

Mental health of adults in contact with the criminal justice system

NICE guideline

Published: 21 March 2017

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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Overview

This guideline covers assessing, diagnosing and managing mental health problems in adults (aged 18 and over) who are in contact with the criminal justice system. It aims to improve mental health and wellbeing in this population by establishing principles for assessment and management, and promoting more coordinated care planning and service organisation across the criminal justice system.

Also see NICE's guideline on [physical health of people in prison](#), which covers mental health assessment for the prison population as part of the first-stage health assessment for people going into prison, and continuity of mental health care for people leaving prison.

Who is it for?

- Commissioners and providers of health and justice services
- All health and social care professionals working with adults in contact with the criminal justice system in community, primary care, secondary care and secure settings
- Adults in contact with the criminal justice system who have or may have mental health problems

Recommendations

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

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

1.1 *Using this guideline together with other NICE guidelines*

1.1.1 Use this guideline with the NICE guidelines on [service user experience in adult mental health](#) and [patient experience in adult NHS services](#) to improve the experience of care for people with mental health problems including those with neurodevelopmental disorders.

1.1.2 Use this guideline with any NICE guidelines on specific mental health problems^[1]. Take into account:

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

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

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

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

1.2 *Principles of assessment*

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

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

1.2.2 Carry out assessments:

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

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

1.3 *Identification and assessment throughout the care pathway*

- 1.3.1 Be vigilant for the possibility of unidentified or emerging mental health problems in people in contact with the criminal justice system, and review available records for any indications of a mental health problem.
- 1.3.2 Ensure all staff working in criminal justice settings are aware of the potential impact on a person's mental health of being in contact with the criminal justice system.

First-stage health assessment at reception into prison

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

There is also a [downloadable version](#) of the first stage health assessment table as shown in table 1.

- 1.3.3 At first reception into prison, a healthcare professional (or trained healthcare assistant under the supervision of a registered nurse) should carry out a health assessment for every person. Do this before the person is allocated to their cell. As part of the assessment, identify:
- any issues that may affect the person's immediate health and safety before the second-stage health assessment
 - priority health needs to be addressed at the next clinical opportunity.
- 1.3.4 Ensure continuity of care for people transferring from one custodial setting to another (including court, the receiving prison or during escort periods) by, for example:

- accessing relevant information from the patient clinical record, prisoner escort record and cell sharing risk assessment
- checking medicines and any outstanding medical appointments.

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

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

Table 1 Questions for first-stage prison health assessment

Topic questions	Actions
Prison sentence	
1. Has the person committed murder, manslaughter or another offence with a long sentence?	Yes: refer the person for mental health assessment by the prison <u>mental health in-reach team</u> if necessary. No: record no action needed.
Prescribed medicines	

<p>2. Is the person taking any prescribed medicines (for example, insulin) or over-the-counter medicines (such as creams or drops)? If so:</p> <ul style="list-style-type: none"> • what are they • what are they for • how do they take them? 	<p>Yes: document any current medicines being taken and generate a medicine chart.</p> <p>Refer the person to the prescriber for appropriate medicines to be prescribed, to ensure continuity of medicines.</p> <p>If medicines are being taken, ensure that the next dose has been provided (see recommendations 1.7.10 and 1.7.11 in the NICE guideline on physical health of people in prison).</p> <p>Let the person know that medicines reconciliation will take place before the second-stage health assessment.</p> <p>No: record no action needed.</p>
<p>Physical injuries</p>	
<p>3. Has the person received any physical injuries over the past few days, and if so:</p> <ul style="list-style-type: none"> • what were they • how were they treated? 	<p>Yes: assess severity of injury, any treatment received and record any significant head, abdominal injuries or fractures.</p> <p>Document any bruises or lacerations observed on a body map.</p> <p>In very severe cases, or after GP assessment, the person may need to be transferred to an external hospital. Liaise with prison staff to transfer the person to the hospital emergency department by ambulance.</p> <p>If the person has made any allegations of assault, record negative observations as well (for example, 'no physical evidence of injury').</p> <p>No: record no action needed.</p>
<p>Other health conditions</p>	

<p>4. Does the person have any of the following:</p> <ul style="list-style-type: none"> • allergies, asthma, diabetes, epilepsy or history of seizures • chest pain, heart disease • chronic obstructive pulmonary disease • tuberculosis, sickle cell disease • hepatitis B or C virus, HIV, other sexually transmitted infections • learning disabilities • neurodevelopmental disorders • physical disabilities? 	<p>Ask about each condition listed.</p> <p>Yes: make short notes on any details of the person's condition or management. For example, 'Asthma – on Ventolin 1 puff daily'.</p> <p>Make appointments with relevant clinics or specialist nurses if specific needs have been identified.</p> <p>No: record no action needed.</p>
<p>5. Are there any other health problems the person is aware of that have not been reported?</p>	<p>Yes: record the details and check with the person that no other physical health complaint has been overlooked.</p> <p>No: record no action needed.</p>
<p>6. Are there any other concerns about the person's health?</p>	<p>Yes: make a note of any other concerns about physical health. This should include any health-related observations about the person's physical appearance (for example, weight, pallor, jaundice, gait or frailty).</p> <p>Refer the person to the GP or relevant clinic.</p> <p>No: note 'Nil'.</p>
<p>Additional questions for women</p>	

<p>7. Does the woman have reason to think she is pregnant, or would she like a pregnancy test?</p>	<p>If the woman is pregnant, refer to the GP and midwife.</p> <p>If there is reason to think the woman is pregnant, or would like a pregnancy test: provide a pregnancy test. Record the outcome. If positive, make an appointment for the woman to see the GP and midwife.</p> <p>No: record response.</p>
<p>Living arrangements, mobility and diet</p>	
<p>8. Does the person need help to live independently?</p>	<p>Yes: note any needs. Liaise with the prison disability lead in reception about:</p> <ul style="list-style-type: none"> • the location of the person's cell • further disability assessments the prison may need to carry out. <p>No: record response.</p>
<p>9. Do they use any equipment or aids (for example, walking stick, hearing aid, glasses, dentures, continence aids or stoma)?</p>	<p>Yes: remind prison staff that all special equipment and aids the person uses should follow them from reception to their cell.</p> <p>No: record response.</p>
<p>10. Do they need a special medical diet?</p>	<p>Yes: confirm the need for a special medical diet. Note the medical diet the person needs and send a request to catering. Refer to appropriate clinic for ongoing monitoring.</p> <p>No: record response.</p>
<p>Past or future medical appointments</p>	

<p>11. Has the person seen a doctor or other healthcare professional in the past few months? If so, what was this for?</p>	<p>Yes: note details of any recent medical contact. Arrange a contact letter to get further information from the person's doctor or specialist clinic. Note any ongoing treatment the person needs and make appointments with relevant clinics, specialist nurses, GP or other healthcare staff.</p> <p>No: record no action needed.</p>
<p>12. Does the person have any outstanding medical appointments? If so, who are they with, and when?</p>	<p>Yes: note future appointment dates. Ask healthcare administrative staff to manage these appointments or arrange for new dates and referral letters to be sent if the person's current hospital is out of the local area.</p> <p>No: record no action needed.</p>
<p>Alcohol and substance misuse</p>	
<p>13. Does the person drink alcohol, and if so:</p> <ul style="list-style-type: none"> • how much do they normally drink? • how much did they drink in the week before coming into custody? 	<p>Urgently refer the person to the GP or an alternative suitable healthcare professional if:</p> <ul style="list-style-type: none"> • they drink more than 15 units of alcohol daily or • they are showing signs of withdrawal or • they have been given medication for withdrawal in police or court cells. <p>No: record response.</p>

<p>14. Has the person used street drugs in the last month? If so, how frequently?</p> <p>When did they last use:</p> <ul style="list-style-type: none"> • heroin • methadone • benzodiazepines • amphetamine • cocaine or crack • novel psychoactive substances • cannabis • anabolic steroids • performance and image enhancing drugs? 	<p>Yes: refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support. Take into account whether:</p> <ul style="list-style-type: none"> • they have taken drugs intravenously • they have a positive urine test for drugs • their answers suggest that they use drugs more than once a week • they have been given medication for withdrawal in police or court cells. <p>If the person has used intravenous drugs, check them for injection sites. Refer them to substance misuse services if there are concerns about their immediate clinical management and they need immediate support.</p> <p>No: record response.</p>
<p>Problematic use of prescription medicines</p>	
<p>15. Has the person used prescription or over-the-counter medicines in the past month:</p> <ul style="list-style-type: none"> • that were not prescribed or recommended for them or • for purposes or at doses that were not prescribed? • If so, what was the medicine and how did they use it (frequency and dose)? 	<p>Yes: refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support.</p> <p>No: record response.</p>
<p>Mental health</p>	

<p>16. Has the person ever seen a healthcare professional or service about a mental health problem (including a psychiatrist, GP, psychologist, counsellor, community mental health services, alcohol or substance misuse services or learning disability services)?</p> <p>If so, who did they see and what was the nature of the problem?</p>	<p>Yes: refer the person for a mental health assessment if they have previously seen a mental health professional in any service setting.</p> <p>No: record response.</p>
<p>17. Has the person ever been admitted to a psychiatric hospital, and if so:</p> <ul style="list-style-type: none"> • when was their most recent discharge • what is the name of the hospital • what is the name of their consultant? 	<p>Yes: refer the person for a mental health assessment.</p> <p>No: record response.</p>
<p>18. Has the person ever been prescribed medicine for any mental health problems? If so:</p> <ul style="list-style-type: none"> • what was the medicine • when did they receive it • when did they take the last dose • what is the current dose (if they are still taking it) • when did they stop taking it? 	<p>Yes: refer the person for a mental health assessment if they have taken medicine for mental health problems.</p> <p>No: record response.</p>
<p>Self-harm and suicide risk</p>	

<p>19. Is the person:</p> <ul style="list-style-type: none"> • feeling hopeless or • currently thinking about or planning to harm themselves or attempt suicide? 	<p>Yes: refer the person for an urgent mental health assessment. Open an <u>Assessment, Care in Custody and Teamwork (ACCT)</u> plan if:</p> <ul style="list-style-type: none"> • there are serious concerns raised in response to questions about self-harm, including thoughts, intentions or plans, or observations (for example, the patient is very withdrawn or agitated) or • the person has a history of previous suicide attempts. <p>Be aware and record details of the impact of the sentence on the person, changes in legal status and first imprisonment, and the nature of the offence (for example, murder, manslaughter, offence against the person and sexual offences).</p> <p>No: record response.</p>
<p>20. Has the person ever tried to harm themselves, and if so:</p> <ul style="list-style-type: none"> • do they have a history of suicide attempts • was this inside or outside prison • when was the most recent incident • what was the most serious incident? 	<p>Yes: refer the person for a mental health assessment if they have ever tried to harm themselves.</p> <p>No: record response.</p>

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

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

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

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

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

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

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

Carrying out a mental health assessment

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

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

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

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

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

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

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

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

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

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

- use validated tools relevant to the disorders or problems being assessed
- take into account the views of practitioners from other services involved in the person's care.

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

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

1.3.15 When assessing people in contact with the criminal justice system all practitioners should:

- recognise potential barriers to accessing and engaging in interventions and methods to overcome these at the individual and service level
- discuss mental health problems and treatment options in a way that gives rise to hope and optimism by explaining that change is possible and attainable
- be aware that people may have negative expectations based on earlier experiences with mental health services, the criminal justice system, or other relevant services.

1.3.16 All practitioners should share the outcomes of a mental health assessment, in accordance with legislation and local policies, subject to permission from the person where necessary, with:

- the person and, if possible, their family members or carers
- all staff and agencies (for example, probation service providers and secondary care mental health services) involved in the direct development and implementation of the plan
- other staff or agencies (as needed) not directly involved in the development and implementation of the plan who could support the effective implementation and delivery of the plan.

Reviewing the mental health assessment

1.3.17 Practitioners should review and update mental health assessments:

- if new information is available about the person's mental health problem
- if there are significant differences between the views of the person and the views of the family, carers or staff that cannot be resolved through discussion
- when major legal or life events occur
- when the person is transferred between, or out of, criminal justice services
- if a person experiences a significant change in care or support, for example, stopping an Assessment, Care in Custody and Teamwork (ACCT) plan
- if a person disengages or does not stick to their treatment plan
- annually, or as required by local policy such as Care Programme Approach or Care Treatment Plan.

1.3.18 When updating mental health assessments, practitioners should consider:

- reviewing and ensuring demographic information is accurate
- reviewing psychological, social, safety, personal historical and criminological factors

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

1.4 *Risk assessment and management*

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

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

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

1.4.3 During a risk assessment the practitioner doing the assessment should explain to the person that their behaviours may need to be monitored. This may include:

- external monitoring of behaviours that may indicate a risk to self or others
- self-monitoring of risk behaviours to help the person to identify, anticipate and prevent high-risk situations.

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

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

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

- informed by the assessments and interventions in relevant NICE guidance for the relevant mental health disorders, including the NICE guidelines on self-harm in over 8s: short-term management and prevention of recurrence and self-harm in over 8s: long-term management
- implemented in line with agreed protocols for safeguarding vulnerable people and the provision of appropriate adults
- implemented in line with agreed protocols in police custody, prisoner escort services, prison, community settings and probation service providers.

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

1.5 *Care planning*

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

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

1.5.2 When developing or implementing a mental health care plan all practitioners should take into account:

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

1.6 *Psychological interventions*

Delivering psychological interventions for mental health problems

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

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

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

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

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

Personality disorder

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

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

- problem solving
- emotion regulation and impulse control

- managing interpersonal relationships
- self-harm
- use of medicine (including reducing polypharmacy).

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

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

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

Specific psychological interventions

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

1.6.8 Practitioners delivering contingency management programmes should:

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

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

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

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

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

1.7 *Pharmacological interventions*

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

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

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

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

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

1.8 Organisation of services

Service structures and delivery

- 1.8.1 Commissioners and providers of criminal justice services and healthcare services should support the development of liaison and diversion functions for police custody and the courts that provide prompt access to the following:
- the effective identification and recognition of mental health problems
 - a comprehensive mental health assessment
 - advice on immediate care and management
 - appropriate treatment and care (including medication).
- 1.8.2 Providers of criminal justice services and healthcare services should consider diverting people from standard courts to dedicated drug courts if the offence is linked to substance misuse and was non-violent.
- 1.8.3 Commissioners and providers of criminal justice services and healthcare services should consider establishing joint working arrangements between healthcare, social care and police services for managing urgent and emergency mental health presentations in the community (for example, [street triage](#)).
Include:
- joint training for police, healthcare and social care staff
 - agreed protocols for joint working developed and reviewed by a multi-agency group
 - agreed protocols for effective communication within and between agencies
 - agreed referral pathways for urgent and emergency care and routine care.
- 1.8.4 Commissioners and providers of criminal justice services and healthcare services should ensure effective identification, assessment, coordination and delivery of care for all people with a mental health problem in contact with the criminal justice system. This should include people who are transferring from young offender services and those on probation. In particular, ensure that:

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

1.9 *Staff training*

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

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

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

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

- 1.9.3 Provide multidisciplinary and multi-agency training (as part of both induction training and continuing professional development) to increase consistency, understanding of ways of working, and promotion of positive working relationships for all staff who work in the criminal justice system on:
- the prevalence of mental health problems in the criminal justice system, and why such problems may bring people into contact with the criminal justice system
 - the main features of commonly occurring mental health problems seen in the criminal justice system, and the impact these may have on behaviour and compliance with rules and statutory requirements
 - recognising and responding to mental health problems and communication problems that arise from, or are related to, physical health problems.
- 1.9.4 Give all staff involved in direct care, training (as part of induction training and continuing professional development) and supervision to support them in:
- dealing with critical incidents, including emergency life support
 - managing stress associated with working in the criminal justice system and how this may affect their interactions with people and their own mental health and wellbeing
 - the recognition, assessment, treatment and management of self-harm and suicide
 - de-escalation methods to minimise the use of restrictive interventions
 - recognition of changes in behaviour, taking into account that these may indicate the onset of, or changes to, mental health problems
 - knowledge of effective interventions for mental health problems
 - developing and maintaining safe boundaries and constructive relationships
 - delivering interventions within the constraints of the criminal justice system (for example, [jail craft](#) training, formulation skills).

Terms used in this guideline

Assessment, Care in Custody and Teamwork (ACCT)

ACCT is a prisoner-centred, flexible care-planning system which, when used effectively, can reduce risk, primarily of self-harm. The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed.

Acquired cognitive impairment

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

Appropriate adult

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

Carer

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

Contingency management

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

Correctional Mental Health Screen for men (CMHS-M) or women (CMHS-W)

This is a screening tool that measures acute mental health issues present in people in prison. Questions are answered in a yes–no format, and then rated on a Likert-scale from 1 (low risk or need) to 5 (high risk or need), depending on severity.

In-possession medicine

Medicine is said to be held in-possession if a person (usually in a prison or other secure setting) is responsible for holding and taking it themselves.

Jail craft

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

Liaison and diversion service

This is a service that aims to identify people who have mental health problems who come into contact with the criminal justice system before they enter prison. They may be able to liaise and refer people they identify with mental health problems to local services or divert someone out of the criminal justice system, for example by arranging a Mental Health Act assessment. A liaison and diversion service may be in the form of a street triage service (see below) or they can be based in police custody suites or the court cells.

Mental health in-reach team

A secondary mental health team based in prisons to support adults in prison. The team will be part of the NHS trust for the area the prison is located. This team may consist of the same types of staff who work in community mental health teams, including community psychiatric nurses, social workers, psychologists, occupational therapists and psychiatrists.

Multi-Agency Public Protection Arrangements (MAPPA)

These arrangements are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

Multi-Agency Risk Assessment Conference (MARAC)

This is a monthly meeting where professionals across criminal justice agencies and other bodies dealing with offenders share information on high risk cases of domestic violence and abuse and put in place a risk management plan.

Multidisciplinary

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

Offender Assessment System (OASys)

This is a risk and needs assessment tool. It identifies and classifies offending related needs, such as a lack of accommodation, poor educational and employment skills, substance misuse, relationship problems, and problems with thinking and attitudes and the risk of harm offenders pose to themselves and others.

Programme of care

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

Street triage

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

SystemOne

A clinical computer system used widely by healthcare professionals in the UK to manage electronic patient records. SystemOne is the standard system currently used in prisons in England and Wales.

^[1] This guideline covers the full range of mental health problems including common mental disorders, substance misuse disorders, neurodevelopmental disorders and personality disorders.

Putting this guideline into practice

NICE has produced [tools and resources](#) to help you put this guideline into practice.

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

Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

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

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

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

- 1. Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.
- 2. Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.
- 3. Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.
- 4. Think about** what data you need to measure improvement and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

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

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

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

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

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

Context

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

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

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

This guideline covers recognition, assessment, treatment and prevention of mental health problems in adults who are in contact with the criminal justice system (police and court custody, prison custody, street triage and liaison and diversion services, as well as probation service providers). Mental health problems include common mental health problems, severe mental illness, paraphilias, neurodevelopmental disorders and [acquired cognitive impairment](#). There are recommendations on care planning and pathways, and organisation and structure of services, as well as training for health, social care and criminal justice professionals and practitioners. Although the focus of this guideline is on healthcare, the [Care Act 2014](#) has relevance to people in the criminal justice system, in the community and in prisons. This may be of particular relevance for people with neurodevelopmental disorders, including learning disability and autistic spectrum disorders.

More information

You can also see this guideline in the NICE pathway on [health of people in the criminal justice system](#).

To find out what NICE has said on topics related to this guideline, see our web page on [prisons and other secure settings and mental health and behavioural conditions](#).

See also the guideline committee's discussion and the evidence reviews (in the [full guideline](#)), and information about [how the guideline was developed](#), including details of the committee.

Recommendations for research

The guideline committee has made the following recommendations for research. The committee's full set of research recommendations is detailed in the [full guideline](#).

1 Psychological and pharmacological interventions for people with paraphilic disorders

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

Why this is important

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

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

Important outcomes could include:

- offending and re-offending rates
- mental health problems
- cost-effectiveness
- service utilisation.

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

2 Structured clinical management interventions in probation service providers

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

Why this is important

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

Important outcomes could include:

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

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

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

Why this is important

There is low quality evidence for a range of systems for the delivery and coordination of care in the criminal justice system (for example, drug or mental health courts, and case management).

However, there is clear evidence of poor engagement, uptake and retention in treatment for people with mental health problems in contact with the criminal justice system. A number of models (for example, case management and collaborative care) have shown benefit for people with common and severe mental health problems in routine healthcare settings. A programme of research and development is needed, which will first develop and test different models of care coordination for the delivery of care in small feasibility studies, and then test models that have shown promise in the feasibility studies in large scale randomised clinical trials in the criminal justice system.

Important outcomes could include:

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

4 Tools for case identification for cognitive impairment in criminal justice system populations

What are the reliable and valid tools to identify cognitive impairment among people in contact with the criminal justice system (including people who have experienced physical trauma, neurodevelopmental disorders or other [acquired cognitive impairment](#))?

Why this is important

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

5 Prevalence of mental health problems

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

Why this is important

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

6 Identification of factors associated with suicide

What factors are associated with suicide attempts and completed suicides?

Why this is important

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

ISBN: 978-1-4731-2381-6

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