NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Mental health of adults in contact with the criminal justice system

Date of quality standards advisory committee post-consultation meeting:
2 November 2017.

2 Introduction

The draft quality standard for Mental health of adults in contact with the criminal justice system was made available on the NICE website for a 4-week public consultation period between 7 September and 5 October 2017. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 24 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific question:

4. For draft quality statement 1: The statement currently focuses on police officers recognising and responding to mental health problems in adults taken into police custody. Quality statements usually focus on 1 area for quality improvement. Which of these 2 is the priority area?

Stakeholders were also invited to provide examples of local practice case studies:

5. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4 General comments

The following is a summary of general (non-statement specific) comments on the quality standard.

- General support for the quality standard and the quality statement areas.
- There is a disproportionate focus on the police with 2 statements relating to the rest of the criminal justice system (CJS) however the guidance focuses mostly on prison.
- Unclear how this will improve the standard of care for the most vulnerable who have contact with the CJS. Prison governors' experience is that many people with obvious mental health problems reach prison without this being identified.
- Liaison and diversion services and street triage should be included under service providers.
- Suggestions to include autism and learning disability and to use 'mental health need' instead of 'problem'.
- Several equalities measures suggested including training practitioners in cultural competencies.
- Literacy should not be assumed. In people whose first language is not English, literacy rates can be lower.

General consultation comments on data collection (question 2)

- Some measures should include the views of adults who have been in contact with the criminal justice system about their experience.
- The measures are not overly specific in how the data should be collected meaning local areas can demonstrate progress in ways which suit local need and data collection will not be onerous.

- It is unlikely that there are efficient systems to collect data and audit against the statement measures.

General consultation comments on resource impact (question 3)

- Health services will need additional resources to deliver training to police and custody services and this would need to be factored into commissioning.
- Include timescales for information sharing to ensure any resourcing issues from sharing the plans is minimal for statements 3 and 4.
- All services may lack the resources to implement this quality standard and significant investment in mental health services and improvements in court diversion services are needed.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults taken into police custody are cared for by police officers who recognise and respond to mental health problems.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- The statement should ensure police officers recognise and respond to the mental health needs of all people they are in contact with, not only those in custody.
- Remove ‘cared for’ from statement and replace with ‘dealt with appropriately’ or similar.
- Mental health problems may not be apparent at initial interaction but become evident later in the pathway therefore other parts of the criminal justice system should be included.
- Rationale should include smoking status being recorded and nicotine replacement therapy being offered to reduce anxiety.
- Suggestion of additions to measures: provision of nicotine replacement therapy, ‘multidisciplinary’ training and behaviour changes following training.
- Police and crime commissioners should be included as commissioners under audience descriptors and would ensure officers are appropriately trained.
- The training should be interactive, delivered to all police officers and include areas such as; acquired brain injury, the increased risk of self-harm in some groups and neurodevelopmental disorders such as learning disability and autism.
- Include referral to advocacy if people are seen by liaison and diversion services.
- Define mental health problems as being the result of a range of conditions.
- Equality and diversity considerations should include sexual orientation and gender identity.
- Training is available but uptake is low due to pressures of releasing front-line staff.

- Include HM Inspectorate of Constabulary requirement that people have access to competent healthcare practitioners who meet their mental health needs in a timely way.

Consultation question 2 on data collection

Stakeholders made the following comments in relation to consultation question 2:

- Amend structure measure on liaison and diversion services to note that this service is not yet available in all police custody suites.
- Remove ACCT as a data source as it is not used in police custody.
- Include the Independent Police Complaints Commission data on deaths during or following police contact as a data source for outcome measure (d).
- Data may be collected by liaison and diversion services as per their NHS contract.

Consultation question 4 on the focus of this statement

Stakeholders made the following comments in relation to consultation question 4:

Recognition

- Recognition can trigger support from mental health services; police officers should not respond alone to a mental health situation.
- The police should recognise mental health problems, if they were to also respond there would be significant resource implications, e.g. education and training.

Response

- Response makes the biggest difference, with recognition being part of the necessary skill set.
- Police officers can generally identify people with vulnerabilities including mental health problems, the issue is knowing what to do next.

Both

- Effective identification and knowing how to respond at the initial stages are important to ensure people receive support quickly.
- These areas are interdependent. Officers cannot respond appropriately without recognising the problem and having suitable training.

5.2 Draft statement 2

Adults taken into police custody who have a suspected mental health problem are referred for a comprehensive mental health assessment.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Statement should state that referrals are made in a timely way as this may be key to the outcome.
- Statement should focus on all staff working in police custody which would include liaison and diversion teams.
- Statement should include all people working in the criminal justice system (CJS) and all custodial settings.
- Change statement wording to ‘have a mental health assessment’.
- Although not provided in every area, street triage can make a preliminary assessment prior to referral for a comprehensive assessment.
- Suggestion to add the custody health team to the measures and include additional measures including a competent practitioner carrying out the assessment and all documentation being considered.
- Include smoking under the comprehensive mental health assessment definition.
- Commissioners of health services should include this as part of overall mental health service provision. However, local mental health services are stretched meaning intervention may not be timely.
- Include forensic medical examiners to the service provider or police and mental health practitioner audience descriptors. Police and crime commissioners should be added to the commissioner audience descriptor.
- The assessment suggested will not capture the complex nature of people presenting to CJS with mental health problems. The assessments should be multidisciplinary.
- Include obtaining information from family, carers and friends to the definition of the assessment. It should also include a case formulation based on identified needs and clear recommendations for colleagues.

- Equality and diversity considerations should include sexual orientation and gender identity as some groups may benefit from an LGBT advocate.

Consultation question 2 on data collection

Stakeholders made the following comments in relation to consultation question 2:

- HM Inspectorate of Constabulary reports may contain some of the data.
- Remove ACCT as a data source as it is not used in police custody.
- Data may be collected by liaison and diversion services as per their NHS contract.
- The number of people referred to liaison and diversion services during working hours would be easy to obtain but data on people with a suspected mental health problem released outside liaison and diversion hours would be difficult.

Consultation question 3 on resource impact

Stakeholders made the following comment in relation to consultation question 3:

- Timescales for assessment are not mentioned. Some areas have local structures in place but this is not consistent across the country and there would be resource implications for those areas without a service.

5.3 Draft statement 3

Adults with mental health problems in contact with the criminal justice system have a care plan that is communicated with relevant services.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Include ‘when people are transferred to prisons’.
- It is unclear who is responsible for communicating the plan and what communicating means in this context.
- Rationale should include information on smoking status and nicotine addiction management.
- Include acquired brain injury in this statement.
- What is meant by ‘other’ in rationale, is this prison services?
- Additional process measures: evidence of a sharing protocol and evidence of a lead case coordinator responsible for sharing plans.
- Mental health care plans are available on the mental health records system accessed by liaison and diversion staff. If there is no mental health care plan on entry to police custody, liaison and diversion services can develop one and share with relevant agencies.
- Outcome (b) applies only to police custody and those with access to liaison and diversion services.
- Police and crime commissioners need to be added to the commissioners section.
- Service providers should include the voluntary sector as advocacy and support networks may be important when developing mental health care plans.
- The care plan should include reference to the involvement of family and other informal support networks.
- The agreed process for sharing the care plan will need to include an agreed process for consent to share information being taken.
- Care plans should be developed with advocacy and support groups as some LGBT people may not have connections with family members.
- Include referrals to advocacy services.

- An agreed process is needed for mental health care plans to be informed by subsequent assessments by healthcare professionals.
- Consistent records systems and information sharing agreements would make the implementation and measurement of the statements easier.

Consultation question 2 on data collection

Stakeholders made the following comments in relation to consultation question 2:

- It is not clear which organisations will be measured against the statement and which will conduct data audits.
- Prison service data can be collected through the Health and Justice Indicators of Performance.
- Potential difficulty in measurement based on knowing which service or services the mental health assessment should be shared with.
- The use of encrypted and secure systems make this more difficult to measure.

Consultation question 3 on resource impact

Stakeholders made the following comments in relation to consultation question 3:

- The majority of responsibility for this statement would be on the police service, as the most likely entry point into the criminal justice system, and there are potential significant resource and training implications.
- Statement will need more resources to be achievable.

5.4 Draft statement 4

Adults who have a mental health risk management plan have their plan reviewed by the receiving service when they are transferred within the criminal justice system.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Statement does not cover discharge from the criminal justice service (CJS). The service should engage with local mental health services to ensure continuity of care and records transfer.
- Statement does not make it clear if all people with a mental health problem should have a risk management plan.
- Statement does not include a timescale for risk management plans to be shared.
- Rationale should state risk management plans should be shared with all agencies.
- Audience descriptor should be 'criminal justice staff' and include probation and community rehabilitation companies.
- Commissioner section should include the Ministry of Justice, Her Majesty's Police and Probation Service and police and crime commissioners.
- The risk management plan should clearly outline the roles and responsibilities of professionals to ensure accountability.
- Cognitive problems should also be considered under mental health risk management plans.
- People should be reviewed on transfer to assess whether they have developed a mental health problem.
- The current prisoner escort record (PER) contains very limited space to include a mental health issue. The Ministry of Justice are working on electronic PERs to be used for all people moving within the CJS and are currently piloting a form which includes mental health conditions.

Consultation question 2 on data collection (general)

Stakeholders made the following comments in relation to consultation question 2:

- Collecting data will be difficult.

- Additional data sources for outcome measure (b) suggested: Ministry of Justice data on suicide and self-harm in prisons and Independent Police Complaints Commission data on police custody suites.
- Include monitoring of sexual orientation and gender identity to identify trends in risk management plans.

Consultation question 3 on resource impact

Stakeholders made the following comment in relation to consultation question 3:

- Statement will need more resources to be achievable.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- A stakeholder suggested interventions earlier in the criminal justice pathway, prior to people being taken into police custody. They suggested mental health and social care staff should work within police call centres as they will have access to records and be able to provide advice on first response. No NICE accredited recommendations have been identified which support a statement on interventions prior to people being taken into police custody or on mental health and social care staff working in police call centres.
- A stakeholder suggested triage on entry to police custody by a qualified mental health worker. No NICE accredited recommendations have been identified which support a statement on triage by a qualified mental health worker.
- A stakeholder suggested implementing appropriate rehabilitation for people with acquired brain injury who are in prison. No NICE accredited recommendations have been identified which support a statement on rehabilitation for people in prison with an acquired brain injury.
- A stakeholder commented that timely access to beds for people in contact with the criminal justice system who have a mental health problem would be another area for quality improvement. No NICE accredited recommendations have been identified which support a statement on access to mental health beds.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Organisation name	Statement No	Comments[1]
1	Action on Smoking and Health (ASH)	General comments	It is estimated that 60% of arrestees smoke, with this rising up to 80% among those in prison. Among people with a mental health condition the smoking rate is approximately 40.5% which rises up to 70% among those in inpatient settings. Smokers with mental health conditions tend to smoke more heavily and are thus more addicted to nicotine. This means that management of nicotine addiction is essential for people who are detained with up to 80% of detainees suffering from a mental health condition.
2	Action on Smoking and Health (ASH)	General comments	The overall outcomes of the quality standard include: reducing morbidity and mortality rates of people with mental health problems who have had contact with the criminal justice system. Tobacco kills half of all long-term users and is the leading cause of the 10-20 year difference in life expectancy between adults with mental health conditions and the general population. Therefore the aims of reducing morbidity and mortality rates will not be achieved unless serious action is taken to reduce smoking rates among those in contact with the criminal justice system which includes managing nicotine addiction.
3	African Health Policy Network	General comments	We should measure whether ethnicity, language and faith are recorded and monitored and whether the statistics are analysed to ensure equality of access to services and treatment.
4	African Health Policy Network	General comments	We should measure the extent to which practitioner /staff make up reflects the community it serves.
5	African Health Policy Network	General comments	We should measure the extent to which practitioners are trained in cultural competencies;
6	African Health Policy Network	General comments	we should measure the extent to which the assessment process proactively considers an individual's cultural and religious needs and that these are addressed by any care plan.
7	African Health Policy Network	General comments	We should measure whether agencys' operating protocols include a statement on equality and diversity and whether they have been subject to an Equality Impact assessment
8	African Health Policy Network	General comments	As well as training for police in de escalation etc it might be an idea to ensure and measure that police, and all practitioners are in receipt of both anti racist practice and equality and diversity training.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Organisation name	Statement No	Comments[1]
9	Association for Family Therapy and Systemic Practice in the UK	General comments	Rather than focusing on 'mental health problems' (as only a subset of what might be classified as 'mental health problems' seems to be the focus of these standards), would it perhaps be an option to focus on reducing risk of harm to and from adults in the criminal justice system? The skills and organisational supports are likely to be of benefit to making all interactions safer, rather than only for a subset of people who are 'recognised'. Focusing on risk might make the role of interactions in the criminal justice system more visible, rather than encouraging the mindset that there are only 'certain people' where these skills are relevant.
10	Joint NHS / HMPPS (formerly NOMS) Offender Personality Disorder Team	General comments	There is a disproportionate focus on the police (two out of four standards) and only two standards applying to the rest of the criminal justice system. The two that apply more widely are both focused on *process* rather than anything to do with the *quality* of healthcare received by service users. The OPD team provided extensive comments on the 'Mental health of adults in contact with the criminal justice system quality standard' in May 2017. What is the relationship between this quality standard and the earlier one? None of our earlier comments seem to have been taken into account.
11	NHS England	General comments	The Quality standard should recognise autism, and make reference to learning disability. Rather than use of the term "problem" the term "need" may be more appropriate. In addition their could be more collaborative and recovery focused language throughout.
12	NHS England	General comments	We welcome these standards however feel that they require revision slightly. I feel that they focus rather specifically on Police Custody which is one small part of the pathway. I do feel that the commissioning environment is not accurately portrayed in the development of them. There is no mention of Police and Crime Commissioners as the responsible commissioner. There is no recognition of the prison quality networks quality standards for mental health which are a significant set of standards embedded within the draft specification for prison mental health.
13	Northamptonshire Mental Health Criminal Justice Board.	General comments	Overall, we welcome the quality standards in this area. It helps to fill a gap in the current system and is a long overdue step forward in ensuring that the mental health pathway through the criminal justice system meets identified standards of quality.
14	Northamptonshire Mental Health Criminal Justice Board.	General comments	There is no mention in the quality statements under the 'commissioner's section to Police and Crime Commissioners, who retain the statutory responsibility for provision of healthcare in police custody and often also commission other interventions in relation to mental health and the criminal justice system. It would be helpful for the quality standards to recognise this role.
15	Prison Governors Association	General comments	If I am being truly honest I can't see as how this will help drive up the standard of care for those most vulnerable who brush with the CJ System.

ID	Organisation name	Statement No	Comments[1]
			The members of our association, and myself on a personal \ professional basis see on a daily basis individuals who have been through most stages of the system and have ended up in Prison Custody – For the majority of whom this includes at least: • Initial contact with a Law Enforcement Agency • Police Custody (possibly overnight) • Being bailed and remanded back to custody • Health Professionals • Attending courts – Magistrates \ Higher Court judges • Solicitors \ Barristers • Possible pre sentence reports – Interactions with Probation By the time an individual enters prison custody for the first time numerous opportunities to intervene will have taken place. The most frustrating part for us is when prisons are clearly used as a place of last resort – Exampled by the number of individuals who enter our custody, having already been through 'The System' who end up in prison custody in significant crisis presenting with clear and obvious mental health issues, in some cases this most obvious of states not being picked up and recorded anywhere. I genuinely understand that the intention is to improve outcomes , but this standard does not feel robust enough to do that – Sadly I would struggle to give a more suitable alternative which did not rely on significant investment in main stream mental health services, significant improvement in court diversion schemes and magistrates who stop remanding vulnerable people in to custody – These comments are from a prison perspective only.
16	Public Health England	General comments	Two of the four quality standards relate specifically to the management of people in police custody but the guidance from which they are derived deals primarily with prison settings (although other criminal justice settings are described). It would be beneficial for the guidance to make specific reference to prison custody as well as police custody with similar consideration for quality metrics.
17	Public Health England	General comments	This quality statement is very limited in its focus on only police custody staff and should include all staff working in police custody. This would include staff working in healthcare and liaison and diversion teams.

ID	Organisation name	Statement No	Comments[1]
18	Public Health England	General comments	If you want to contribute to improving the mortality and reducing the morbidity of people in contact with CJS then there is a need for these quality standards to make more emphasis on the physical health needs of people with mental health problems and link to NICE guidance on physical health of people in prison and associated standards. PHE also recommends reducing rates of suicide, self-harm and violence www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2017
19	Public Health England	General comments	For reference, please see the RCPsych Quality Network for Prison mental Health Services standards which includes standards in prisons on assessment, case management and treatment, referral discharge and transfer, patient experience, patient safety, environment, workforce capacity and capability, workforce training , CPD and support, governance www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/prisonmentalhealth/standards.aspx
20	Royal College of Nursing	General comments	The NICE Quality Standard for mental health of adults in contact with criminal justice system should meet the aims and principles of the Prison Reform Trust **'Care not Custody'** coalition which has a primary driver to divert (where appropriate) someone who has poor mental health and or a learning disability into more appropriate health services.
21	Royal College of Physicians and Surgeons of Glasgow	General comments	The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the United Kingdom. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments. The College welcomes this Quality Standard seeing that it can only improve medical and in particular psychiatric care in the criminal justice system of the United Kingdom whether it refers to the constabulary or HM prison service or other support services in the system. Some of the Standards will be challenging for many services but that does not mean that services should not change and be regularly audited.
22	Royal College of Physicians and Surgeons of Glasgow	General comments	These are reasonable and relevant to a civilised and caring society.

ID	Organisation name	Statement No	Comments[1]
23	South Gloucestershire Council, Public Health and Wellbeing Division (PH&WBD)	General comments	In theory the whole document makes good sense in ensuring there are service improvements from street triage, through the custody, courts and prison, liaison and diversion services. Without the appropriate expertise in these areas the below comments are more general observations in relation to the document. Whilst very interested in all the statements, I will focus some bullet type responses to statement 1 and look forward to colleagues from the CCG and social care for a view on how current commissioning pressures affect the ability to provide, monitor processes and the expectation providers have the resources to attend training and maintain process / service improvements.
24	Association of Police and Crime Commissioners Same comments from Dorset Police and Crime Commissioner	Question 1	Does the draft quality standard accurately reflect the key areas for quality improvement? Yes
25	NHS England	Question 1	Yes it accurately reflects the need for police and custody officers to be able to recognise and respond to people with mental health issues. Custody officers need to be able to recognise mental health issues and bring specialist mental health providers in.
26	Northamptonshire Mental Health Criminal Justice Board.	Question 1	We believe that in general the areas identified by the standards represent the key points within the criminal justice system where contact with mental health patients exist and therefore they cover the right areas.
27	Revolving doors agency	Question 1	The areas highlighted for improvement seem appropriate. However, they may benefit from the inclusion/reference to Liaison and Diversion services, and also to Street Triage under 'service providers' I acknowledge that NHS England is listed under 'commissioners'; they are the responsible body for commissioning L&D services, although Street Triage is generally commissioned locally.
28	Revolving doors agency	Question 1	Through the piece, it may be worth considering the inclusion of Police and Crime Commissioners, who have roles both as a commissioner of services and also in holding the police to account, bringing together community safety and criminal justice partners etc. As senior (and directly elected) stakeholders who sit outside both operational

ID	Organisation name	Statement No	Comments[1]
			police services and health or local authority commissioning, highlighting the relevance of this QS for them may be beneficial.
29	Royal College of General Practitioners	Question 1	Does this draft quality statement accurately reflect the key areas for quality improvement? No. These standards are more about assessment rather than ensuring services to interrupt the presentation to the criminal justice system. Community services equipped to manage complex patients with dual diagnosis and an ability to provide assertive outreach which prevents patients presenting to the criminal justice system is a much better use of resources.
30	Royal College of Nursing	Question 1	The Royal College of Nursing supports the draft quality standard for mental health of adults in contact with the criminal justice system. We however, have some overarching comments, which we have detailed below.
31	Royal College of Physicians and Surgeons of Glasgow	Question 1	These reflect key areas for improvement.
32	South Gloucestershire Council, Public Health and Wellbeing Division (PH&WBD)	Question 1	Yes.
33	Association for Family Therapy and Systemic Practice in the UK	Question 2	In terms of measurement it would seem logical to engage meaningfully with adults who have been in contact with the criminal justice system about their experiences in custody, and elsewhere in the criminal justice system, to determine if any progress is happening in a way which might make a meaningful difference. We appreciate that this might not be straightforwards because of the often conflictual nature of the reasons why people might be within this system, nevertheless, if all measures of progress are biased towards the records and documents created by one party, then it is unlikely that the experiences of the other party will be validated.
34	NHS England	Question 2	For police service systems and processes to respond to.
35	Northamptonshire Mental Health	Question 2	Much of the data that is suggested as being the way to monitor the output of the quality standards should be being collected at a local level in any case. It is pleasing to note that standards are not being overly specific in what

ID	Organisation name	Statement No	Comments[1]
	Criminal Justice Board.		information should be collected, enabling local areas to best demonstrate progress against the standards in ways that meet local need and mean it is less onerous to collect the data. What is not clear from the quality standard at present is 'what does good look like?' for each standard. It would be helpful to set some level of 'bar' for the standards to enable local areas to understand what good looks like.
36	Royal College of General Practitioners	Question 2	Data collection. Are local systems and structures in place? No
37	Royal College of Physicians and Surgeons of Glasgow	Question 2	It is highly unlikely that there are efficient systems to collect data to audit against quality measures. To be effective they need to be performed and evaluated within each service e.g. Police, Courts and Prisons. Existing Mental health services may be able to collect data but it is likely to be incomplete and miss out the most vulnerable individuals.
38	South Gloucestershire Council, Public Health and Wellbeing Division (PH&WBD)	Question 2	As mentioned in the general comment Public Health may not be best placed to answer this and feel that colleagues in the CCG and social care may be able to respond with detail on current services and how much resource is required to provide the noted services improvements. Many of these practices are probably already accepted and from the documents the challenges that are faced may arise from:- • Standards of commissioning, placing suitable monitoring requirements on providers and effective contract monitoring • Resources:- financial values of contract; staff levels affecting training provision and availability of staff to attend training • The delays created between services as resources are stretched at the same time as one agency may become increasingly dependent on another. For example for people in custody, the delay is a MH assessment could lead to further distress and delays in ID of MH conditions / risk assessment and care plans. The challenges of having these in place needs to be sought from CCG.
39	Association of Police and Crime Commissioners Same comments from Dorset Police	Question 3	Statements 3 & 4 will need more resources for these to be achievable. I am concerned about the potential resource and training implications for the police service for the effective delivery of Statement 3 if arrest/police custody is the most likely first point of contact with the CJS as these could be substantial.

ID	Organisation name	Statement No	Comments[1]
	and Crime Commissioner		
40	NHS England	Question 3	Health service providers need resources to deliver training to police and custody services. This needs to be factored into commissioning of services
41	Northamptonshire Mental Health Criminal Justice Board.	Question 3	With regard to quality statements 3 and 4, we welcome the desire to ensure that care plans and risk assessments are shared between agencies to ensure that the best possible service can be provided across the entire system. We would suggest that specific timeframes should be agreed for sharing. Ideally this should be immediately but more realistically 3-5 working days. This will help to ensure that any resourcing issues from sharing the plans would be kept to a minimum.
42	Royal College of General Practitioners	Question 3	No response
43	Royal College of Physicians and Surgeons of Glasgow	Question 3	Currently it is likely that all services lack resources to cope with this heavy demand. It will undoubtedly require investment to achieve the desired aims.
44	South Gloucestershire Council, Public Health and Wellbeing Division (PH&WBD)	Question 3	The statements all make good sense – however the feasibility needs to be answered by commissioners and providers of these services.
45	Association of Police and Crime Commissioners Same comments from Dorset Police and Crime Commissioner	Question 5	No specific examples.

ID	Organisation name	Statement No	Comments[1]
46	Action on Smoking and Health (ASH)	Statement 1	The rationale states that it's important for officers to know how to reduce anxiety and keep people calm. Due to the level of nicotine addiction within those detained, managing this will be essential to keeping people calm. Once in the body nicotine is broken down quickly meaning that smokers an start to experience withdrawal symptoms within 30 minute of their last cigarette. Withdrawal symptoms can be extreme and exacerbated by stressful situations in which people know they can't smoke. In order to deal with this, all detainees should be asked about their smoking status and then smokers should be offered nicotine replacement therapy within half an hour of their admission to a smokefree setting. The Quality Statement is about: recognition and response to mental health problems, providing nicotine replacement therapy must be part of this response. Data sources would be local data collection covering the number of smokers who have been in the care of a service and what nicotine management they were offered.
47	Association for Family Therapy and Systemic Practice in the UK	Statement 1	In addition to providing training for Police officers it is also important that any organisational and cultural changes necessary are made in order to support the use of training and skills in the right place, and the right time, and to support the aim of avoiding judgemental attitudes / inappropriate terminology.
48	Association for Family Therapy and Systemic Practice in the UK	Statement 1	We would also add that it is not only the skills of Police officers which might support more positive interactions, but also the extent to which police officers feel supported / at risk / are overstressed.
49	Association of Directors of Public Health	Statement 1	This is too narrow as it focusses on adults who have already been taken into custody. There are crisis points and opportunities to intervene earlier in the criminal justice pathway. The standard should make reference to joint working between mental health services and criminal justice (particularly police). A high percentage of people who are taken into custody with suspected mental health problems are already known to mental health services. Therefore street triage schemes should be developed locally. Initially these schemes tended to be mental health nurses working alongside police within the community. However a more effective model is now being employed in many areas with mental health staff (and possible also social care staff) working within police call centres. These staff have access to patient records and are able to advise on appropriate first response, provide specific clinical details and info about care plans, and potentially avert an arrest or caution, referring adults back to appropriate services. Ideally this should be put in a separate quality statement

ID	Organisation name	Statement No	Comments[1]
			Statement 1 Adults at risk of being taken into custody are cared for by police officers working in real time with local mental health services to recognise and respond to mental health problems. Or incorporated Statement 1 Adults taken into police custody or at risk of being taken into custody are cared for by police officers (working in real time with mental health services) who recognise and respond to mental health problems.
50	Headway	Statement 1	This QS refers to adults with mental health problems. However, we urge that the QS explicitly defines 'mental health problems' as being the result of a range of conditions, including acquired brain injury (ABI), with a section designated to ABI in order to discuss this in sufficient detail. People with ABI can present with a range of cognitive, psychological, emotional and behavioural effects that can result in them contacting the criminal justice system; it is imperative that these individuals' needs are also recognised and that they are supported accordingly, for instance under guidance provided by this QS. To illustrate, a person with ABI may experience problems with their balance, speech, anxiety and memory after their injury. As a result, they might be arrested under the assumption that they are drunk, when in fact these are common effects of ABI. Once in custody, the person might become extremely anxious and may forget key events when being questioned by the police. If someone is identified as having a brain injury by police at a police station, they must be deemed to be a vulnerable adult and provided with an appropriate adult and referred to the liaison and diversion service for further assessment. Diversion from the criminal justice system must be considered if appropriate. There are approximately 1 million people living with the long-term effects of brain injury in the UK. Studies indicate the brain injury is prevalent in offender populations in the UK and across the world. UK studies reveal that this prevalence is as high as 60%.[2] It is therefore vital for police to appropriately and sensitively manage such individuals who find themselves involved in the criminal justice system. While the QS in question does offer such guidance, it does not clarify whether this applies to individuals who have sustained ABI. Headway's Justice Project scheme aims to raise awareness of brain injury throughout the criminal justice system. As part of the project, Headway has developed the Brain Injury Identity Card. This card helps police officers and others easily identify if someone they are in contact with has a brain injury. Information is available at www.headway.org.uk/idcard.

[2] Williams, W. H, et al (2010) Traumatic brain injury in a prison population: Prevalence and risk for re-offending. Brain Injury, 24 (10) 1184 - 1188.

ID	Organisation name	Statement No	Comments[1]
			The card is endorsed by the National Police Chiefs' Council, Police Scotland, the Police Service of Northern Ireland, the National Appropriate Adults Network, Liaison and Diversion services, and the Police Federation of England and Wales. It may not always be the case that a brain injury survivor will carry their card on them, so it is vital that staff working in the criminal justice system receive training to help them better identify if someone has a brain injury as part of their mental health training. Headway is also able to deliver induction training tailored to policing roles, or training on various aspects of brain injury. For more information on this, visit www.headway.org.uk/about-brain-injury/professionals/training. The QS should also endeavour to clarify that while ABI can result in mental health problems, these are also two separate conditions that can often be confused due to overlapping symptoms. For instance, someone with an ABI can present with anger issues or behavioural problems, without necessarily being diagnosed with a mental health condition. Further information about this is available in the Headway factsheet *Mental health and brain injury*; NICE would be welcome to utilise this document and make reference to it within the QS in question.
51	NHS England North west H&J team	Statement 1	It would be good to add the expectations from Her Majesty's inspectorate of custody (HMIC) – that detainees have access to competent healthcare practitioners who meet their mental health needs in a timely way.
52	NHS England	Statement 1	We welcome the standard but suggest that a clear expectation is included in the scope of training in the understanding of mental disorder that includes neurodevelopmental disorders such as learning disability and autism particularly where this may impact on an individual's ability to communicate, understand and respond to complex information in high stress situations.
53	NHS England	Statement 1	We welcome the reference to NHS England's Accessible Information Standard
54	NHS England	Statement 1	The standards appear to reflect that it should be the Liaison and Diversion services role to train police custody staff. Whilst this would be absolutely part of their role to support knowledge we would expect that PCC's ensure their staff are appropriately trained.
55	National LGB&T Partnership	Statement 1	Police officers' training should also include the higher risks of self-harm and suicide for certain groups and therefore the need to monitor the proportion of officers trained on such equality issues.
56	National LGB&T Partnership	Statement 1	People with mental health problems should also be referred to advocacy services as well as liaison and diversion services, which may be delivered by the voluntary sector.
57	National LGB&T Partnership	Statement 1	The Equality and Diversity considerations are too narrow, focusing on physical accessibility and language. This should also address issues regarding sexual orientation and gender identity of the person in custody.

ID	Organisation name	Statement No	Comments[1]
58	Northumbria Police & Northumberland Tyne and Wear NHS Foundation Trust	Statement 1	Within Northumbria Police, all permanent custody sgts have recently received a 4 hour input on MH based on the College of Policing's APP. This focussed on an understanding of what MH is with a brief overview of common illnesses such as depression as well as looking at some of the causes and warning signs around suicide. An awareness of learning disability was also discussed focussing on some dealing with issues such as autism. Whilst measuring numbers of officers trained can be done via training records, this will not detail areas such as "Proportion of police officers who are trained to develop and maintain safe boundaries and constructive relationships". Ensuring custody staff have a broad understanding of common MH related issues will ensure that the appropriate referral can be made to the liaison and diversion nurses. Whilst it is essential that officers are given general MH awareness training, they are not clinicians and ensuring the safety and wellbeing of those suffering mental illness must be a joint partnership role with the nurses.
59	Public Health England	Statement 1	This statement should be widened to address skills of police officers in recognising and responding to the mental health needs of all people they engage with, not only those brought into police custody. We recognise police custody is an appropriate setting for action but not the only important point of engagement between police services and vulnerable adults.
60	Public Health England	Statement 1	This area of improvement is important for all people working in the Criminal Justice System (CJS). The training identified in the NICE guidance does not differentiate between police custody and other settings and therefore should apply to prison officers, police staff and wider relevant healthcare workers within these settings. For reference, please see the relevant section on workforce training Continuing Professional Development (CPD) and supporting Royal College of Psychiatry (RCPsych) Quality Network for Prison mental Health Services standards www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/prisonmentalhealth/standards.aspx
61	Public Health England	Statement 1	Please amend evidence to include - 'multidisciplinary training' is offered as stated in the guidance (www.nice.org.uk/guidance/ng66/resources/mental-health-of-adults-in-contact-with-the-criminal-justice-system-pdf-1837577120965 (hereafter referred to as 'Guidance'), p. 28)
62	Public Health England	Statement 1	Public Health England (PHE) recommends that police specific measures should be expanded to include at least prison officers and appropriate amendments made to reflect this. Standards may need to be changed to ensure link to prison specific response to identified mental health needs as described in the NICE guidance.
63	Public Health England	Statement 1	PHE recommends including evidence that training includes managing the stress associated with working with CJS and the impact on interaction with others and their own mental health and wellbeing ('Guidance', p. 28)

ID	Organisation name	Statement No	Comments[1]
64	Public Health England	Statement 1	PHE recommends including evidence of police officers trained on understanding local referral services/support, as learning and development (L&D) services are not yet rolled out universally across all police areas.
65	Public Health England	Statement 1	Not all police custody suites have liaison and diversion services yet (82% March 18 & 100% by 2020) and therefore this should include "…or other local services where liaison and development is not available'. For reference, please see: www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-faqs/#q4 for reference.
66	Public Health England	Statement 1	Liaison and Diversion services are in police custody and therefore it is inadequate to say referral from police custody.
67	Public Health England	Statement 1	Assessment, Care in Custody and Teamwork (ACCT) is not used in police custody so this is not a tool that could be used to gather evidence. There is no single standard assessment tool used uniformly in all police custody suites.
68	Public Health England	Statement 1	These outcomes do not adequately focus on the outcome of this statement. Outcome measures associated with the training, i.e. evidence that the training has changed police officer behaviour would be better. For example, the proportion of police officers who are able to identify 1) risk of self-harm and suicide 2) changes of behaviour 3) able implement de-escalation methods 4) develop safe boundaries and constructive relationships Data source: (1) use of appropriate assessment tool used in custody suite, 2 – 4 self-reported or other local evidence.
69	Public Health England	Statement 1	If this measure remains police custody suites collect local data which is published by the Independent Police Complaints Commission (IPCC) www.ipcc.gov.uk/page/deaths-during-or-following-police-contact
70	Public Health England	Statement 1	There is a notable error in the section on what the quality standard means for different audiences where described: "Commissioners (local authorities, NHS England and clinical commissioning groups) ensure that the police services they commission provide training to frontline staff". None of these commissioners commission police services or police custody healthcare. NHS England (NHSE) is only responsible for Liaison and Diversion Services; Clinical Commissioning Groups (CCGs) are responsible for

ID	Organisation name	Statement No	Comments[1]
			community mental health services. Local government commissions drug and alcohol services (which may be relevant). The key audience for these guidance quality standards are Police and Crime Commissioners who do commission police custody healthcare and have a direct role in commissioning police services, including training.
71	Revolving doors	Statement 1	*Adults taken into police custody are cared for by police officers who recognise and respond to mental health problems* This is not a criticism of the police or the way that they work, but I am not sure I'd describe the role of the police as a caring one as such, even though they have a duty of care in the legal sense. I would suggest changing the wording to something along the lines of "Adults taken into police custody are dealt with appropriately by police officers…" or similar.
72	Revolving doors	Statement 1	*For many people entering the criminal justice system, the police are the first service they come into contact with. When people who have mental health problems are taken into police custody it is important that officers can recognise that a person may have mental health problems.* The intention behind this QS is presumably to improve the way that people are dealt with who come into contact with the criminal justice system either as offenders, or individuals who are suspected of committing an offence. This is appropriate, and relates to the majority of people who come into police custody. However, people who have not committed an offence and/or are not suspected of committing one may be taken into custody as a result of the use of the Mental Health Act. The number of instances where police custody rather than a health-based place of safety is used is falling, but it may be worth considering whether this scenario is adequately covered as the statement stands.
73	Revolving doors	Statement 1	Under 'data source', please consider specifying Liaison and Diversion dataset.
74	Royal College of General Practitioners	Statement 1	What is the level and accreditation of training in mental health required for police officers? How/Who accredits the training for police officers? Is this training standardised across police forces? Regarding the provision of care by officers able to recognise and respond to adults with mental health problems. The level of training suggested is quite basic and should be an attribute universal to police officers rather than a

ID	Organisation name	Statement No	Comments[1]
			quality only in a few officers. Skills such as de escalation, keeping prisoners calm, recognising an underlying mental health problem or a risk of self harm should be universal.
75	Royal College of Nursing	Statement 1	It is critical that policing staff and healthcare staff work collaboratively from the first point of contact. This standard relies on a shared approach to supporting individuals who are in police custody and who have poor mental health (including learning disabilities).
76	Royal College of Physicians and Surgeons of Glasgow	Statement 1	Whilst the need is immediate there needs to be a strict stepwise method of implementation. Each jurisdiction will need to develop an action plan. Information needs to be given in different forms. The writers should not assume literacy. In people whose first language is not English literacy rates fall.
77	Royal College of Psychiatrists	Statement 1	These focus on the police custody but there is no consideration of other interfaces with the criminal justice services such as probation and prison. Mental health problems may not be apparent at initial interaction but may become evident later in the pathway.
78	South Gloucestershire Council, Public Health and Wellbeing Division (PH&WBD)	Statement 1	• MH training for Police is available • Take up of training is low and this is due to the pressure of releasing frontline staff • Police feedback is that they feel under skilled • A mandatory training requirement may help the resource barriers in place • Recommendation to the HWBB to ask for mandatory training. • Based on the rates of people affected by MH in custody and prisons, it suggests that early triage of people through the process may reduce vulnerable people accumulating or developing MH conditions if Police and prison staff had adequate training. Agreeing with paragraph 2.4 on page 4 of the accompanying briefing paper.
79	South Gloucestershire Council, Public Health and Wellbeing Division (PH&WBD)	Statement 1	• Queries about how CJS links with Drug and alcohol services; domestic abuse and violence programmes; CVS; housing and employment – rehabilitation.
80	Together for Mental Wellbeing	Statement 1	It will be important that the training is not just e-learning but has interactional components that allows police officers to learn and discuss in a group
81	Together for Mental Wellbeing	Statement 1	The delivery of the training should also involve people who have lived experience of mental distress and who have had previous contact with the police

ID	Organisation name	Statement No	Comments[1]
82	Together for Mental Wellbeing	Statement 1	It will be important to clearly define what is meant by 'initial safety precautions' – for the police the understanding of this may be in terms of restraint but it for the majority of people, being spoken to in a calm and considered manner that conveys empathy for their situation is likely to be more supportive and reduce risk concerns
83	Together for Mental Wellbeing	Statement 1	Police officers need also to be trained to understand the impact on the custodial environment on people with mental health needs – for example, that trauma-informed approaches are incorporated in to their understanding and approaches to people who appear potentially vulnerable
84	Together for Mental Wellbeing	Statement 1	Data source – this could also include data that is collated by liaison & diversion services as per their standard NHS contracts
85	Association for Family Therapy and Systemic Practice in the UK	Question 4 re: statement 1	The question you pose is not clear. If you mean which of the 2 is most important 'recognition' or 'response' then it is response which makes the biggest difference, recognition may be part of the skill set necessary to respond in the ways you hope, but so also are the systemic / organisational supports for officers to increase the desired ways of responding.
86	Association of Police and Crime Commissioners Same comments from Dorset Police and Crime Commissioner	Question 4 re: statement 1	[Quality statement 1 only] The statement currently focuses on police officers recognising and responding to mental health problems in adults taken into police custody. Quality statements usually focus on one area for quality improvement. Which of these two is the priority area? Recognising mental health problems.
87	NHS England	Question 4 re: statement 1	Recognising is important. If they are then unequipped to manage this within the service, they should be bringing in additional support and referring to their health service partners.
88	NHS England	Question 4 re: statement 1	The consultation question suggests that only one area - recognition or response - can be given priority for improvement however they are inter-dependent; officers will not be able to respond appropriately without recognising the nature of the problem and will not be able to respond appropriately without high quality fit for purpose training.
89	Northamptonshire Mental Health Criminal Justice Board.	Question 4 re: statement 1	The focus for the quality statement should be on police officer recognising mental health problems. The recognition should then trigger the officer getting support from relevant mental health professionals to enable the response. It is not the responsibility of police officers to respond alone to a mental health situation.

ID	Organisation name	Statement No	Comments[1]
90	Public Health England	Question 4 re: statement 1	PHE recommends this statement should focus on responding to mental health problems rather than recognising them.
91	Revolving Doors	Question 4 re: statement 1	Would it be necessary to focus on one or the other, rather than both? The ability to provide an effective response may be somewhat meaningless without the capacity and skills to recognise mental ill health or distress, and vice versa. The two seem so intrinsically linked that prioritising one above the other may risk losing sight of the essential connection between the two elements.
92	Royal College of General Practitioners	Question 4 re: statement 1	Regarding draft quality statement no 1, there would appear to be no point in recognising mental health problems if you are not going to respond.
93	Royal College of Physicians and Surgeons of Glasgow	Question 4 re: statement 1	To achieve quality statement one there is a need for education of police officers to recognise and respond to mental health issues. It is common currently for these to be missed or managed inappropriately eg adults with learning difficulties who are put in solitary confinement. Both facets are needed to improve quality.
94	Royal College of Psychiatrists	Question 4 re: statement 1	The use of the word 'cared' is ambiguous and open to interpretation. The key part of this statement is that police recognise mental health problems. There are significant resource implications for police if they were to respond to mental health problems such as education and training.
95	South Gloucestershire Council, Public Health and Wellbeing Division (PH&WBD)	Question 4 re: statement 1	From PH&WB division perspective the priority relates to statement 1 and must be the training and awareness raising for the Police. Effective ID and knowing how to respond at the initial stages of the CJS are paramount in ensuring people get the right support asap.
96	Together for Mental Wellbeing	Question 4 re: statement 1	In terms of which should be the quality improvement area (recognising or responding), responding should be the quality area. Our experience as an organisation working in police custody suites delivering liaison & diversion service is that police officers generally can identify people who may have vulnerabilities including in relation to their mental health. The issues are focused more on then knowing what to do next in terms of which professionals to speak with / which services to refer to. Together has produced a guide aimed at supporting frontline criminal justice staff, including the police, with their interactions with people with mental health needs. This also includes information about what to do to respond to a person once mental health concerns have been identified.

ID	Organisation name	Statement No	Comments[1]
97	Action on Smoking and Health (ASH)	Statement 2	Under the definition of what's included in a comprehensive mental health assessment, there is no mention of smoking or tobacco use. Smoking and smoking cessation can both have an impact on mental health with smoking cessation being shown to reduce levels of depression and anxiety. Smoking status should be included alongside coexisting physical health problems in the list of what's included in an assessment.
98	Association of Police and Crime Commissioners Same comments from Dorset Police and Crime Commissioner	Statement 2	Statement 2 already occurs across parts of the country and I would support this being extended further.
99	Headway	Statement 2	The guidelines suggest that adults taken into police custody who have a suspected mental health problem are referred for a comprehensive mental health assessment. We urge that individuals with a suspected ABI (for instance, a history of head injury) should be referred for neuropsychological examination to ensure appropriate assessment.
100	NHS England North west H&J team	Statement 2	It would be good to add – other agencies such as the custody health team that will include physical health substance misuse
101	NHS England North west H&J team	Statement 2	HMIC reports
102	NHS England	Statement 2	The statement should refer to making referrals for mental health assessment in a timely way as this may be a key determinant of the outcome for an individual particularly if there is risk of suicide, self-harm or suspected physical health problems.
103	National LGB&T Partnership	Statement 2	The Equality and Diversity considerations are too narrow, focusing on physical accessibility and language. This should also address issues regarding sexual orientation and gender identity of the person in custody. Such people will benefit from advocacy from an LGBT advocate. This may be vital since such support may be key to assessing their mental health needs.
104	Northumbria Police & Northumberland	Statement 2	The statement 'a comprehensive mental health assessment may result in (A) referral from police custody to liaison and diversion services' – Northumbria Police have adopted a new risk assessment tool with focused questions

ID	Organisation name	Statement No	Comments[1]
	Tyne and Wear NHS Foundation Trust		about Mental health, Risk and Substance use – this information would then generate a referral to Liaison and Diversion services when a comprehensive assessment would be completed. This encourages a joint partnership role within the custody environment. Measuring outcomes of those referred to Liaison and Diversion services during working hours would be easy to obtain but we could not provide data on those suspected with a mental health problem and released out of Liaison and Diversion hours.
105	Public Health England	Statement 2	This quality statement is limited by its focus on only police custody staff and should include all staff working in police custody which would include healthcare and liaison and diversion teams. Please see previous comments made on page one with specific reference to prison services.
106	Public Health England	Statement 2	These quality standards relate to police custody but the guidance itself makes only limited reference to police custody or police services and therefore quality statements are not directly derived from the guidance.
107	Public Health England	Statement 2	This area of improvement is important for all people working in the CJS and should refer to all custodial settings – see RCPsych Quality Network for Prison mental Health Services standards on assessment which includes when an assessment should be done, by whom and how www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/prisonmentalhealth/standards.aspx
108	Public Health England	Statement 2	PHE recommends you change the statement to: 'All adults taken in to police custody who have a suspected mental health problem 'have' a mental health assessment, not just referred'.
109	Public Health England	Statement 2	This measure does not demonstrate referral. It could be a more appropriate associated outcome with quality statement 1 unless you change statement 2 as recommended above.
110	Public Health England	Statement 2	ACCT is a specific process in prison settings only and so cannot be a data source relating to contact between police services and vulnerable adults with mental health problems.
111	Public Health England	Statement 2	Evidence that the assessment is 1) undertaken by a competent practitioner ('Guidance', p. 16) 2) undertaken in an appropriate environment and 3) includes the recommended areas to cover ('Guidance', p. 18) Data source: local audit
112	Public Health England	Statement 2	Evidence of appropriately responding to people with mental health needs Numerator number identified as having a mental health need denominator numbers referred for MH assessment
113	Public Health England	Statement 2	Evidence that 1) a coordinator is leading the assessment and 2) that it is a collaborative process ('Guidance', p. 17) and 3) all relevant documentation are taken into consideration during a mental health needs assessment

ID	Organisation name	Statement No	Comments[1]
114	Public Health England	Statement 2	Evidence that with the person's consent, assessment is undertaken with family members, partner/carer/advocate/legal rep to help inform decisions (see guidance p. 6) Data: audit of documentation
115	Public Health England	Statement 2	Evidence of outcome of assessment is shared with all relevant personal (with permission of the person) (see guidance p19) Data: audit of documentation
116	Public Health England	Statement 2	This cannot be an outcome without a recommended performance target.
117	Public Health England	Statement 2	The data source cannot be ACCT as it is a specific process used in prison settings only (see above)
118	Public Health England	Statement 2	This outcome is only relevant if there is a L & D service 'within' police custody (need to change 'from' police custody in wording) but this is not an outcome for this statement
119	Public Health England	Statement 2	PHE recommends amending commissioner to include Police and Crime Commissioners (PCC) who are responsible for commissioning police custody services including healthcare
120	Revolving Doors	Statement 2	Although not provided in every area, and with no national programme with an ambition to do so, it may be worth mentioning the role of Street Triage as a means of making a preliminary assessment prior to referral for a comprehensive assessment.
121	Revolving Doors	Statement 2	Suggest adding Liaison and Diversion dataset.
122	Royal College of General Practitioners	Statement 2	Forensic Medical Examiners (formerly known as Police Surgeon) are not explicitly mentioned in either the 'service provider' or 'police and mental health practitioners' audiences section. These doctors may be neither 'primary care practitioners' or 'secondary care psychiatrists' and may come from a wide background of medical experience . Regarding a comprehensive mental health assessment, there are concerns that the nature of the assessment suggested will not capture the complex nature of patients presenting to criminal justice systems with mental health problems. Patients are usually very complicated and have a mix of mental health, substance misuse, personality disorder and severe social stress. Assessments need to reflect this and should be multidisciplinary. Patients may be subject to multiple assessments (as they tend to be revolving door patients) with little done to interrupt their behaviour. There are concerns amongst some experienced practitioners that this client group do not often benefit from the response from treatment services needed for their dual (or triple) diagnosis.

ID	Organisation name	Statement No	Comments[1]
123	Royal College of Nursing	Statement 2	This quality standard is heavily reliant upon good social care support and upon adequate staffing resource both in the community and in the police custody setting. Getting safe staffing levels is the key to success alongside the importance of having appropriately skilled staff able to respond.
124	Royal College of Physicians and Surgeons of Glasgow	Statement 2	This is a service which needs to be provided by local mental health services. These are stretched and intervention is not always timely. This service must be part of an acute mental health service. Commissioners of health services need to understand this is part of overall mental health service provision. Information needs to be given in different forms. The writers should not assume literacy. In people whose first language is not English, literacy rates fall.
125	Royal College of Psychiatrists	Statement 2	There is no mention of timescales for assessment. Local structures are in place in many areas but services are not provided consistently across the country. This would therefore have resource implications in those areas that have no such services.
126	Together for Mental Wellbeing	Statement 2	Data sources – this could also include data that is collated by liaison & diversion services as per their standard NHS contracts
127	Together for Mental Wellbeing	Statement 2	Data sources – this could also include data that is collated by liaison & diversion services as per their standard NHS contracts
128	Together for Mental Wellbeing	Statement 2	It will be important that in order for the mental health assessments to be completed that appropriate facilities are made available to the staff undertaking the mental health assessments, including that the space is confidential and safe.
129	Together for Mental Wellbeing	Statement 2	Data sources – this could also include data that is collated by liaison & diversion services as per their standard NHS contracts
130	Together for Mental Wellbeing	Statement 2	The assessment should also seek to obtain, with the person's consent', information from family, carers and friends.
131	Together for Mental Wellbeing	Statement 2	The assessment needs to include a clear case formulation based on the needs identified and clear recommendations for criminal justice colleagues, as appropriate, to inform their decision-making in the interests of the person's health and wellbeing and safety and for the safety of others.
132	Action on Smoking and Health (ASH)	Statement 3	Information on an individual's smoking status and the management of their nicotine addiction should be included in care plans to ensure the continuity of care. Smokers may also require referrals to community Stop Smoking Services on their release from police custody.

ID	Organisation name	Statement No	Comments[1]
133	Association of Police and Crime Commissioners Same comments from Dorset Police and Crime Commissioner	Statement 3	Statements 3 and 4 are positive although as I have already stated, I would be concerned about the bulk of the responsibility for Statement 3 falling to the police service as the most likely point of entry into the CJS and the significant resourcing and training implications that this would potentially have as a result.
134	Headway	Statement 3	We endorse the recommendation of data sharing within the boundaries of confidentiality and urge this suggestion to also be applied to those with ABI. This ensures that multiple agencies are kept informed and involved to provide integrated care.
135	NHS England North west H&J team	Statement 3	Add – and when people are transferred to prisons
136	NHS England	Statement 3	It is not clear which organisation the statement is aimed at i.e. who is responsible for communicating the plan
137	NHS England	Statement 3	It is not clear what 'communicating' means in this context
138	NHS England	Statement 3	It is not clear which organisations will be measured against this standard and which organisation is responsible for conducting collecting data audits and therefore this will be hard to measure
139	NHS England	Statement 3	It is not clear which organisations will be measured against this standard and which organisation is responsible for conducting collecting data audits and therefore this will be hard to measure
140	National LGB&T Partnership	Statement 3	People with mental health problems should also be referred to advocacy services as well as liaison and diversion services, which may be delivered by the voluntary sector.
141	National LGB&T Partnership	Statement 3	Service Providers should also include the voluntary sector since such advocacy and support networks will be vital for developing and delivering mental health care plans.
142	National LGB&T Partnership	Statement 3	The care plans should include liaison with advocacy and support groups since LGBT may not have connections with family members.
143	Northumbria Police & Northumberland Tyne and Wear NHS Foundation Trust	Statement 3	Audience descriptor: All Mental Health care plans will be available on the Mental health Records system that Liaison and Diversion Practitioners have access to – there may not be one relevant to police custody at the time of detention. Liaison and Diversion services can develop these care plans when in police custody and share with relevant agencies.

ID	Organisation name	Statement No	Comments[1]
			Who is responsible for the review of this plan? If the person is not involved with Community mental health services, would the responsibility fall to the identified pathway service? What is the monitoring process for this?
144	Public Health England	Statement 3	The use of the word 'other' needs to be clarified: other to what, prison services?
145	Public Health England	Statement 3	PHE recommend including evidence of a sharing protocol/policy using local audit as the data source. Data source: local audit
146	Public Health England	Statement 3	PHE recommends including evidence of a lead coordinator responsible to sharing care plans.
147	Public Health England	Statement 3	For a data source for prison services, refer Health and Justice Indicators of Performance (HJIPs)
148	Public Health England	Statement 3	This outcome would only relate to police custody and for those who have liaison and diversion services.
149	Public Health England	Statement 3	The audience needs to include PCC commission services in police custody, including staff and healthcare.
150	Royal College of General Practitioners	Statement 3	This may be difficult to measure based on knowing which service or services to share the mental health care plan with. For example, people in contact with the criminal justice system may have a number of providers, including substance misuse, primary care (GP), secondary care (A&E, community mental health) as well as statutory services (Probation, housing, social services) who would benefit from having this information shared with them but this must be balanced and within the relevant Caldicott principles. Evidence for this statement could include the presence of 'consent and information sharing agreements'. The use of encrypted and secure systems may make this more difficult to measure.
151	Royal College of Physicians and Surgeons of Glasgow	Statement 3	Sharing a care plan with the individual and all agencies is a necessary part of safe management.
152	Royal College of Psychiatrists	Statement 3	These standards could be more easily implemented and measured if there were consistent information/records systems and agreements to share information. There is no reference to the governance processes for information sharing (such as gaining consent).
153	Together for Mental Wellbeing	Statement 3	There should also be an agreed process for how mental health care plans can be informed by subsequent assessments by health professionals and follow the person along the criminal justice pathways as required i.e.

ID	Organisation name	Statement No	Comments[1]
			that the care plans are dynamic and 'live' documents that recognise that a person's needs may change whilst they are in contact with the criminal justice systems
154	Together for Mental Wellbeing	Statement 3	The agreed process for the plan to be shared will also need an agreed process for how the consent of the person has been obtained to support information sharing
155	Together for Mental Wellbeing	Statement 3	The care plan should also include references to the involvement of family / other 'informal' support networks
156	Action on Smoking and Health (ASH)	Statement 4	In order to mitigate risks during transfer between settings, smokers should be identified and informed if they are being moved into a smokefree service. Smoking status should be included in a risk management plan and nicotine replacement therapy provided to reduce stress and anxiety during transfer.
157	Association for Family Therapy and Systemic Practice in the UK	Statement 4	Again, risk management during transfers is not solely to do with people identified as having 'mental health problems'. Those who present a risk to others may do so in the absence of 'mental health problems'. Identification of risk would seem to be more pertinent than identification of 'mental health problems' in an individual, since risk is dynamic and contextual, not a property of an individual.
158	Association of Directors of Public Health	Statement 4	**The quality statement does not cover discharge from criminal justice service.** This is a particularly important transition point at those leaving (particularly from prison) may be returning to locations where a variety of risk factors remain that could worsen their mental health. The criminal Justice system should have a duty to actively engage with home location adult mental health services for continuity of care and transfer of records.
159	Association of Police and Crime Commissioners Same comments from Dorset Police and Crime Commissioner	Statement 4	Collecting data for Statement 4 will be difficult and has been the subject of Home Office discussion.
160	Headway	Statement 4	Cognitive problems should also be considered under mental health risk management plans, for instance providing memory aids for individuals who have memory problems when being moved between services. Physical problems, such as issues with dizziness, balance, one sided weakness etc, must also be considered to ensure safe and appropriate transferral arrangements.

ID	Organisation name	Statement No	Comments[1]
161	NHS England North west H&J team	Statement 4	Ensure that risk management plans are shared with all agencies and implemented
162	NHS England	Statement 4	The quality statement is ambiguous. It is not clear if there is an expectation that all individuals with a mental health problem, neurological disability including learning disabilities and autism should have a risk management plan.
163	NHS England	Statement 4	There is no expectation of timeliness in sharing risk management plans which may lead to individuals being held in unsuitable locations adding to risk for individuals and others they come into contact with
164	NHS England	Statement 4	It is not clear which organisation will be measured against this standard
165	National LGB&T Partnership	Statement 4	Local data collection should include monitoring of sexual orientation and gender identity to ensure tracking of experiences of LGBT people and identify trends in risk management plans.
166	Public Health England	Statement 4	Data source; MoJ collect suicide and self-harm data in prisons; www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2017 police custody suites collect local data which is published by IPCC https://www.ipcc.gov.uk/page/deaths-during-or-following-police-contact
167	Public Health England	Statement 4	Commissioners should include commissioners of prison services e.g. MoJ, HMPPS and PCCs Retitle Criminal Justice professionals to Criminal Justice Staff and include probation and community rehabilitation companies (CRCs) Under adults in contact with CJS… include transfers between prisons and transfer into the community
168	Royal College of General Practitioners	Statement 4	The current paper Person Escort Record (PER) form contains only two very small boxes for the inclusion of at most two lines of handwritten text where a practitioner can record the presence of a mental or physical health issue. There is a separate box for medication. Frequently these boxes contain only a tick or nothing at all. This is an area where practitioner have been reluctant to share information for fear of breaking Caldicott guidelines. It is worth noting that the Ministry of Justice Digital Transformation team is working on a project called Moving People Safely which will in effect digitize the PER form (= e-PER) and that ultimately this will be used for ALL journeys for someone in contact with the criminal justice system. Mental health conditions are included within one of the sections on this form which is currently only being piloted.
169	Royal College of Physicians and	Statement 4	Safe transfer between agencies with a mental health management plan often fails to happen at present. There needs to be adequate audit to show this happens and that all contracts have explicit clauses to make sure it does

ID	Organisation name	Statement No	Comments[1]
	Surgeons of Glasgow		happen. This is important with private providers. There is equally a need to review individuals on transfer to assess whether they have developed a mental health problem.
170	Together for Mental Wellbeing	Statement 4	The risk management plans need to have the roles and responsibilties of professionals clearly outlined within them to ensure clarity around accountability.
171	Association of Directors of Public Health	Additional areas	This is too narrow as it focusses on adults who have already been taken into custody. There are crisis points and opportunities to intervene earlier in the criminal justice pathway. The standard should make reference to joint working between mental health services and criminal justice (particularly police). A high percentage of people who are taken into custody with suspected mental health problems are already known to mental health services. Therefore street triage schemes should be developed locally. Initially these schemes tended to be mental health nurses working alongside police within the community. However a more effective model is now being employed in many areas with mental health staff (and possible also social care staff) working within police call centres. These staff have access to patient records and are able to advise on appropriate first response, provide specific clinical details and info about care plans, and potentially avert an arrest or caution, referring adults back to appropriate services. Ideally this should be put in a separate quality statement Statement 1 Adults at risk of being taken into custody are cared for by police officers working in real time with local mental health services to recognise and respond to mental health problems. Or incorporated Statement 1 Adults taken into police custody or at risk of being taken into custody are cared for by police officers (working in real time with mental health services) who recognise and respond to mental health problems.
172	False Allegations Support Organisation	Additional areas	Having skipped through your process of recognition, you would need many more staff, paperwork, and identification of clients by non-professionals. Even qualified mental health workers can never always identify all those with mental health. What is needed in all departments of the justice system – dependant on size of the organisation, ie police station, prison, parole area – is a triage system run by a qualified experienced mental health worker(s) along with a junior. Whilst the professional is triaging, the junior can speak with family and take a short history (this area is never used) They should also be triaging and assessing those with special needs, which may mean a different way of doing it.

ID	Organisation name	Statement No	Comments[1]
			Those identified should then be put under the mental health programme with all police and prison officers identified to manage the person under the mental health act until a full diagnosis and formal treatment is given. This would mean be supportive of the prisoner and encouraging them to do things instead of pushing them. Being aware of the physical danger of mental health, - persons becoming aggressive. This awareness could be added on to their first aid training. The above would ten put the responsibility of recognition onto the qualified person and the prison and probation staff treating them by using their first aid skills. This leads to cost effective wok ensuring the police and prison officer's ae not encumbered with excess work when there is no necessity.
173	Headway	Additional areas	We urge NICE to consider the implementation of appropriate rehabilitation for adults with ABI who are in prison. Some adults with ABI may find themselves in prison having received little/no formal rehabilitation following their injury. Behaviours that involved them in the system in the first place can sometimes be improved with specialist rehabilitation from clinical neuropsychology services (for instance, receiving therapy for management of anger issues after brain injury). Receiving such rehabilitation could contribute towards improving outcomes by reducing the reoffending rates of people with mental health problems from ABI, as well as improving mortality and morbidity rates. Better access to rehabilitation services in the first place (i.e. upon hospital discharge) could reduce the number of people with ABI related mental health problems in prison in the first place as a preventative measure.
174	Royal College of Psychiatrists	Additional areas	Another area for quality improvement would be the timely access to beds for mentally unwell prisoners.

Registered stakeholders who submitted comments at consultation

- Action on Smoking and Health (ASH)
- African Health Policy Network
- Association of Police and Crime Commissioners
- Association for Family Therapy and Systemic Practice in the UK
- Association of Directors of Public Health
- Department of Health
- Dorset Police and Crime Commissioner
- False Allegations Support Organisation
- Headway
- Joint NHS/ Her Majesty's Prisons and Probation Service Offender Personality Disorder Team
- National LGB&T Partnership
- NHS England North West Health and Justice team
- NHS England
- Northamptonshire Mental Health Criminal Justice Board
- Northumbria Police
- Prison Governors Association
- Public Health England
- Revolving Doors Agency

- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Physicians and Surgeons of Glasgow
- Royal College of Psychiatrists
- South Gloucestershire Council, Public Health and Wellbeing Division (PH&WBD)
- Together for Mental Wellbeing