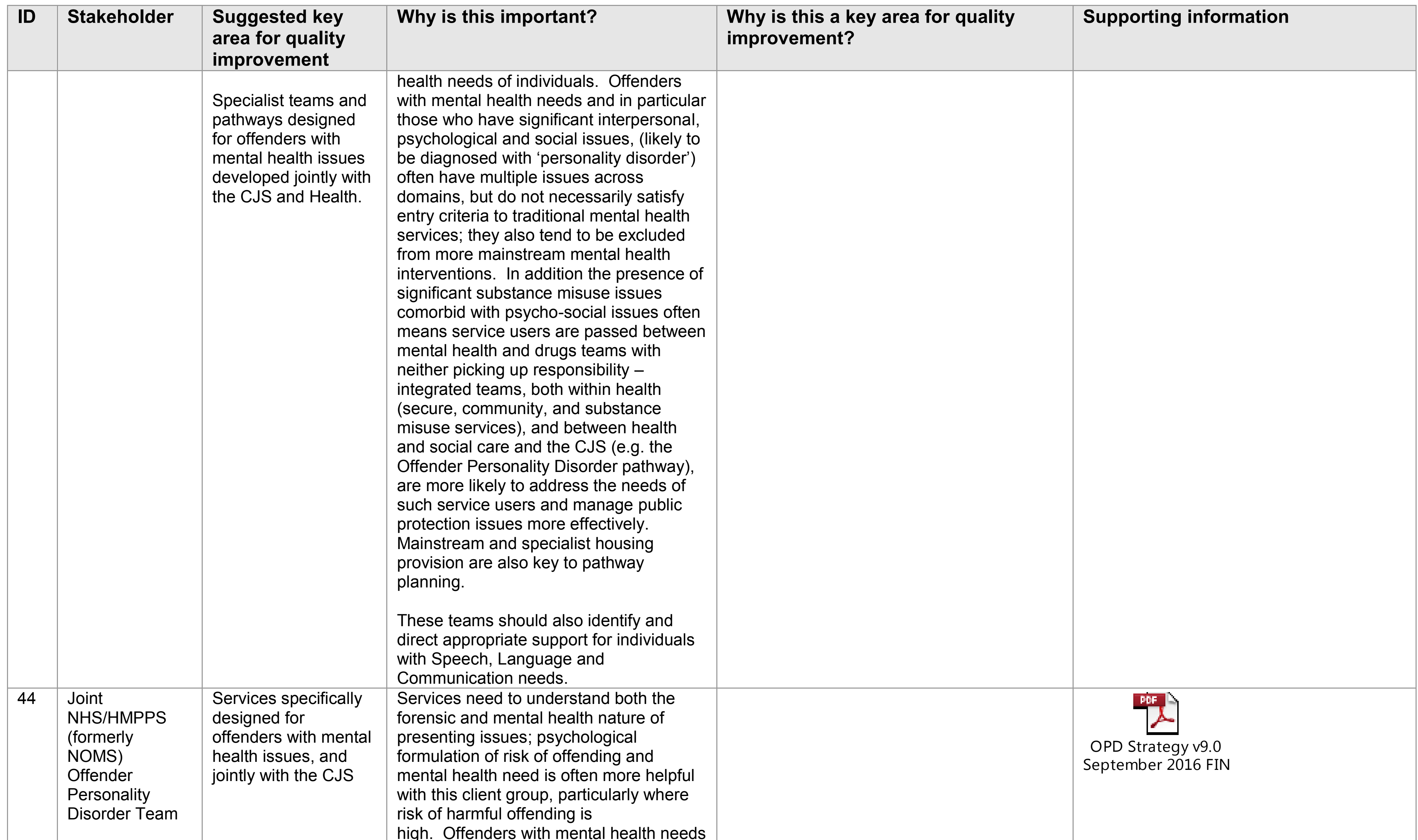
		Specialist teams and pathways designed for offenders with mental health issues developed jointly with the CJS and Health.	health needs of individuals. Offenders with mental health needs and in particular those who have significant interpersonal, psychological and social issues, (likely to be diagnosed with 'personality disorder') often have multiple issues across domains, but do not necessarily satisfy entry criteria to traditional mental health services; they also tend to be excluded from more mainstream mental health interventions. In addition the presence of significant substance misuse issues comorbid with psycho-social issues often means service users are passed between mental health and drugs teams with neither picking up responsibility – integrated teams, both within health (secure, community, and substance misuse services), and between health and social care and the CJS (e.g. the Offender Personality Disorder pathway), are more likely to address the needs of such service users and manage public protection issues more effectively. Mainstream and specialist housing provision are also key to pathway planning. These teams should also identify and direct appropriate support for individuals with Speech, Language and Communication needs.		
44	Joint NHS/HMPPS (formerly NOMS) Offender Personality Disorder Team	Services specifically designed for offenders with mental health issues, and jointly with the CJS	Services need to understand both the forensic and mental health nature of presenting issues; psychological formulation of risk of offending and mental health need is often more helpful with this client group, particularly where risk of harmful offending is high. Offenders with mental health needs		 OPD Strategy v9.0 September 2016 FIN

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			and in particular those who have significant interpersonal, psychological and social issues (likely to be diagnosed with 'personality disorder') often have multiple issues across domains, but do not necessarily satisfy entry criteria to traditional mental health services; they also tend to be excluded from more mainstream mental health interventions. In addition the presence of significant substance misuse issues comorbid with psycho-social issues often means service users are passed between mental health and drugs teams with neither picking up responsibility – integrated teams, both within health (secure, community, and substance misuse services), and between health and the CJS (eg the Offender Personality Disorder pathway), are more likely to address the needs of such service users AND manage public protection issues more effectively.		
45	SCM5	Organisation and delivery of MH services	Multiagency working crucial to achieve optimal societal and individual benefit	Highly variable structures and variably effective relationships. MAPPA variably well done. Variable quality relationships NOMS/police/health/housing /LA	
46	SCM5	Additional developmental areas of emergent practice	What is the latest on street triage?		
47	SCM3	Key area for quality improvement 5 Support the development of liaison and diversion services	To avoid inappropriate imprisonment by diversion to MH provision. Ensure that appropriate and continuous care is given during transitions between services	Ensure appropriate and timely diversion from the CJS and into more appropriate services.	
48	Revolving Doors Agency	Pick-up between prison-based mental	There is a substantial degree of unmet needs relating to mental ill health both in	Expert opinion suggests that pick-up between prison and community drug treatment is likely to be higher than for other	PHE statistics record the pick-up rate between prison and community substance misuse treatment service. Discussion with

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		health services and community services	the community, and among those in contact with the criminal justice system There is evidence that suggests that there is a significantly higher excess mortality rate faced by people on release from prison, including, for around 70 times higher for women, compared to around 30 for males. For women, almost all of this elevated rate can be accounted for by drug related deaths; for men, most of it can.	services, and the rate for that, nationally, is only 30.3%. Significant variation between and within English regions suggests that good practice can substantially increase this number, and that ineffective practice can reduce it. Non-engagement with, or ineffective use of, services poses avoidable risks and costs.	key stakeholder suggests that effective practice can increase the pick-up rate beyond the headline national and regional rates: http://www.nta.nhs.uk/uploads/secure-setting-statistics-from-the-national-drug-treatment-monitoring-system-2015-2016.pdf A joint report by HM Inspectorates of Prisons and Probation highlighted the importance of making links with and referring to existing community provision upon release from prison: https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2016/09/Through-the-Gate.pdf Rebalancing Act contains further detail about the excess mortality rate faced by people on release from prison.
49	Royal College of Nursing	Key area for quality improvement 1 Service structures and delivery: Waiting times - transfer between prison and secure setting	NICE guidelines state that commissioners and providers of criminal justice services and healthcare services should ensure effective identification, assessment, coordination and delivery of care for all people with a mental health problem in contact with the criminal justice system. We find that there is often long waiting times prior to the transfer of people between prisons and secure setting, leading to delays is people receiving appropriate intervention to support recovery.	The transfer between prisons and secure settings waiting times continues to be an issue, there is a potential and an opportunity to commission mental health units within prisons where practicable to drive down waiting times and improve therapeutic intervention and recovery.	NICE NG66 - Mental health of adults in contact with the criminal justice system https://www.nice.org.uk/guidance/ng66/chapter/Recommendations#organisation-of-services
			Psychological interventions		
50	SCM5	Therapeutic communities for substance misuse in prison	Good evidence (relatively) for outcomes following this provision	Current models of service provision have poor evidence to support them	

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51	Royal College of Psychiatrists	There should be NICE-compliant psychological treatment available, delivered by competent staff who have time protected to allow them to deliver the therapy.	Recommended by NICE.	?what evidence exists	
52	SCM3	Key area for quality improvement 3 Staff awareness of the issues associated with personality disorder and approaches and interventions adapted with this in mind	To facilitate rehabilitation activity in prison and reduce levels of conflict	High rates of childhood adversity are present in prisoner populations which are likely to lead to significant social and psychological difficulties associated with a diagnosis of PD. Prevalence rates of around 60% are frequently cited for prisoner populations (Coid et al).	
53	SCM2	Key area for quality improvement 4 People with personality disorder are not excluded from and interventions for comorbid disorders as a result of their PD diagnosis1.6.6	Personality disorder is very common in criminal justice settings as is comorbidity with other disorders. Interventions need to be delivered to patients with comorbid PD	Psychological interventions are evidence based, supported by NICE guidelines and should be widely available (delivered as advised in NG66)	
			Staff training		
54	Cambridgeshire Constabulary	training of key non-clinical professionals in terms of initial risk assessments in custody and also in the areas of personality disorders and dual diagnosis			
55	Cambridgeshire and Peterborough		We will ‘develop comprehensive training and development opportunities for staff at all levels; both to continually enrich the		

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	NHS Foundation Trust		skill-base of staff and to improve recruitment and retention as a result of this commitment.'		
56	Cambridgeshire and Peterborough NHS Foundation Trust		Improving quality by looking at systems currently in place within integrated services for staff to feel safe to deliver services in non-CPFT premises.		
57	Cambridgeshire and Peterborough NHS Foundation Trust		Promotion of the Dual Diagnosis Strategy to encourage integrated working between CPFT and third sector organisations		
58	SCM4	Staff training	It is essential those staff in contact with service users at any point of the care pathway are skilled in recognising and positively responding to individuals with mental health issues. Basic fundamental training is essential for all.	Consistency in basic training needs to be achieved to maintain positive engagement at any point of contact on the pathway with service users. Currently training is varied for police, prison, court, clinical staff and other professionals within the criminal justice pathway.	
59	Deputy NCD and adult CRG	iii. Specialist Training of Staff in Generic and Specialist Approaches Especially Trauma Informed Care Principles.	There should be clear guidelines in relation to staff training to identify and deliver mental health care. For example: The Knowledge and Understanding Framework is a set of training materials specifically developed (and co-produced in training), to help staff understand and better manage complex and difficult behaviour. It helps staff see that their responses can sometimes exacerbate situations, and helps them to remain resilient in the face of difficult and risky behaviour. This coupled with reflective supervision and access to psychologically informed supervision and consultation, has been shown to improve confidence and competence in probation officers as part		

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			of the Offender Personality disorder pathway. Training in Recovery models and basic functional assessments of behaviours which challenge the system and the inappropriateness of punishment models in response to behaviours resulting from mental health or trauma difficulties would be key components. In addition, awareness raising and development of skills of staff to maximise their ability to understand the impact of their own interactions on service users and work effectively with service users with speech language and communication needs is also required. With regards to training, evidence-based, flexible academic masters programmes and higher degrees in forensic mental health to support expertise and innovation in this area, to cover such topics as: • A systematic and integrated knowledge of mental disorder and how it relates to offending behaviour • A comprehensive understanding of the law and how it is applied to forensic mental health services • Advanced clinical skills in mental state assessment, risk assessment, formulation and management • Research skills • Advanced clinical skills in offence analysis, sex offender assessment and intervention, and personality disorder assessment and intervention		

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60	Joint NHS/HMPPS (formerly NOMS) Offender Personality Disorder Team	Improving the confidence and competence of frontline staff	The Knowledge and Understanding Framework is a set of training materials specifically developed (and co-produced in training), to help staff understand and better manage complex and difficult behaviour. It helps staff see that their responses can sometimes exacerbate situations, and helps them to remain resilient in the face of difficult and risky behaviour. This coupled with reflective supervision and access to psychologically informed supervision and consultation, has been shown to improve confidence and competence in probation officers as part of the Offender Personality Disorder pathway.		
61	Joint NHS/HMPPS (formerly NOMS) Offender Personality Disorder Team	Information sharing	A national agreement to enable information sharing between criminal justice and health would be very welcome; often there is incomplete sharing of information in both directions, from the CJS to health and particularly vice versa. A legislative framework such as that in place for MAPPA could enable wider sharing of information where forensic and mental health issues overlap and have a bearing on each other. Staff are unsure what they can and cannot do, and often default to not sharing information which can have a negative impact on service users, and contribute to serious further offences.		
62	Public Health England	**Multidisciplinary Training**	Given the high levels of mental health issues, particularly depression and anxiety, it is important that staff (law enforcement, custodial as well as healthcare) should receive training on mental health- a ‘core’ offer supplemented by more advanced modules according to the level of contact,		

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			care and supervision they exercise in their roles. This should, where possible, include multi-disciplinary training to improve co-ordination across services and continuity of care. This would assist with early identification, assessment and treatment of existing and emerging mental health issues, including low level issues e.g. depression and anxiety, and should include the use of trauma informed approaches		
63	Royal College of Nursing	Key area for quality improvement 3 **Staff training**	NICE guidelines recommends that multidisciplinary and multi-agency training should be provided both as part of both induction training and continuing professional development to staff to increase consistency, understanding of ways of working, and promotion of positive working relationships for all staff who work in the criminal justice system.	Our members have indicated that the quality of training for staff in prisons and secure settings is not consistent. We have been told that currently there is a lack of available quality courses that teach staff the skills required to deliver and develop group work within secure settings.	NICE NG66 - Mental health of adults in contact with the criminal justice system https://www.nice.org.uk/guidance/ng66/chapter/Recommendations#organisation-of-services
64	Royal College of General Practitioners	Additional developmental areas of emergent practice	Number of primary care staff who have received mental health training Number of healthcare staff who have received suicide prevention training People with SMI under care of MHT who have received physical health check		
65	SCM3	Key area for quality improvement 4 Induction and training for all staff	Likely to have a direct impact on the quality of the environment, enable early identification of mental health and risk issues, improve the impact of any care and interventions.	To minimise harm from the experience of imprisonment, maximise the opportunity for a positive relational environment to develop.	Alison Lieblings work on extremism in prisons and the importance of good relationships between staff and prisoners.
66	Royal College of Psychiatrists	Availability of a training programme specifically around mental health awareness and improving recognition of mental health	Evidence that prison staff may have minimal understanding of mental health conditions, which might delay referral to mental health in-reach teams.	?what evidence exists around impact of lack of knowledge/skills in discipline staff?	

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		problems and providing basic understanding of mental health services for discipline staff.			
			Additional areas		
67	NHS Improvement Patient Safety Team	Ensuring the QS development group is mindful of potential for safety risk related to restrictive interventions/manual restraint	We appreciate the QS group is already mindful of the risks of asphyxia, collapse etc. during restraint or seclusion used on adults with MH needs in contact with the criminal justice system.	We would like to point out the relative under-recognition of the persistence of this risk in the time subsequent to restraint, and the importance of physiological as well as visual observation highlighted in an NHS England Alert	The importance of checking vital signs during and after restrictive interventions/manual restraint NHS England, December 2015 https://improvement.nhs.uk/news-alerts/importance-checking-vital-signs-during-and-after-restrictive-interventionsmanual-restraint/
68	SCM5	Completion of 7 day assessment after detention in prison	Allows early identification of most relevant health problems in very disadvantaged population	Currently an areas of practice inconsistently adhered to, with variable uptake of assessment, and lack of adherence to any identified standard	
69	SCM3	Key area for quality improvement 2 Second stage, more thorough assessment within 7 days of reception.	To identify any pre-existing and/or current mental health issues that need to be further assessed or managed during sentence.	To ensure that risks are managed and appropriate care is given throughout sentence.	
70	Action on Smoking and Health (ASH)	**Key area for quality improvement 1** In September 2015, the Prisons Minister announced the intention for prisons in Wales to become fully smokefree with this policy then being rolled out in prisons across England.[1] The quality standard needs to acknowledge the	It is estimated that 60% of arrestees smoke[3] with smoking rates in prisons standing at approximately 80%.[4,5] Among people with a mental health condition the smoking rate is approximately 40.5%,[6] and people with a mental health condition tend to smoke more heavily meaning they are more addicted to nicotine.[7] This means that management of nicotine withdrawal will be essential for individuals who are detained, as up to 80% of whom suffer from a mental health condition.	The NICE Guidance published in March 2017 does not include smoking status within the 'Questions for first-stage prison health assessment'. Given the moves towards implementing smokefree policies it is likely that individual institutions are asking these questions on an ad hoc basis so it is unfortunate that the NICE Guidance does not provide advice on the best way to do this. In quitting smoking, someone does not only reduce their risk of premature morbidity and mortality but can improve their mental health. Smoking cessation has been shown to	1 Ministry of Justice, Smoking in prisons, September 2015 2 ASH, PHE, NCSCT. Joint Briefing: Managing nicotine withdrawal within police custody. April 2016 3 Payne-James JJ, Green PG, Green N, McLachlan GMC, Munro MHW M & Moore TCB. Healthcare issues of detainees in police custody in London, UK. Journal of Forensic and Legal Medicine. 2010. 4 Singleton N, Farrell M & Meltzer H. Substance Misuse among Prisoners in England and Wales. London: Office for National Statistics. 1999 5 Public Health England (PHE). Survey of local prisons. Unpublished, 2014. 6 Public Health England Local Tobacco Control Profiles. Original data from the Health and Social Care Information Centre:

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		progress the Prison Estate is making towards being smokefree, with prisons in Wales and South West England having adopted smokefree policies. Police custody is already a smokefree environment and ASH has worked with Public Health England and the National Centre for Smoking Cessation and Training to develop a briefing on dealing with nicotine withdrawal in police custody.[2]	Once in the body nicotine is broken down quickly meaning that smokers can start to experience withdrawal symptoms within 30 minutes of their last cigarette.[8] The withdrawal symptoms experienced by smokers can be extreme and exacerbated by stressful situations in which they know they cannot smoke.[9] Contact with the criminal justice system can be stressful and maybe especially so for someone with a mental health condition. Therefore, treatment of nicotine addiction is very important in caring for the mental health of adults in contact with the criminal justice system.	reduce levels of stress and depression while improving overall positive mood.[10] Further, evidence shows that quitting smoking can reduce the necessary dose of some anti-psychotic medicines**Error! Bookmark not defined.** thereby reducing any side-effects from these medicines and saving money for institutions supplying this medication. The Guidance and topic engagement discuss the important interactions between mental and physical health, and need to treat both sensitively. However, the absence of any guidance around treating nicotine withdrawal for smokers is a serious omission, in terms of treating both mental and physical health which should be addressed within the Guidance and quality standard.	Smoking rates in people with serious mental illness. (By Clinical Commissioning Group) (Dataset 1.23) 7 Royal College of Physicians and Royal College of Psychiatrists, Smoking and Mental Health, March 2013 8 Hendricks, PS, Ditre JW, Drobes DJ, Brandon TH, The early time course of smoking withdrawal effects. Psychopharmacology, 2006;187(3). 9 Faculty of Forensic and Legal Medicine. Nicotine-dependent detainees in police custody, 2014. 10 Taylor G et al. Change in mental health after smoking cessation: systematic review and meta-analysis, BMJ 2014; 348: g1151.
71	ADPH	Wider determinants – housing	A lack of safe and appropriate accommodation on release increases the risk of reoffending and would be likely to exacerbate existing mental health problems.	A 2014 MOJ report found that one in five prisoners surveyed had no accommodation to go to upon release and 15% reported being homeless shortly after release.[30] The Prison Reform Trust has drawn particular attention to this issue in relation to women's house – 60% of women prisoners may not have homes to go to on release.[31]	Housing First model: http://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2017/03/CSJJ5157_Homelessness_report_070317_WEB.pdf
72	Cambridgeshire Constabulary	social care involvement for CPAs and MDTs, particulary in relation to housing people released from prison			

[30] Ministry of Justice (MOJ), Prisoners' experience of prison and outcomes on release: Waves 2 and 3 of SPCR,London: MOJ, 2014.
[31] Prison Reform Trust, 'Home truths: housing for women in the criminal justice system', September 2016, available here: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Home%20Truths.pdf

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73	Headway – the brain injury association	Key area for quality improvement 2 **Specialist support for probationers with brain injury**	We recommend that research is carried out to identify how many community-based criminal justice services provide interventions tailored to the needs of someone with a brain injury, and that provision is made to ensure services do provide such appropriate interventions.	Without this support a brain injury survivor is less likely to pass their probation and may not receive appropriate support within the criminal justice system. Without appropriate support, they may also fall into a self-sustaining cycle of their brain injury increasing risky/unlawful behaviour, and such behaviour leading to a risk of further injuries to the brain.	
74	Headway – the brain injury association	Key area for quality improvement 3 **Better training in the understanding of acquired brain injury**	Training and guidance must be given for all police officers and custody sergeants to help them identify brain injury. Any training in brain injury must be distinct from training in mental health and other cognitive disorders as although brain injury can cause mental health problems, they are separate conditions and it is vital that these are not confused.	Brain injury is a complex condition. Often, there will be no physical manifestation of the injury, but yet the individual may have cognitive difficulties (information processing, memory, impaired reasoning), physical issues (difficulties with speech, epilepsy, one-sided weakness), or behavioural challenges (disinhibition, impulsiveness, irritability or aggression. It is vital these effects are identified and recognised as manifesting from the brain injury.	More information on the distinction between mental health and brain injury is available in the Headway factsheet *Mental health and brain injury*, available at www.headway.org.uk/media/4051/mental-health-and-brain-injury-factsheet.pdf More information on the common effects of brain injury is available on the Headway website at www.headway.org.uk/about-brain-injury/individuals/effects-of-brain-injury For information on training available from Headway, visit https://www.headway.org.uk/about-brain-injury/professionals/training/
75	Headway – the brain injury association	Key area for quality improvement 4 **Promotion and awareness of tools to assist in the identification of brain injury survivors**	More needs to be done to promote tools that can assist police officers and custody sergeants identify brain injury survivors. Headway has created a photo identity card designed to help police officers and staff more easily identify brain injury survivors and ensure that they receive an appropriate response. Recipients of the card will have had their brain injury clinically verified. The card should be recognised by police as a tool to identify brain injury in a custody setting. The cards are personalised to show the challenges faced by the holder.	Studies indicate a high prevalence of brain injury in offending institutions and many people enter prison without their brain injury being identified. Early identification will ensure the survivor is provided with the support and rehabilitation they need. This could also lead to some being diverted away from prisons or the criminal justice system altogether, or reduce reoffending rates.	For further information on the Headway Brain Injury Identity Cards, visit www.headway.org.uk/idcard

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			The cards are endorsed by the National Police Chiefs' Council, Police Scotland, and the Police Service of Northern Ireland. The cards display the number of a free 24-hour helpline staffed by solicitors with an understanding of brain injury.		
76	Headway – the brain injury association	Key area for quality improvement 5 Research into the prevalence of brain injury in the criminal justice system	We recommend more research be carried out to identify the scale of the prevalence of brain injury in the criminal justice system, and whether having a brain injury increases the risk of re-offending. This research should build on existing studies suggesting that up to 60% in offending institutions and that having a brain injury increases the chances of re-offending. More research is needed to identify the extent of this issue in England and Wales.	Only by identifying the extent of the problem to be able to put in place appropriate and effective interventions.	Studies indicate that up to 60% of people in offending institutions have sustained a head injury at some point in their life (Shiroma et al, 2010). Research has also found the increased risk of arrest following TBI (Elbogen et al, 2014). However, a systematic review conducted by O'Rourke et al (2016) identified inconsistencies in the way TBI is measured among prison populations, and gaps in the related literature.
77	Deputy NCD and adult CRG	iv. Specific Focus on the Needs of People from Black, Asian and Minority Ethnic Groups	Detailed consideration of the cultural and psychosocial needs of this over represented group. Provision of culturally sensitive assessments and therapeutic options for the BAME group of people who may find current provision inadequate and insensitive to their cultural contexts and needs.		
78	Revolving Doors Agency	The particular and often quite distinct levels and types of need faced by women in contact with the criminal justice system should be met.	Female offenders, in addition to often featuring higher rates of prevalence for some mental health conditions, and for some forms of substance misuse, also tend to have far higher rates of experience of trauma. There are distinct disparities of vulnerability and risk among the prison population, with the rate of instances of	The Ministry of Justice has published a prison safety white paper, which sets out, in sparse form, the ambition to improve the female estate. The previous government's intention was to shortly accompany this with a Female Offender Strategy; as with the Prison and Courts Bill, the future is now unclear.	Phyllis Modley and Rachelle Giguere, Re-entry Considerations for Women Offenders, Coaching Packet, Center for Effective Public Policy: **http://www.reentrycoalition.ohio.gov/do**

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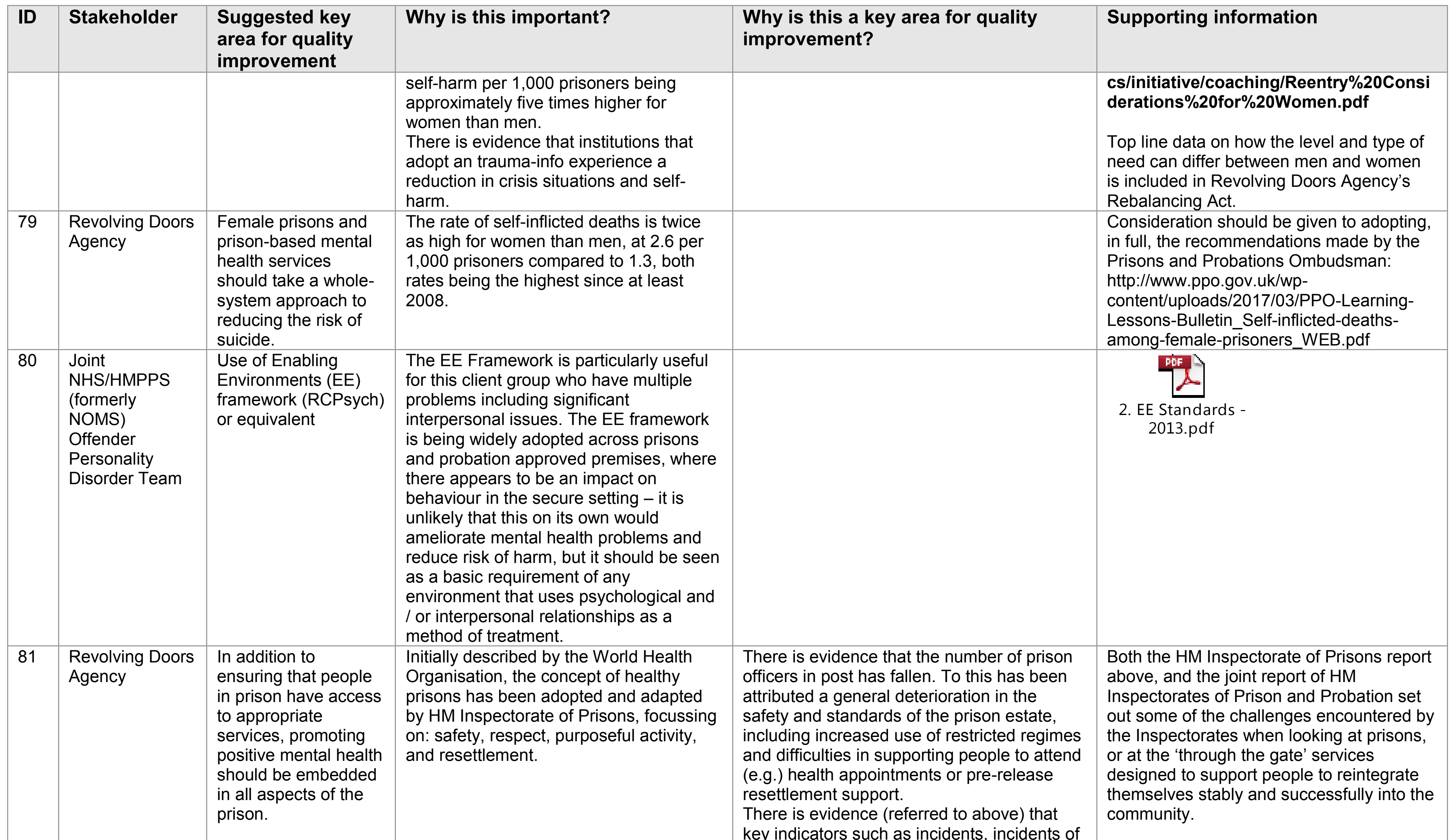
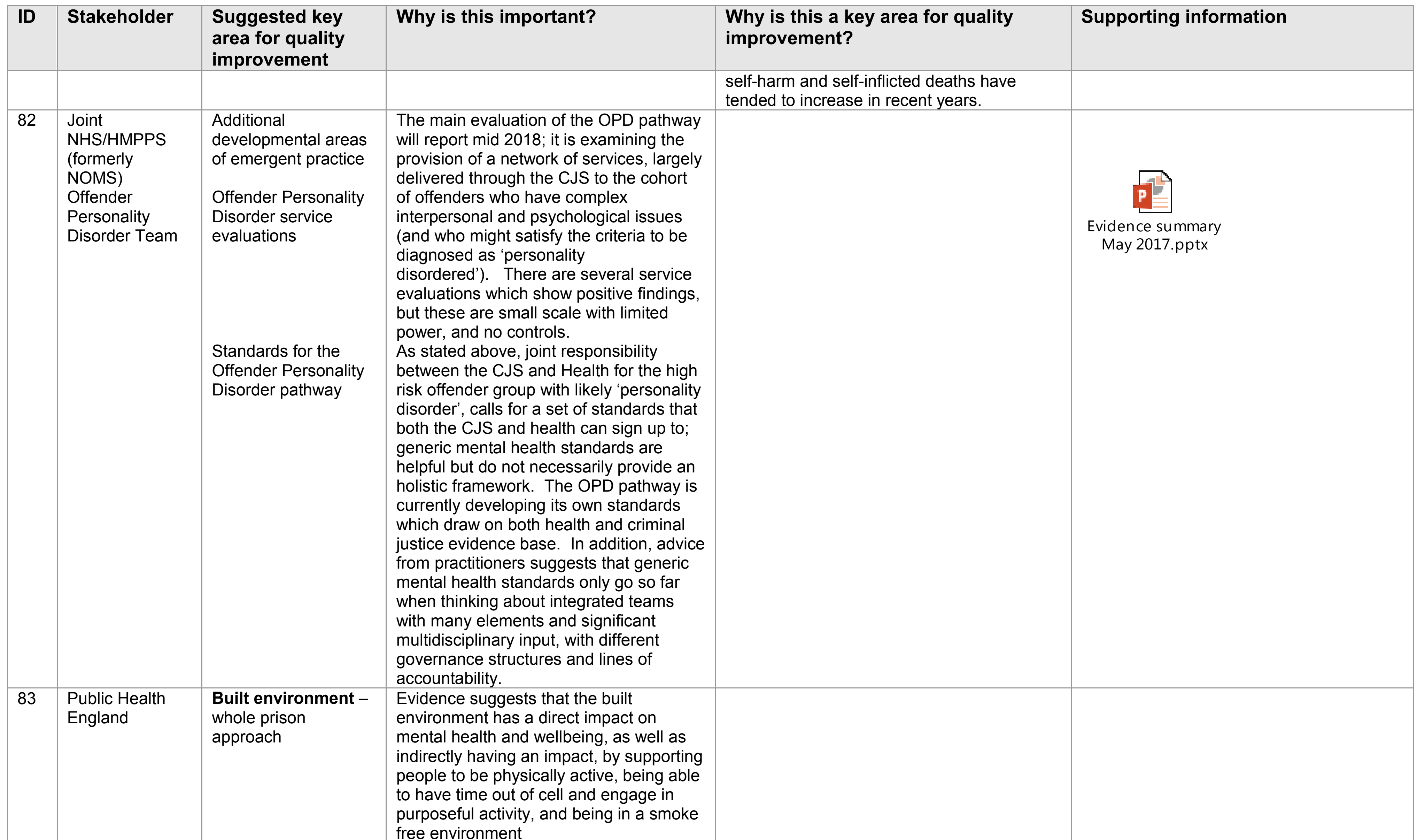
			self-harm per 1,000 prisoners being approximately five times higher for women than men. There is evidence that institutions that adopt an trauma-info experience a reduction in crisis situations and self-harm.		**cs/initiative/coaching/Reentry%20Considerations%20for%20Women.pdf** Top line data on how the level and type of need can differ between men and women is included in Revolving Doors Agency's Rebalancing Act.
79	Revolving Doors Agency	Female prisons and prison-based mental health services should take a whole-system approach to reducing the risk of suicide.	The rate of self-inflicted deaths is twice as high for women than men, at 2.6 per 1,000 prisoners compared to 1.3, both rates being the highest since at least 2008.		Consideration should be given to adopting, in full, the recommendations made by the Prisons and Probations Ombudsman: http://www.ppo.gov.uk/wp-content/uploads/2017/03/PPO-Learning-Lessons-Bulletin_Self-inflicted-deaths-among-female-prisoners_WEB.pdf
80	Joint NHS/HMPPS (formerly NOMS) Offender Personality Disorder Team	Use of Enabling Environments (EE) framework (RCPsych) or equivalent	The EE Framework is particularly useful for this client group who have multiple problems including significant interpersonal issues. The EE framework is being widely adopted across prisons and probation approved premises, where there appears to be an impact on behaviour in the secure setting – it is unlikely that this on its own would ameliorate mental health problems and reduce risk of harm, but it should be seen as a basic requirement of any environment that uses psychological and / or interpersonal relationships as a method of treatment.		 2. EE Standards - 2013.pdf
81	Revolving Doors Agency	In addition to ensuring that people in prison have access to appropriate services, promoting positive mental health should be embedded in all aspects of the prison.	Initially described by the World Health Organisation, the concept of healthy prisons has been adopted and adapted by HM Inspectorate of Prisons, focussing on: safety, respect, purposeful activity, and resettlement.	There is evidence that the number of prison officers in post has fallen. To this has been attributed a general deterioration in the safety and standards of the prison estate, including increased use of restricted regimes and difficulties in supporting people to attend (e.g.) health appointments or pre-release resettlement support. There is evidence (referred to above) that key indicators such as incidents, incidents of	Both the HM Inspectorate of Prisons report above, and the joint report of HM Inspectorates of Prison and Probation set out some of the challenges encountered by the Inspectorates when looking at prisons, or at the 'through the gate' services designed to support people to reintegrate themselves stably and successfully into the community.



ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				self-harm and self-inflicted deaths have tended to increase in recent years.	
82	Joint NHS/HMPPS (formerly NOMS) Offender Personality Disorder Team	Additional developmental areas of emergent practice Offender Personality Disorder service evaluations Standards for the Offender Personality Disorder pathway	The main evaluation of the OPD pathway will report mid 2018; it is examining the provision of a network of services, largely delivered through the CJS to the cohort of offenders who have complex interpersonal and psychological issues (and who might satisfy the criteria to be diagnosed as 'personality disordered'). There are several service evaluations which show positive findings, but these are small scale with limited power, and no controls. As stated above, joint responsibility between the CJS and Health for the high risk offender group with likely 'personality disorder', calls for a set of standards that both the CJS and health can sign up to; generic mental health standards are helpful but do not necessarily provide an holistic framework. The OPD pathway is currently developing its own standards which draw on both health and criminal justice evidence base. In addition, advice from practitioners suggests that generic mental health standards only go so far when thinking about integrated teams with many elements and significant multidisciplinary input, with different governance structures and lines of accountability.		Evidence summary May 2017.pptx
83	Public Health England	**Built environment** – whole prison approach	Evidence suggests that the built environment has a direct impact on mental health and wellbeing, as well as indirectly having an impact, by supporting people to be physically active, being able to have time out of cell and engage in purposeful activity, and being in a smoke free environment		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
84	Royal College of Psychiatrists	Availability of Forensic Outreach – this should be developed and used to support liaison services, particularly for those in contact with community CJS	Emerging area – recommended by NHSE service specifications for MSU/LSU	Preventative – has face validity, but is there any actual evidence of benefit?	
			General		
85	Cambridgeshire and Peterborough NHS Foundation Trust		Review the ability to have access to the CPFT IT network in non-CPFT premises to improve access to patient clinical information and staff efficiency.		
86	Royal College of Psychiatrists		We would also like to make sure that NICE is aware of the CCQI Quality Network for Forensic Mental Health Services.		
			No comments		
87	NHS England		This is a NIL response from NHS England		