NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

SCOPE

1 Guideline title

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

1.1 Short title

Mental health of adults in contact with the criminal justice system

2 The remit

The Department of Health has asked NICE to develop guidance on the identification and management of mental health problems of people in contact with the criminal justice system.

3 Need for the guideline

3.1 Epidemiology

a) Mental health problems are very common in people in contact with the criminal justice system. An estimated 39% of people detained in police custody have some form of mental disorder, and over 25% of residents in approved premises (previously known as bail hostels) have been found to have a psychiatric diagnosis. An estimated 39% of adults serving community sentences have a mental disorder, and it has been estimated that over 90% of prisoners have at least one of the following psychiatric disorders:

- psychosis

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

b) Rates of mental disorder in remand prisoners have been found to be even higher than in sentenced prisoners.

c) Gender inequalities in the prevalence of mental health problems have also been reported, with 40% of women compared with 20% of men in prison having had treatment for a mental health problem in the 12 months before entering prison.

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

e) The prevalence of common mental disorders is also high among people in contact with the criminal justice system. An estimated 15% of people detained in police custody have a mild or moderate depressive disorder. Among people serving community sentences, 21% have an anxiety disorder and at any given time an estimated 15% will be having a major depressive episode. An estimated 76% of female remand prisoners, 63% of female sentenced prisoners, 59% of male remand prisoners and 40% of male sentenced prisoners have an anxiety disorder or depression. This compares with 16% of the general population.

f) The prevalence of personality disorders is very high among people in contact with the criminal justice system. Among people serving

community sentences, an estimated 47% are likely to have a personality disorder. Among the prison population, an estimated 58% of male remand prisoners, 64% of male sentenced prisoners and 50% of female prisoners (remand and sentenced combined) have a personality disorder. This compares with 5% of the general population.

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

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

i) Rates of alcohol misuse are also high. An estimated 56% of people serving community sentences show current hazardous drinking behaviour, and 60% of male prisoners (remand and sentenced combined) and 38% of female prisoners (remand and sentenced combined) report hazardous drinking in the year before going to prison.

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

k) Estimates for the prevalence of learning disabilities among people in police custody range from 0.5–9%, while an estimated 7% of the

prison population have a learning disability compared to 2% of the general population.

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

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

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

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

3.2 Current practice

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

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

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

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

- the high number of people being detained who are intoxicated on arrival at the police station
- the lack of a standard mental health assessment
- the lack of a national standard for police training in mental health
- a reliance on self-reporting
- barriers to disclosure including stigma, previous negative experiences and the custody suite environment.

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

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

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

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

- improving identification of mental health problems
- making transfer to hospital (when appropriate) easier
- assessing people appearing in court to help with case completion options
- signposting and referring to appropriate services

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

i) Prisoners receive a brief health reception screen on arrival in prison, intended to identify immediate needs. A subsequent, more in-depth health assessment is supposed to be done outside of the time-constrained reception environment. However, the implementation of health screening, in particular the longer and more detailed post-reception assessment, is variable and often does not happen. Because of this, identification of mental health problems, particularly depression and anxiety disorders, is poor.

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

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

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

m) As well as treatments offered by specialist mental health services, interventions for sexual offenders or people with severe antisocial behaviour may be provided by the prison forensic psychology service or by the probation service.

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

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

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

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

4 The guideline

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

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

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

4.1 Population

4.1.1 Groups that will be covered

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

- in police custody
- in court custody
- in contact with liaison, diversion and street triage services
- remanded on bail
- remanded in prison
- who have been convicted and are serving a prison or community sentence
- released from prison on licence
- released from prison and in contact with a community rehabilitation company (CRC) or the probation service.

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

- people with neurodevelopmental disorders (including learning disabilities)
- women
- older adults (aged 50 years and over)
- young black men
- young adults that have transitioned from juvenile services.

4.1.2 Groups that will not be covered

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

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

4.2 Setting

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

4.3 Management

4.3.1 Key issues that will be covered

When there is existing NICE guidance for the assessment, treatment or management of a mental health problem, the primary source for the evidence in this guideline will be drawn from the relevant guidance. A key concern for this guideline will be reviewing evidence relevant to the criminal justice system to identify any modifications needed to existing recommendations or to the current structure and systems for the delivery of health and social care services in the criminal justice system, in order to support implementation of existing guidance. When there is no existing NICE guidance a new review will be carried out for this guideline.

a) Identification and assessment:

- recognising people who have a mental health problem (including formal recognition tools)

- assessing mental health problems (including formal assessment tools).

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

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

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

- care planning and pathways, and organisation and structure of services, which promote:
  - appropriate access to services
  - positive experience of services
  - care coordination
  - transitions between services
  - discharge from services

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

4.3.2 Issues that will not be covered

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

4.4 Main outcomes

a) Mental health outcomes

b) Offending and re-offending

c) Service use

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

e) Rates of self-injury in service users

f) Experience of care

4.5 Economic aspects

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

4.6 Status

4.6.1 Scope

This is the final draft of the scope.

4.6.2 Timing

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

5 Related NICE guidance

5.1 Published guidance

5.1.1 NICE guidance to be incorporated

This guideline will incorporate the following NICE guidance: TBC

5.1.2 Other related NICE guidance

- Psychosis and schizophrenia in adults. NICE clinical guideline 178 (2014).
- Social anxiety disorder. NICE clinical guideline 159 (2013).
- Patient experience in adult NHS services. NICE clinical guidance 138 (2012)
- Autism in adults. NICE clinical guideline 142 (2012).
- Service user experience in adult mental health. NICE clinical guidance 136 (2011).
- Self-harm: longer term management. NICE clinical guideline 133 (2011).
- Common mental health disorders. NICE clinical guideline 123 (2011)
- Psychosis with coexisting substance misuse. NICE clinical guideline 120 (2011).
- Alcohol-use disorders. NICE clinical guideline 115 (2011).
- Alcohol dependence and harmful alcohol use. NICE quality standard 11 (2011)

- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011).
- Alcohol-use disorders: physical complications. NICE clinical guideline 100 (2010)
- Depression with a chronic physical health problem. NICE clinical guideline 91 (2009).
- Depression in adults. NICE clinical guideline 90 (2009).
- Borderline personality disorder. NICE clinical guideline 78 (2009).
- Antisocial personality disorder. NICE clinical guideline 77 (2009).
- Medicines adherence. NICE clinical guideline 76 (2009)
- Attention deficit hyperactivity disorder. NICE clinical guideline 72 (2008).
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007).
- Interventions to reduce substance misuse among vulnerable young people. NICE guidelines PH4 (2007).
- Dementia. NICE clinical guideline 42 (2006).
- Obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).
- Post-traumatic stress disorder. NICE clinical guideline 26 (2005).
- Violence. NICE clinical guideline 25 (2005).
- Self-harm. NICE clinical guideline 16 (2004).

5.2 Guidance under development

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

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

6 Further information

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

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

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