Offender Health: Scoping Review and Research Priorities within the UK

Report for Offender Health at the Department of Health

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Glossary of Abbreviations

AA  Appropriate Adults
ASW  Approved Social Workers
ARS  Arrest Referral Schemes
ACPO  Association of Chief Police Officers
BIO  Bail Information Officers
CCG  Continuing Care Group
CDT  Clock Drawing Test
CMHN  Community Mental Health Nurses
CMHT  Community Mental Health Teams
CPN  Community Psychiatric Nurse
CARAT  Counselling, Assessment, Referral, Advice and Throughcare
CJS  Criminal Justice System
DAT  Drug Action Team
DH  Department of Health
DIP  Drug Intervention Programme
DIR  Drug Interventions Record
DRR  Drug Rehabilitation Requirement
DTTO  Drug Treatment and Testing Order
FME  Forensic Medical Examiner
GHQ  General Health Questionnaire
QT  Quick Test
HMCS  Her Majesty’s Court Service
HoNOS  Health of the Nation Outcome Scales
IPCC  Independent Police Complaints Commission
LIPS  Learning Disabilities in the Probation Service
MAST  Brief Michigan Alcohol Screening Test
MHRT  Mental Health Treatment Requirement
MRSA  Methicillin-resistant Staphylococcus Aureus
MDO  Mentally Disordered Offenders
MoJ  Ministry of Justice
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>NDTMS</td>
<td>National Drug Treatment Monitoring System</td>
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<td>NPS</td>
<td>National Probation Service</td>
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<td>NMI</td>
<td>Near Miss Incidents</td>
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<td>NFA</td>
<td>No Further Action</td>
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<td>OASys</td>
<td>Offender Assessment System</td>
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<td>OHRN</td>
<td>Offender Health Research Network</td>
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<tr>
<td>PACE</td>
<td>Police and Criminal Evidence Act</td>
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<td>PCA</td>
<td>Police Complaints Authority</td>
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<td>PCSO</td>
<td>Police Community Support Officers</td>
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<td>PNC</td>
<td>Police National Computer</td>
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<td>PER</td>
<td>Prisoner Escort Record</td>
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<td>SLA</td>
<td>Service Level Agreement</td>
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<td>VABSs</td>
<td>Vineland Adaptive Behaviour Scales</td>
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<td>WASI-R</td>
<td>Wechsler Adult Intelligence Scale, revised version</td>
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1 Introduction

Addressing the health needs of people in contact with the criminal justice system (CJS) is a potentially important contribution to reducing recidivism and health inequalities. Previous reports have highlighted the links between socially excluded people and poor health (Social Exclusion Unit, 2002). This report is a scoping review of the literature surrounding health of people in contact with police custody, court, and probation settings.

Since 1999, the NHS has worked in partnership with HM Prison Service to improve prison-based healthcare, aiming to increase the quality and scope of services so as to improve the health and social status of offenders. As a result there has been a wealth of large scale, methodologically sound prison health research published, and, although a review of this literature is probably warranted, it is outside the remit of this review. Most recently, the Department of Health (DH) has recognised that prison healthcare is just one part of an individual’s complex pathway through the CJS. Recently, an independent review of diversion from custody for people with mental health problems and learning disabilities, The Bradley Review, has been published (Bradley, 2009). This review is to be followed later in 2009 by the publication of overarching DH strategy for improving health and social care across all parts of the CJS. Both documents will likely recommend radical changes to the way in which health and social care services for offenders are structured and delivered.

The aim of this report is:

- conduct a review of the current literature the health of people in police custody, courts and probations
- discuss and evaluate the implications of the literature
- provide research priorities based on the knowledge gaps

This report was completed using several methods. Seven databases were searched: CINAHL, Embase, Ovid Medline, PsycINFO, Web of Science, ASSIA and Criminal Justice Abstracts. The terms used were (i) Police custody* AND health* AND UK*, (ii) Courts* AND Health* AND UK*, (iii) Probation* AND Health* AND UK*. Search terms were slightly adapted for each search engine in order to exploit the databases most effectively. The searches were limited to English Language Journals from 1990 onwards. Duplicated findings were removed and the remaining articles reviewed to see if they met the specific criterion set by the aims of the report:

- Is the publication health related?
- Was it conducted in the UK?
- Did it include offenders in contact with police, court or probation services?
Direct targeting was also used to comb the articles for policy and government documents and any other relevant studies, such as audits or service evaluations. Broad internet searches and targeted examination of relevant offender related websites supplemented the literature review, including, but not limited to, websites belonging to the Association of Chief Police Officers (ACPO), Department of Health (DH), Her Majesty’s Court Service (HMCS), Home Office, Ministry of Justice (MoJ), Nacro, National Probation Service (NPS), the Sainsbury Centre for Mental Health, and the Revolving Doors Agency.

This report is a scoping review, rather than a formal systematic review of evidence and the results therefore represent evidence deemed by the authors as relevant to the research question, rather than offering any guarantee of being wholly inclusive.

Following the scoping review, interviews were conducted with relevant stakeholders within the police, court and probation services to ascertain their research priorities. In January 2008, the Offender Health Research Network (OHRN) hosted a national conference, attended by delegates representing the police, courts, probation, prisons and community based agencies. An interactive session was hosted which enabled delegates to identify subjects they regarded as the most urgent research priorities in their area of work. A synthesis of results from the interviews and conference session is presented in the final section of this report.
2 Police custody

The police are generally the first point of contact with the CJS for members of the public. Around 1.3 million people are arrested each year. Despite this, very little is known about the health of people in contact with the police or detainees in police custody. It is believed that many have chronic or acute healthcare needs and are amongst the least likely in our society to be accessing healthcare services (DH, 2007).

2.1 Current provision of healthcare within police custody

In England and Wales there are 43 police services and 603 custody suites. When someone is arrested by the police and taken to a police station they have three basic rights:

• the right to free and independent legal advice;
• the right to have someone informed of their arrest; and
• the right to consult the Codes Of Practice (concerning police powers and procedures).

They will also be given a written notice informing them of their rights and entitlements whilst in custody. The custody officer must make sure that interviews and other procedures are conducted as soon as possible and in the proper manner.

2.1.1 Appropriate adult

Custody officers also have a responsibility to identify potentially vulnerable people. Those considered vulnerable include anyone who appears to be under the age of 17, people with mental health difficulties, people with a learning disability and those who have trouble communicating and understanding things. A custody officer has a duty to request the attendance of a responsible adult, known as an Appropriate Adult (AA). The AA may be a relative or guardian, someone with experience of dealing with mentally vulnerable/disordered people, or a responsible adult over the age of 18 who is not in, or employed by, the police. The role of the AA was created by the Police and Criminal Evidence Act 1984, with the intention of safeguarding the rights and welfare of young people and vulnerable adults in custody. If a detainee is considered to have mental health difficulties or be mentally vulnerable then an AA should always be contacted (Home Office, 2006). The custody officer should advise the detainee of the duties of the AA (such as giving advice and support) and of their right to consult privately at anytime (Home Office, 2006). The guidelines recommend that
an AA should be experienced in dealing with mental health problems, but the preferences of the detainee must be respected. The custody officer should inform the AA of the grounds for detention and whereabouts of the detainee, and then ask them to come to the police station.

If an AA is not present the police may not interview a detainee about any suspected criminal offences, ask for a written statement, nor record an interview unless there are exceptional circumstances. This requires an officer of at least superintendent rank to deem that delay will interfere or harm evidence connected with the case, other people or property; alert others who may later be arrested for an offence; delay the recovery of property acquired because of an offence; and that the interview will not damage the detainee’s mental health (Home Office, 2006).

Once the AA arrives at the police station any cautions that the detainee has previously received must be repeated in their presence (Home Office, 2006). Similarly, any charges must be laid in the presence of the AA. The AA has the authority to request legal advice if the detainee has not already done so, and the detainee has the right to consult privately with their solicitor, either with or without their AA present. The AA must also be given the opportunity to represent the detainee if a review officer or superintendent reviews the detention of the individual. If an intimate or strip search is required then this must take place in the presence of an appropriate adult of the same sex (unless the detainee requests otherwise), unless there is an urgency because of risk of harm to the detainee or others. During interview an AA should be informed about their role. Home Office guidelines state that they should not be a passive observer; instead their role is to advise the detainee, facilitate communication in the interview and observe whether the interview is being conducted to a satisfactory standard (Home Office, 2006).

2.1.2 Fitness for Detention/Interview

The Police and Criminal Evidence Act 1984 guides the police in matters involving persons detained in police custody. In particular, the Codes of Practice advise on when appropriate healthcare professionals should be called to assess detainees. Formal assessments in police custody include; fitness to be detained, fitness for interview, fitness to charge, fitness to be released, fitness to be transferred, mental health assessments, assault and injury, road traffic offences and obtaining forensic samples. The custody officer has responsibility for ensuring that a detainee is fit for detention and interview. If the custody officer has any doubts about whether a detainee is fit to be interviewed then a healthcare professional must assess the detainee (ACPO, 2006). Both the reason for suspecting the detainee was not fit to be interviewed and the results of the healthcare professional’s assessment must be recorded. A custody officer is not allowed to let a detainee be interviewed if they think that it would damage their mental state (ACPO, 2006; Home Office, 2006).
2.1.3 Screening, medical examination and treatment

Once a detainee arrives at the police station they are placed under the care of the custody officer. A custody record is opened, routinely including all available information that may constitute risk factors. Information about potential risks can be gathered from the detainee, those close to the detainee, witnesses and any staff who have had contact with the detainee, as well as legal and healthcare professionals. The custody officer will ask the detainee a series of questions to evaluate the potential risks of custody; these include:

- Do you have any illness or injury?
- Have you seen a doctor or been to hospital for this illness or injury?
- Are you supposed to be taking any tablets or medication?
- What are they? What are they for?
- Are you suffering from any mental health problems or depression?
- Have you ever tried to harm yourself?

(ACPO, 2006)

If a detainee answers yes to any of these questions, they are asked for further details including their current condition, if they require any additional help and if they would like to speak to a doctor or nurse. The Home Office (2006) stated that, if a healthcare professional is called in, the custody officer must consult them about any potential risks when making decisions regarding the detainee’s continued detention.

The custody officer is also expected to refer to the Police National Computer (PNC) as a potential source of risk pertinent information. The PNC does not routinely record any known health problems into specifically designed ‘fields’, but there is the facility to add ‘markers’ to the records of a detainee, and this may be used to record any known health problems or psychiatric illnesses if the police have previous knowledge of such (House of Commons, 1992). However, it is unclear how widely this facility is currently used, to what extent, or the accuracy of the information held as it is not possible to routinely audit the markers on the PNC. The system is limited through its reliance on police officers having access to relevant information, as it does not automatically gather information from other sources. While these assessments are designed to identify need, their primary focus is risk. Problems with assessments conducted in custody suites can lead to inaccurate documentation of information.

Revolving Doors explored current mechanisms to identify and address mental health problems at the earliest opportunity for those in contact with criminal justice agencies (Revolving Doors, 2006). They initially organised a seminar, which brought together key professionals from the Home Office, national police services, Social Services, the Magistrates’ Association, academia, the voluntary sector and the legal profession to map current opportunities for the multiple needs of offenders to be identified within the criminal justice process. The session traced the pathway of an offender from the point of arrest up to the court stage.
Following the seminar, Revolving Doors undertook a substantial literature review of current legislation, guidance, and protocols relating to early interventions for people with mental health problems in the CJS and sought additional input from a range of professionals and their own frontline staff and service users. The final report mainly focused on access to healthcare in police custody. The report stated that assessments in police custody are generally conducted in open custody suites, where there is little privacy or confidentiality. They found that assessments varied between forces, with no standard definition of terms. Police training was also found to be determined and delivered locally; therefore no national standards are available against which to measure services or performance. The report also stated that many detainees in custody had dual diagnosis, for example, mental illness and substance abuse, making it difficult for untrained custody staff to accurately identify need. Custody officers also have few avenues to seek further support or guidance on health issues (Revolving Doors, 2006).

If a detainee requires medical attention then, in many cases, a Forensic Medical Examiner (FME) is called. These are usually full-time GPs contracted privately to cover a given number of shifts for the police. Revolving Doors (2006) highlighted that there were several limitations with this type of service, including cost, lack of transparency over recruitment, training, issues with some FMEs refusing to see repeat offenders, and problems with availability due to other commitments. In approximately 50% of police services, health care is now privately provided (Revolving Doors, 2006). Such arrangements allow a police service to contact comprehensive healthcare services through a single agency, which then works to an agreed service level agreement (SLA). Potentially, an advantage of this should be cost efficiencies. However, this type of service has also been criticised; Revolving Doors, (2006) stated that, while some companies provided excellent service, others cut costs by employing overseas doctors on short-term contacts, accompanied by little monitoring of the service they provided. Some services are provided by nursing rather than medical staff and other services rely on paramedic staff to deal with health problems in police custody. An examination of the efficacy of these staffing models is required.

The Revolving Doors (2006) report examined two schemes (London’s Charing Cross and Kent) which used directly employed custody nurses to provide 24 hour healthcare cover in police stations. While both schemes were identified as good models of practice, there were felt to be serious issues around the confidentiality of healthcare records. FMEs are not required to record in police files any information which does not relate to the immediate care needs of the detainee or criminal case; however all information given to directly employed custody nurses may be available to the police as their employers. In Kent, there was a written protocol on confidentiality asserting that custody nurses should not have to assess whether clinical information may relate to a suspect’s criminal case. However, this amounted to a policy that all information disclosed to nurses should be available for access by the police. This was meant to protect the
nurses from having to defend clinical decisions, but in turn impacted on their independence (Revolving Doors, 2006).

Bond et al. (2007) examined the operational impact of a police custody nursing service on healthcare delivery in one police service in the North of England. During the course of the six-month evaluation six nurses were contracted to deliver first-contact care and triage assessment over an eight-hour period from 18:00 to 2:00 hours. With two custody nurses on each shift, nursing was provided in parallel with a team of experienced FMEs who continued to provide a 24-hour on-call medical and forensic service. In comparison to the traditional FME service, nurses demonstrated faster response times, comparable consultation times, and were perceived by custody staff as more approachable than their medical colleagues in providing handover information. However, due to the sample size associated with this case study, the results have limited generalisability. The authors do state that if the results were generalisable than there could be improvements in service reliability and the responses give an indication of the benefits of collaborative working.

Revolving Doors (2006) stated that the failure to assess and divert people with mental health, drug and alcohol problems has contributed to the extremely high rates of mental health morbidity in prisons, with 72% of male and 70% of female sentenced prisoners suffering two or more mental health disorders. Data from the Revolving Doors Agency's Islington scheme show that clients referred through the police have an average of 6 health and social care needs, and almost half of these have no contact with the a GP (Bruton & Keil, 2006). This was a Neighbourhood Link Worker Scheme, where Link Workers would work with three of the London Borough of Islington's Safer Neighbourhood Teams in order to support people with unmet mental health needs who are involved in low level offending or anti-social behaviour. Safer Neighbourhood Teams are a UK wide initiative aimed at tackling concerns in local communities through local policing and working closely with members of the community. These teams usually consist of one sergeant, two police constables and three Police Community Support Officers (PCSOs) (Bruton & Keil, 2006).

2.2 Health of offenders in contact with the police and in police custody

The following sections detail health research conducted within the police and police custody in relation to specific health problems.

2.2.1 Alcohol

Detainees under the influence of alcohol are a major problem for the police (Best et al. 2002). Despite this, there has been little research on prevalence rates or effective management.
Robertson et al. (1995) observed all detainees at seven police stations within the Metropolitan Police. Continuous 24-hour cover was provided at each station for a 3 week period. The number of people arrested for offences of drunkenness was noted, as was the apparent degree of drunkenness of all detainees, irrespective of arrest offence. Two thousand, nine hundred and forty-seven custody records were opened during the 6 month observation period. After removing people who appeared in relation to a prior arrest, the sample size was 2,708. Five hundred and ninety people (22%) were diagnosed as being drunk on arrival at the station. A 4-point rating scale was used to assess observed disorders in a detainees’ level of consciousness on reception. Of those, 122 (5%) were identified as having a major impairment (needs help walking). The mean age of this subgroup was 40 (SD = 12.8) and the majority were men (n = 113; 93%).

Sixty two (50%) appeared smelly or dirty on arrival at the police station, 23 (19%) had cuts or bruises, 20 (16%) were verbally aggressive and 5 (4%) were physically aggressive. Ninety seven (79%) were taken to the cells immediately as they were too drunk to be given their rights and, in 43 (37%) of cases, a doctor was called. In this study only 5% of those arrested for drunkenness alone were subsequently charged. The authors stated that, despite this, the police must continue to arrest and detain the drunk and incapable in the absence of other suitable alternatives. In contrast with other mentally disordered offenders, diversion of the chronic drunken offender from the CJS has not resulted in diversion to health care. This research was conducted in police stations within the Metropolitan Police Service in London; therefore the detainee population is likely to be unrepresentative of the national population as a whole. The diversity of ethnic groups and the percentage of people from other parts of the United Kingdom are likely to be considerably higher than would be found in most provincial police force areas. A further problem with the research may be that, as the study relied on observer ratings of intoxication, this may be not wholly consistent, nor the methodology therefore accurately replicable.

Bennett (1998) published the results of a study in which people were tested for drug use upon arrest. Testing took place in five police services over a two-year period. In total, 839 arrestees were interviewed across the five research sites and 622 (74%) provided a urine specimen. Additionally, detainees were tested for alcohol use which was detected in 25% of the sample. This study employed a convenience sample; therefore the majority of people were recruited into the study during normal working hours. It is possible that if the study had included those arrested during evenings and weekends, results would have varied. Additionally, the study specifically excluded detainees who were unfit for interview due to alcohol/drugs/medication; detainees considered mentally disordered; children and juveniles; those who required an interpreter; those considered potentially violent; those who had been in custody in excess of 48 hours; and detainees who were deemed ineligible for other reasons at the discretion of the custody sergeant. It is highly likely therefore that the selection of participants consented into this study would not be representative of arrestees in general.
Several studies have looked at the detection, management and treatment of drunken detainees. Deehan et al. (1998) examined the feasibility of FMEs expanding their role to include the routine detection of problem drinking by detainees in police custody. A list of all FMEs (n = 116) in the London metropolitan police area was obtained. They all received a postal questionnaire requesting details of detainees seen over the last 24 hours. Seventy six (66%) questionnaires were returned. Thirty nine percent of detainees were seen by the FME because they had consumed alcohol. The FMEs attended on average more than 6 drunken detainees during the 24 hour period on call, constituting 40% of their cases. By comparison, GPs made contact with, on average, 3.2 such patients in a four-week period. The study found that FMEs were not averse to the detection of alcohol misuse as part of their role, despite only 43% of the responding FMEs reporting having received alcohol misuse specific training.

Franklin (2000) also devised a postal questionnaire to be sent out to all FMEs (n = 890) in England and Wales requesting information about their management of alcohol dependent persons in police custody. In total 558 (63%) responded, of these 84 (15%) said that they would never, rarely or occasionally ask a detainee about alcohol intake. Twelve (2%) said that they had never seen uncomplicated alcohol withdrawal in custody, 52 (9%) said that they would never use drug treatment to treat alcohol withdrawal and 235 (42%) said that they would only rarely or occasionally use drug treatment. The most common treatment for alcohol withdrawal was a benzodiazepine. The majority, 515 (92%) said that they would never or have never used alcohol to treat withdrawal, 40 (7%) said that they had.

Naik & Brownell (2000), in a discussion article, argued that drunken detainees in police custody should receive management which should include psychological help, social support and pharmacological treatment. They stated that there was currently no evidence based research guidelines indicating which patients should be detoxified in police custody. Good clinical sense indicated that patients with uncomplicated withdrawal could be managed in police custody. Those likely to develop severe withdrawal complications, co-existing severe mental illness and physical illness should be treated in hospital.

Best et al. (2002) explored the possibility of FMEs delivering brief alcohol interventions in custody suites. Fourteen principal FMEs from London (11 men and three women) were interviewed and 11 other FMEs (eight men and three women) completed questionnaires. Additionally, 15 police officers from two London police stations were surveyed to explore their attitudes towards ‘drunken detainees’ and to assess their views on the service provided by FMEs. Overall, the FMEs showed little knowledge of brief interventions for alcohol misuse. Only six of the 14 principal FMEs (43%) and two of the other 11 FMEs (18%) knew what was meant by the term ‘brief alcohol intervention’. After the term was explained, most FMEs had never provided a brief intervention, either in the custody suite or in general practice. While the principal FMEs said that they felt competent enough to provide brief interventions, they questioned whether it was within their remit. Training was highlighted as an important and ongoing issue. Nearly
all FMEs reported that they would like further training in alcohol and drug issues (91%), but most (64%) reported that they were not adequately trained to provide brief interventions. In contrast, the principal FMEs generally felt competent and adequately trained, but that they lacked resources to undertake such work.

Sixty percent of the police officers interviewed reported that 40–70% of detainees were under the influence of alcohol, peaking during evenings and weekends. The officers reported that in a ‘typical week’, they called an FME an average of 22 times. The main problems posed by ‘drunken detainees’ were reported as being related to safety, the need for extra monitoring, cleaning cells and delays. Most officers (80%) had suffered injuries in dealing with violent ‘drunken detainees’, and the same proportion reported they did not like working with this group. More than half (60%) felt that detainees allowed a ‘sleep-off’ period caused unnecessary blockage of cells in police custody. The size and opportunistic nature of the sample means that the results are not representative, but the study provides a useful discussion around the possibilities of delivering brief alcohol interventions in police custody.

The high prevalence of problematic ‘drunk’ detainees in police custody is important as such people are one of the most common groups to die in police custody. Best & Kefas (2004) investigated the role of alcohol in police related deaths between 2000 and 2001. Of the 58 deaths between 2000 and 2001, nearly 40% of arrests were for alcohol specific offences with the arresting officer believing the detainee was alcohol-intoxicated in a further 19% of cases. Of the 58 deaths, 41 (71%) were taken into a police station in the period prior to the death. Of these, 22 (52%) were seen by an FME, with the detainee being declared as fit for detention in 87% of cases. In only around one third of cases (34%) was there adequate recording of satisfactory checking and rousing of the detainee. The authors concluded that detainees who are intoxicated were not routinely cared for adequately whilst in police custody and that, when medical crises occur, police officers did not have the support, resources, skills or training to provide emergency interventions.

### 2.2.2 Substance misuse

Several studies have shown that drug use among detainees in police custody is common. Bennett (1998) reported a study of drug testing of arrestees which was undertaken in five police services over a two-year period. In total, 839 arrestees were interviewed across the five research sites and 622 (74%) provided a urine specimen. Eight drug types were tested; cannabinoid metabolite, opiates (including heroin), methadone, cocaine metabolite (including ‘crack’), amphetamines (including ecstasy), benzodiazepines, LSD and alcohol. Urine analysis results showed that the average rate of positive tests across all locations, excluding alcohol, was 61 per cent. The most common drug identified was cannabis (46% tested positive) followed by alcohol (25%), opiates (18%), benzodiazepines
(12%), amphetamines (11%), cocaine (10%), and methadone (8%). No arrestees tested positive for LSD. As mentioned above, due to the sampling and exclusion criteria adopted, this study will not be representative of arrestees in general.

Bennett & Holloway (2004) reported on the New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) programme, a national research study of interviews and voluntary urine tests designed to establish the prevalence of drug use among arrestees (suspected offenders arrested by the police). The rolling programme covered 16 locations in England and Wales and each data collection cycle lasted two years (8 sites were visited in Year 1 and the remaining 8 in Year 2). The first eight sites were subsequently revisited in Year 3. The sample consisted of 3,091 arrestees interviewed across the 16 locations, of which 95% provided a urine sample for scientific testing. Urine tests of arrestees revealed that 69% of arrestees tested positive for one or more illegal drugs, and 36% tested positive for two or more such substances. The most common drug identified was cannabis (48% tested positive) followed by opiates (31%), alcohol (23%), cocaine (22%), benzodiazepines (13%), amphetamines (7%), and methadone (6%). There are differences in the prevalence rates between this study and Bennett (1998), especially for opiates and cocaine. It is likely that the sampling procedure used in this study obtained a more representative sample as, at each site, recruitment took place over around the clock for 30 days (or until 210 interviews had been achieved). However, results are likely to show only current drug use (within 3 days), with the exception of cannabis, which can be detected up to four weeks following chronic use.

Pearson et al. (2000) assessed all detainees at seven London police stations and tracked them over a six-month period (n = 2,947). Four percent of all arrests were identified as opiate users. Compared to the general population of detainees, significantly more women were known opiate users, a higher percentage were white and/or born in the British Isles. People born in Continental European countries were also over-represented. Just over half of known users did not reveal their drug use on arrival at the police station. At least 60% of known opiate users remained well throughout their detention. Twenty seven per cent were intoxicated with drugs at the time of their arrest, but only 13% displayed signs or symptoms of withdrawal during their detention. Overall, 65% of known opiate users were seen by an FME and, of these, 52% were given medication. All of those withdrawing were given drug treatment; 86% received an opiate (most commonly dihydrocodeine). This was usually given in association with a benzodiazepine. The research team concluded that rates of opiate use were likely to be much higher than the 4% reported, as this only represented those in whom drug use was very clear. Management of opiate users varied among FMEs, but it was felt that the actual medical treatment of opiate-using detainees was generally pragmatic and determined by individual need.

Several studies, rather than reporting prevalence rates, have looked at the characteristics of drug misusers seen in police custody. Payne-James et al. (1994) conducted a prospective survey of 150 unselected consecutive detainees in police custody who stated that they were drug misusers.
Questionnaires were completed by two FMEs and the survey was undertaken from 10th June 1992 to 25th September 1992 within 11 police stations in Central and East London. One hundred and forty four individuals consented to participate; 66% were men and 87% were Caucasian. The mean age was 28.1 (SD = 6.5). Ten percent had no fixed abode and 31% were not registered with a GP. Individuals had been users on average for 6.8 years (SD = 6.1 years) with a mean age of first use 20.1 years (SD = 5.5 years). Heroin was the primary drug used (77%); crack cocaine alone was only used by 2% of individuals. However 30% used both heroin and cocaine regularly and amphetamines were used by 3.5%. At the time of the survey 32% were prescribed drugs by clinics or GPs. Of that group, 82% were prescribed methadone on a reducing or maintenance dose, but only 15% did not then use illicit drugs. Four percent were known to be HIV positive.

Payne-James et al. (2005) gave a structured questionnaire to consecutive, self-admitted illicit drug users; 113 detainees consented to take part. Thirty percent were dependent on heroin or crack cocaine. The majority were male, unemployed with a mean age of 28.5 years. Significant mental health problems were present in 18% of the sample and alcohol dependence in 15%. Ninety three percent of the sample used heroin and 87% crack, the mean daily cost was £76 for heroin and £81 for crack. More than 50% injected heroin and crack simultaneously. From their own knowledge, 6.4% knew they were hepatitis B positive, 20.2% were hepatitis C positive, and 3.6% were HIV positive. Mean length of drug use was 7.5 years, 82% had served a previous prison sentence, 54% had used drugs in prison, 11% had used needles in prison, and 3% stated that they had started using drugs in prison. In terms of previous interventions, 38% had been on a rehabilitation programme, 11% on Drug Treatment and Testing Order (DTTO), 32% had used the Arrest Referral schemes (ARS) and 10% were in contact with community drug teams at time of assessment. Despite these apparent high levels of service contact the authors concluded that very often treatment was not readily available or not followed through in police custody.

More recently, Gregory (2007) explored the characteristics of drug users in police custody and detainees’ expectations of their medical management through the analysis of questionnaires administered by drug referral workers. One hundred and three questionnaires were completed; 63% of respondents said that they took heroin regularly, 32% reported cocaine use. A quarter of the sample reported using both heroin and cocaine, and a further 8% used more than three drugs. Over half (52%) felt that they were getting withdrawal symptoms while in police custody, but 44% said they were not. Of the group reporting withdrawal symptoms, 64% stated that they had not used methadone or a street drug for over 12 hours but 9% stated that they were feeling withdrawal within 6 hours of using. Sixty two percent had asked to see the FME and 45% had seen one by the time of the interview. Of those who asked to see an FME, 51% said that they wanted treatment, but 26% did not. Further investigations into the reasons behind treatment refusal in this setting would be informative.
Stark & Gregory (2005) aimed to determine the current attitudes and practices of FMEs to the management of substance misusers, based around perceived reluctance on the part of FMEs to prescribe or authorise the continued administration of prescribed opiate substitute treatment in police custody. Davison & Forshaw (1993) stated that not continuing with a legal prescription of methadone constituted unacceptable interference in an individual’s medical treatment.

To improve the consistency of approach to the clinical management of substance misusers in police custody, the government has produced a series of guidelines. The first guidelines were produced in 1994, known as the ‘Blue Guidelines’ (Department of Health, Scottish Office Home and Health Department & Welsh Office, 1994). The guidelines were initially updated in 2000 (Association of Police Surgeons & Royal College of Psychiatrists, 2000), again in 2006 (Royal College of Psychiatrists & Association of Forensic Physicians, 2006) and are due for further review in 2010.

To examine the impact of this official practice guidance, Stark & Gregory (2005) sent questionnaires to all members of the Association of Forensics Physicians (n = 937), thought to be the best representation of doctors working as FMEs. Questionnaires were returned by 409 FMEs, a 44% response rate. Eighty six percent said that they had read government guidelines (2000 version). Thirteen percent stated that the police service they worked within had an agreed management policy or formulary for treating substance misusers. Five such protocols were provided. Much of the content was based on the official guidance; however one protocol did state that “as a rule (methadone) should not be used in the custody area…a policy of no methadone permits no discussion or argument with patients.” This is in contravention of the guidelines which state that methadone can be used in cases of marked withdrawal that could not be managed by symptomatic medication, and where opioid drugs may be required to control the symptoms and signs. Another stated that when a detained person requested a doctor because of withdrawal from drugs they should be advised that the doctor could not prescribe a substitute until at least six hours after the time of arrest and therefore the doctor would not be called until six hours had elapsed.

Dihydrocodeine was the routine treatment of choice for withdrawal symptoms for 95% of the respondents. Methadone was not routinely prescribed, however 7% of the respondents said that they allowed custody staff to measure out the dose of methadone despite the guidelines stating this should never happen. The guidelines state that good practice dictates that the FME should still advise the detainee and the police of the possible side effects of intoxication of the prescribed drug. Over half of the FMEs stated that they did not inform the police to look out for signs of intoxication. Whilst 90% of the respondents felt confident in dealing with substance misuse, many commented that further information on specific drugs and additional training on the management of substance misusers would be beneficial.
Studies have also looked at the accuracy of reporting drug problems in police custody. Davidson & Gossop (1999) reviewed the current management of opiate addicts in police custody. They reported that suspects detained at police stations for questioning whilst under the influence of illicit drugs presented a problem, as the reliability of confessions made under the influence of drugs or whilst experiencing withdrawal symptoms may be adversely affected. They reviewed the current management of opiate addicts in police custody, particularly in relation to the specific problem of defining and assessing fitness for interview and looked at the current evidence of the effect of opiates and opiate withdrawal symptoms on the reliability of testimony. They concluded that any framework for the assessment of fitness for interview must address the question of reliability. They also stated that more needs to be known about the effects of opiates and opiate withdrawal symptoms on the reliability of testimony in the police interview situation.

Stark et al. (2002) stated that one of the major problems of assessment was confirming the history of recent drug taking given by the detainee. A false history may result in inappropriate and potentially fatal prescription of substitute drugs such as methadone to non-dependent individuals. They collected the histories of 222 substance misusers. A screen for six substances was used; this was followed by urine samples in 92% of the sample. Detained persons most commonly reported using heroin (80%), benzodiazepines (54%), cocaine (53%), and methadone (39%), with 87% admitting to using more than one drug. Analysis of urine samples revealed that, where the person claimed daily use of methadone, it was absent from the urine screening in 25% of cases, thus emphasising the importance of trying to validate the history before deciding to prescribe methadone in police custody.

2.2.3 Learning disability

In 1997, Mencap produced a document entitled ‘Barriers to Justice’ which discussed the CJS treatment of people with learning disabilities. The survey contacted hundreds of professionals working across the CJS nationally. They found that only 35% of police officers surveyed (n = 285) had received training about learning disabilities and, of these officers, only 26% felt that this was adequate (Mencap, 1997).

Gendle & Woodhams, (2005) interviewed eight police sergeants employed by Humberside Police about their perceptions and knowledge of people with learning disabilities. From the interviews three themes were identified, perceptions of people with learning disabilities, processing suspects with learning disabilities and training. With regards to perceptions, officers felt that people with learning disabilities were more likely to commit offences that did not involve sophisticated planning. They also felt that they would be more likely to be led into crime by others. With regards to the processing of suspects many officers felt that sometimes the Appropriate Adult was not always appropriate, as sometimes the AA was a family
member who was not trustworthy and was of limited assistance. The officers stated that they had great difficulty in diagnosis; they were concerned about ‘getting it right’ and about cases being overlooked. The officers showed great concern in wanting to achieve the best justice for people with learning disability and felt that sometimes police cells were not the right place for them. They felt a weight of responsibility when they had a suspect with possible learning disabilities in custody, not wanting things to go wrong. Additionally, there were questions around comprehension of cautioning and questioning. With regards to training, the officers cited the potential usefulness of practical elements such as visiting services for people with learning disabilities and refresher training. The biggest problem cited was confusion between mental health problems and learning disabilities. This seemed to occur because topics were taught either together or consecutively. They concluded that police officers were keen to ensure that people with learning disabilities entering the police station received the support they need, however they highlighted variability in training and the need for proactive networking.

Currently, few studies have looked at the numbers of people with a learning disability arrested and detained in police stations and there is little consensus across published research. Holland et al. (2002) reviewed studies that looked at the prevalence of learning disabilities within the CJS as part of the Department of Health’s National Research and Development Programme on Forensic Mental Health. They examined what they considered to be significant pieces of research that had been discussed in previous literature reviews on the topic (e.g. Noble & Conley, 1992). They concluded that the reported prevalence of learning disabilities in police custody varied from 0.5% to 9% of all detainees. However, these studies may not be accurate as identification of learning disability was reliant on individuals being known to learning disabilities services, which may result in the inclusion of individuals with severe, rather than mild to moderate, learning disabilities.

Leggett et al. (2007) suggested that there were a small but significant number of people arrested and taken into police custody who have learning disabilities. They reported several studies that had looked at prevalence; studies have ranged from 5% (Gudjonsson et al. 1993) to 12.5% (Ahmad et al. 2000). Lyall et al. (1994) found that, of 992 persons taken into custody during a 2-month period in two London police stations, 251 were screened by custody officers for the presence of a possible learning disability. A total 4.8% of this group had attended special schools and 8.2% of suspects detained and interviewed had a Full Scale IQ of less than 70.

Scott et al. (2006) looked at prevalence and mental health needs of people with learning disability detained in police custody. Two forensically trained Community Mental Health Nurses (CMHNs) screened all custody record forms (n = 9,014) for evidence of mental health problems or learning disability in an inner-city inter-agency police liaison service during a three year period. They interviewed positively screened detainees (n=1,088).
Detainees were typically single, unemployed males in their 20s who lived with parents. Almost one in ten were judged to have a possible or definite learning disability. Sixty-three percent had a history of causing harm to others and 56% a history of self-harm. Fifty-six percent regularly consumed harmful levels of alcohol and 27% abused drugs. They concluded that there were a sizable number of offenders with learning disability who often had complex mental health needs which were currently not being met.

In 2005, the Prison Reform Trust received funding to examine learning disability and learning difficulties amongst offenders. The programme, No One Knows, sought to gain a better understanding of the experiences of this group within the criminal justice system and to identify how their needs could be addressed. Preliminary findings of the programme have been reported by Talbot & Riley (2007). Several meetings were held with the ‘Working for Justice Group’, involving 11 people with learning disabilities, all of whom had experiences of the CJS. They discussed experiences of being arrested and held in custody. A common complaint was police officers not recognising or asking whether they had a learning disability or even checking that they understood what was happening or ensuring that an appropriate adult was present. They felt that they were less respected and less readily believed than people without a learning disability.

Loucks (2008a, 2008b) reviewed and critiqued previous literature which attempted to investigate the prevalence of learning disability in the CJS. The report stated that, based on the evidence available, 20-30% of offenders have learning difficulties or learning disabilities that interfere with their ability to cope within the criminal justice system. However it was noted that there was wide variety in how learning disabilities were defined and assessed. The report stated that people with learning difficulties experienced a number of problems within the CJS. As there was no routine assessment process, they were unlikely to be identified unless their behaviour gave cause for concern. Their general and mental health was likely to be poorer than those without learning disabilities. Additionally, due to this lack of identification of their problems they were likely to struggle with comprehending CJS processes e.g. police questioning and cautions.

Leggett et al. (2007) recruited 15 consecutive referrals to a community learning disabilities service who had been interviewed by the police as suspects in alleged offences. They were all interviewed by a member of the Avon Forensic Community Learning Disabilities Team about their experiences of the Appropriate Adult, and the police interview itself. With regards to AAs, only 11 of the 15 participants had an AA present during the interview, one participant had refused an AA as they had been told it would take 4 hours for them to arrive. Of the 11 who had an AA present, one did not know who the person was as they did not introduce themselves, five had a relative, four a social worker and two had care support workers. Only 11 of the 15 had some understanding of what an AA’s role was. The actual input that the AA had in the interviews varied. One person said that his AA had an argument with the police during the interview. Three people said that the AA helped them to communicate and made sure that they had adequate breaks. However, the remainder said that the AA said and did
nothing during the interview. With regards to the interview generally a number of participants raised concerns about the manner of the police officers during the interview, this included reported intimidating tactics such as shouting and being treated unfairly. Others did have a positive view. Many focused on issues concerning the environment and refreshments offered. Also most expressed negative feelings about the situation, feeling angry, frustrated at their treatment and bored because they had to wait around so long.

2.2.4 Mental health

There has been some research on the prevalence of mental illness in detainees in police custody; however the reported prevalence rates differ greatly between studies.

Brown et al. (1992) conducted a Home Office research study that examined the operation and impact of the recently introduced revisions to Code C of the Police and Criminal Evidence Act (PACE). The code contains detailed guidance on the detention, treatment and questioning of suspects. Brown et al. (1992) examined custody records drawn from 12 police stations for two periods of two weeks prior to and following the introduction of the revised Code. For the four periods of two weeks, data were extracted from the records of all prisoners held, a total of 10,167 custody records. The custody record sample contained 106 cases (60 in phase one; 46 in phase two) in which detainees were treated as mentally disordered or handicapped (terminology in use within the Police and Criminal Evidence Act, 1984). This represented 1% of the total custody records. The researchers stated that the sample size was large enough to be representative. However, decisions on whether detainees were treated as mentally disordered or handicapped were made by police officers rather than healthcare workers and thus likely to be flawed.

Gudjonsson et al. (1993) administered a range of psychological assessments and questionnaires to 163 detainees at two London police stations. The assessments covered current mental state; intellectual functioning; reading ability; interrogative suggestibility; anxiety proneness; and understanding of legal rights. The sample comprised those due to be interviewed by the police i.e. they had been arrested for an offence, therefore may not necessarily be representative of detainees generally. The study excluded cases in which there was insufficient time between the detainee’s initial detention and police interview to complete the tests (which took approximately an hour). The study also excluded anyone under the age of 18. Assessments were conducted by psychiatrists and, on the basis of the researchers’ clinical judgements they identified 7% as having a mental illness, with diagnoses such as schizophrenia and depression; 3% as having a mental handicap and 5% as having language problems. It is arguable whether, due to the localised nature of the sample, involving only two London police stations, the study findings are generalisable, either to London more widely or to the country as a whole. Additionally, the study did
not look at differences in prevalence rates with regards to gender, age or ethnicity. However, the study did use mental health professionals, specifically trained to diagnose mental illness, therefore the identification of mental health problems is likely to have been more accurate than studies using police officers or non-clinically trained researchers.

Phillips & Brown (1998) conducted a prospective study in which arrestees were tracked through the criminal process. The research took place across seven police services in a total of ten stations, selected to be representative as far as possible of police stations generally. Thus, stations covered a range of areas, classified as city centre, inner-city, large town and suburban. The study also intended to monitor the way in which different ethnic groups were dealt with after arrest and stations included some in areas containing appreciable numbers of people from the main ethnic minority groups. Whether the study sample was representative of arrestees generally cannot be confirmed because data on arrests, broken down by key variables such as offence, are not collected at a national level. The sample comprised 4,250 of those arrested or detained, 85% men (n = 3,610) and 15% women (n = 639). In terms of age, 39% were under 20 years old. With regard to ethnicity, 79% were white, 13% black, 6% Asian and 2% of other ethnic origin. The study found that 2% of detainees (n = 67) were treated as mentally disordered by the police. Researchers observed a further 13 suspects whom they considered to be behaving in a bizarre or irrational way, but who were not treated as mentally disordered. Twenty-two percent of those considered mentally disordered detainees were female. Nearly half of the mentally disordered were aged between 30 and 59 and one third between 20 and 29. The accuracy of this study, as with Brown et al. (1992), rests with whether either mentally disordered or mentally handicapped persons were always correctly identified by the police.

Robertson et al. (1996) studied people held in seven London police stations over a 6 month period with observers, all trained psychiatrists, present in police custody areas, assessing detainees using a psychiatric inventory. There were 2947 custody records opened on 2617 individuals. The study concluded that 26% of the sample was 'mentally disordered'. However, a very broad definition of mental disorder was used which included those who were drunk. Twenty-two per cent of their sample suffered from some degree of intoxication on arrival at the police station; however 2.7% of cases had some form of mental illness, with 1.2% demonstrating symptoms of a serious nature, including suspected schizophrenia, affective disorder, brain damage and psychosis. It is arguable whether generalisations may be safely made from these figures either to London or to the whole country, however mental health professionals specifically trained to diagnose mental illnesses were used, therefore the identification of mental health is likely to be generally accurate. The authors concluded that identifying those suffering from mental disorder present major difficulties for the police and that, although evidence suggests that identification is more accurate in the most severe cases, there are particular concerns that problems such as depression and anxiety and less serious mental illnesses are missed (Robertson et al. 1995).
Keyes et al. (1998) examined 30,304 custody records in two London police stations between 1st April 1993 and 31st March 1994. They identified 499 arrestees who had documented evidence that they were suffering from mental illness; this represented 1.9% of all arrests. Considering the total number of custody records reviewed it is likely that the sample will be representative, however identification was made by the police officers and therefore as mentioned above it likely to not accurately represent the total number likely to be disordered.

More recently Ahmed & Page (2007) conducted a needs assessment to investigate the availability of support for people who have either a personality disorder or multiple complex needs who leave HMP Lewes and return to the Brighton and Hove area. They state that 7,080 people were arrested in Brighton and Hove over the space of a year that were thought to be resident in the city, of which 3.8% were identified as having mental health problems. The study report gives very little information about how this prevalence rate was established, therefore it is very difficult to state how accurate or reliable it is.

2.2.5 Section 136 and ‘places of safety’

The police have specific powers under Section 136 of the Mental Health Act (1983) to remove from a public place to a ‘place of safety’ a person who appears to be suffering from a mental disorder and is in immediate need of care or control. There are additional powers under Section 135 of the Mental Health Act 1983 for the police or other authorised person to gain access to premises by force where a warrant has been granted by a magistrate. This is to allow an assessment to take place where the person may have disengaged from services but they are not in a public place (Nacro, 2005).

Lowe-Ponsford & Begg, (1996) studied the use of Section 136. Seventy-nine adults and nineteen children were arrested at Gatwick Airport under Section 136 over the period of one year although not all were formally held under this section at the police station (i.e. not all were accepted by the custody police officer). Records made by the police and assessments by FMEs were studied. None of the children and only half of the adults were eventually seen by a doctor. The remainder was dealt with just by the police. Half of those not seen by medical staff were missing persons. Those referred to a doctor tended to be suicidal or confused compared with those who were dealt with solely by the police. In addition, the police station as a place of safety probably influenced management in that people were dealt with quickly.

Greenberg et al. (2002) conducted a prospective survey of the use of Section 136 in South West England. The study was carried out between October and December 2000 in six custody centres. Over the study period 178 people were taken into custody under Section 136. A monitoring form completed for these individuals recorded assessment times, behaviour which led to the detention, previous contact and outcome. Most were male
(65.7%), age ranged from 15-79 and most were White Europeans (98.8%). On average, it took 25 minutes for detainees to arrive at a police custody unit and assessments took about 8 hours to complete. The longest delay was for the approved social worker to arrive (average: 3h 25m) which was significantly longer than the arrival time of the Section 12 doctor (2h 10m). After assessment 32% of Section 136 detainees were admitted to hospital. They concluded that although rural areas were meeting the statutory maximum time limits for completing Section 136 assessments, the greater distances involved in comparison to inner city areas led to substantial delays in completing assessments. Also this study found a much lower rate of hospital admission after assessment than in previous studies; this may reflect the differing needs and characteristics of a rural population compared with the inner city populations.

Docking et al. (2008) have just completed a review of police custody as a ‘place of safety’ in England and Wales on behalf of the Independent Police Complaints Commission (IPCC). During a one-year period (2005/06) they found that 11,517 people had been detained in police custody as a place of safety. During the same time period approximately 5,900 people were detained in hospital for the same purpose. There were large variations across police forces in the use of police custody as a place of safety. Cheshire Police and Merseyside Police reported low levels of detention under section 136 (both one per 10,000 people in custody). Sussex Police and Devon and Cornwall Police reported high rates (277 per 10,000 and 174 per 10,000 respectively). Just under two-thirds of Section 136 detainees were male and the average age of detainees was 36 years old. However, detainees’ ages ranged from 12 to 89 years. The majority of detainees were white (78%). Of the remainder 4% were black, 3% were Asian, 1% were Chinese/other ethnic group, 1% were of mixed ethnicity, and the ethnicity of 14% was unknown/not stated. When compared to local population data, black people were almost twice as likely as white people to be detained. All forces in England and Wales were asked for data on what happened to those held in custody under Section 136 upon their release. However, there were major problems with the data received due to recording problems in police forces. Many individuals were not charged with an offence and police forces often recorded the outcome of the detention as no further action (NFA) even though they may in fact have been taken into hospital care under a further section of the Mental Health Act (1983). Some police forces also used an ‘other’ option to include all those people who were sectioned under the Mental Health Act 1983 but combined this with other outcomes of the detention such as NFA. Therefore the percentage of Section 136 detainees discharged into the community or taken to hospital is unknown.

### 2.2.6 Deaths in police custody

Much of the research surrounding police custody has focused on the number of people who have died during detention or following police contact. Norfolk, (1998) conducted a retrospective analysis of deaths in police custody from 1st January to 31st December 1994 in England and Wales.
During 1994, the Police Complaints Authority (PCA) investigated a total of 42 deaths, of which 32 satisfied the study definition of a death in police custody. Of the 32 people who died in police custody, 30 were male and two female. The ages of the deceased ranged from 16-63 years, with a mean of 38 years. Cases were grouped into three categories, deaths by hanging (n = 12), deaths among those arrested for being drunk and incapable (n = 11) and others (n = 9). Both of the females died as the result of hanging. Deaths by hanging occurred within an average of 11 hours 24 minutes from arrival into the police station and 75% of the deaths occurred between the hours of 6pm and 6am. People who died from hanging were statistically more likely to have a past history of deliberate self harm and a history of psychiatric illness. There were 11 deaths of people who were arrested for being drunk and incapable. All of these deaths involved males between the ages of 31 and 63 years (mean = 46 years). A doctor was called to only three of the 11 cases prior to their collapse or death. Over half died as the result of poisoning by alcohol and all but one of the six deaths occurred within 2 hours and 5 minutes after arrival at the police station. They concluded that there was a need for improved suicide awareness training, the possible introduction of a simple screening tool to assess suicide risk, the introduction of video surveillance for use with high-risk individuals, improvements in cell design and the use of an objective scale of assessing levels of consciousness.

Best et al. (2004) examined cases for possible mental health issues in 43 deaths in custody involving the use of drugs investigated by the Police Complaints Authority, between 1998 and 2002. The majority were white males, 55% had consumed cocaine and of these, 87% had done so to a fatal level. Similarly, 48.8% had consumed alcohol, 23.8% to a fatal level. Eighteen of the 43 (42%) had evidence of mental health issues. Five people had evidence of psychosis; 5 issues with self-harm; and 8 had depression, as identified by their GP or local psychiatric services. They concluded that there was a need for improved research evidence on the rates of dual diagnosis in police care and custody and that it was imperative to improve police officer and FME awareness of the extent of this problem and its likely impact on detainee vulnerability.

Best et al. (2006) examined whether it was realistic to attempt to review all Near Miss Incidents (NMI) in police custody, defined as potentially serious incidents that took place with no adverse outcome and to assess how frequently they occurred. As no previous studies into NMIs had been undertaken, they initially conducted pilot interviews with three FMEs working within the Metropolitan Police Service to assess the feasibility of this work and to generate appropriate research methods for the subsequent stages. A retrospective study was then undertaken, utilising a structured questionnaire that was distributed to all FMEs working for the Metropolitan Police Service to assess the prevalence of near misses, patterns in their occurrence and relevant learning points, focussing on events which had occurred in the preceding six months. Ninety six of the 132 FMEs (73%) responded. Thirty eight NMIs were reported by 27 different FMEs.
The main perceived causes of NMIs were alcohol, illicit drugs and self-harm. The researchers concluded that information collected about NMIs was consistent with documented patterns of deaths in police custody, which state that alcohol, drugs and self-harm are the main risk factors for death in police custody (e.g. Best & Kefas 2004; Havis & Best 2003). However, data collected from this study were retrospective and originated from FMEs alone; thus views as to what were the causes of the NMI were largely subjective.

The most recent figures in England and Wales on deaths in police custody come from the IPPC. Docking & Menin (2007) reported that, during 2006/07, 27 people died in police custody or following police contact. Of these, 21 were white, two were of Asian origin, three were from a black background, and the ethnicity of one was unknown. Four were women and the average age of those who died was 43, with the youngest person being 18 years. Four were declared dead in the police custody suite, while two died during or shortly after arrest. Twenty one deaths occurred after the detainee had been identified as ill. Drugs or alcohol were apparently linked to 22 of the 27 fatalities. In 13 cases the person had been arrested for a drug or alcohol related offence. One person who died had been detained under Section 136 of the Mental Health Act. Further information on two individuals revealed mental health needs. Post mortem results were only available for 20 of the 27 fatalities. Of these, three died as a result of long-term drug or alcohol misuse, one died after overdosing on prescribed medication. One was the result of self-strangulation. Two died after concealing items in their mouth causing them to asphyxiate. One stopped breathing during arrest, six suffered heart failure, one person sustained fatal head injuries and five died of natural causes.

### 2.2.7 Infections

Two studies to date have looked at the issue of infections in police detainees. Lettington, (2002a) stated that there had been concerns about recent unexplained deaths in injecting heroin users, partly attributed to toxins. Thirty-five heroin-using detainees in two South London police stations with injection site infections were subsequently seen and swabs taken. No incidences of Methicillin-resistant Staphylococcus Aureus (MRSA) were found. However Staphylococcus and Streptococci were common. Lettington concluded that these infections should be explicitly mentioned in police publications dealing with control of infection in the custody setting.

In a related study, Lettington, (2002b) discussed a 32 year old male detainee, with multiple injection site abscesses. The main risk of cross contamination from infected heroin injection sites in the custody setting were from staphylococci and streptococci, with no current reports of MRSA in police custody settings. It was concluded that FMEs, forensic physicians, custody nurses or GPs should not initiate new treatment of a patient with MRSA until liaison with an 'Infection Control Advisor’. The paper made suggestions for police custody suites in terms of cleaning. Blankets in a
police cell need to be changed and bagged up separately for cleansing immediately after a known MRSA patient has vacated a cell. Dust control was important and contact surfaces should be first cleansed with soap and water and then disinfected with a chlorine releasing disinfectant; particularly where there has been body fluid contamination or a desquamating skin condition. Extra care was needed with clinical waste, and “double bagging” may be appropriate, with large and clear MRSA labelling of bags. Increased hygiene with hand-washing was recommended; hands should be washed before and after procedures, and, if skin is contaminated with body fluid or blood, then washed immediately with soap, using running water. Alcoholic hand rubs could be used.

2.2.8 General/physical health

There is a lack of research that has looked in detail at the general healthcare needs of people in police custody. Payne-James et al. (2008) aimed to determine the level of general health issues, diseases and/or pathology for detainees in police custody and to determine how well those general health issues were being managed. In August 2007, 201 detainees in police custody in London were approached for inclusion in a prospective anonymised, structured questionnaire survey. One hundred and sixty eight people (83.6%) gave consent and took part. The majority, 143 (85.1%) were male; the mean age of the sample was 33.9 years (SD = 10.4). There were a total of 96 active healthcare issues, requiring current management and assessment in 94 (55.9%) of subjects. The most common were depression (n = 24; 25%), mental health (n = 22; 23%), asthma (n = 20; 21%), gastrointestinal (n = 10, 11%), epilepsy (n = 10; 11%). Other healthcare issues included musculoskeletal, hypertension, hepatitis, Deep Vein Thrombosis/Pulmonary Embolism/leg ulcer, diabetes, alcoholism, thyroid, tuberculosis, polycythemia, cardiac problems, HIV/AIDS, rickets and haemorrhoids. Of those with active medical problems 70/94 (41.7% of the total study population) reported currently being in receipt of prescribed medication. Of those only 4% (n = 3) had their medication available at the police station for administration at the time of examination.

2.3 Interventions and diversions from police custody

There are several types of interventions and diversion schemes available for people arrested or detained in police custody. However, their introduction has been piecemeal and the types of schemes offered differ greatly from area to area. Some of the most common schemes are discussed here, including Arrest Referral Schemes, drug testing, Conditional Cautioning and diversion/liaison schemes.
2.4 Arrest referral schemes

Arrest Referral Schemes (ARS), located in police stations, provide an opportunity for advice, information, assessment and referral to drug services at point of arrest. In 2003, the Drug Intervention Programme (DIP) was launched to integrate various CJS interventions. It was believed that in the past there was too much focus on crime reduction at the expense of public health strategies that promote harm reduction and health and social gains for drug users. ARS have been used in the UK since the 1980’s. The introduction of ARS into every custody suite in England and Wales was an objective of the Government Drug Strategy (1998) and by 2002 this target was achieved. The schemes do not offer an alternative to prosecution and participation was voluntary. There have been several studies which have reviewed these schemes.

Carter & Jenkins (1996) describe the Brighton Project ‘Get it while you can’. This project had two ex-drug addict workers visiting detainees in police custody. They were there to provide information about harm reduction and service provision within the Brighton area. They were also able to provide on-going support to the detainees after they had left the police station and to help them successfully access agencies in the area. This project was evaluated by the Home Office; Turnbull et al. (1996) reported that the project made contact with a wide range of individuals. Interviews with clients seen in the cells showed a high level of satisfaction. The agencies that clients were referred to were judged as appropriate and led to a good uptake of clients (55%).

Crosson-White & Galvin (2002) reported on a follow-up study on the impact that intervention by an ARS had upon a group of drug-misusing arrestees 18 months after initial contact with the scheme. In 1998, a service evaluation of an ARS was undertaken on behalf of the drug action team (DAT). Part of the research involved qualitative interviews with 21 drug-misusing arrestees who had engaged with the ARS. Eighteen months later, the research team was asked to undertake a follow-up study on the interviewees. Contact was achieved with seventeen and it was ascertained that one person had died as the result of a drug overdoses and another had committed suicide. From this potential sample of 17, four no longer lived in the area, and two were involved in drug misuse to such an extent that it was decided they would be unable to give informed consent to participate in the study. Therefore 11 were successfully followed up, comprising two women and nine men. The age range of interviewees was 21–45 years (mean 32 years and 6 months).

Of the 11 people interviewed, eight had entered treatment in 1998 and remained clean since. Two had relapsed following treatment in 1998 and had undertaken other courses since. Both were clean at the time of the follow-up interview. One person had relapsed and, despite other courses of treatment, was misusing drugs when traced for interview. Ten people gave consent for examination of their Police National Computer (PNC) records which showed that 6 of those who had remained clean had not been arrested or convicted since entering treatment in 1998. One had two
convictions for burglary. Of the three who had relapsed since entering treatment in 1998, two had convictions, including deception, burglary, theft and breach of bail conditions. The findings demonstrated that the intervention had had a positive impact on both drug misuse and offending among the sample. However, due to the small sample size the study should be replicated more widely to produce robust results likely of generalisability.

Hunter et al. (2005) investigated ARS in London police stations. They interviewed 84 police officers and 67 drug workers. They found that there were a number of issues which were limiting the effectiveness of the schemes. These included poor communication between the Arrest Referral workers and the police, lack of training and preparation for both parties about running the schemes in a custody environment, the perceived lack of emphasis given to the harm reduction role of Arrest Referral workers and the isolation of the schemes from community-based drug services. In London the routine offer of an ARS by custody officers continued to yield few referrals and thus negative police perceptions of Arrest Referral may well have been nurtured by this lack of interest among arrestees. Officers were sceptical about the success of Arrest Referral at getting drug users to engage with treatment services and CJS staff and health professionals had conflicting viewpoints about drug users and the goals of drug interventions.

Sondhi & Huggins (2005) investigated an ARS called SMART CJS in the Thames Valley region of the UK during 2002-2003. During the study a total of 652 people were assessed by an arrest referral worker in police custody. Eighty-six percent were male, 87% white, and the mean age was 28 years. Ninety-four percent were unemployed and 14% were homeless. Just under half of the sample reported shoplifting in the 30 days since assessment; a quarter had been involved in burglary and a fifth engaged in other forms of theft. The mean weekly expenditure on drugs in the month before assessment was £600 and over three-quarters said that they had used heroin in the past four weeks. Following initial assessment in police custody, arrest referral workers made a total of 378 ‘primary’ referrals at first contact (58%) to a variety of services. At initial assessment, less than one-fifth (19%) of referrals were made immediately to a specialist drug-treatment service (drug treatment and residential rehabilitation services), with a quarter (25%) referred to prison-based schemes such as Counselling, Assessment, Referral, Advice and Throughcare (CARATs) Amongst individuals referred to a specialist drug-treatment service (n = 276), 53% (n = 147) engaged with the treatment provider.

### 2.5 Drug testing

The Criminal Justice and Courts Service Act 2000 set out provisions for the use of drug testing for specific Class A drugs for individuals aged 18 and over who have been charged with or convicted of ‘trigger offences’; these trigger offences included theft and drug offences. In 2001, these provisions were piloted in police stations in Stafford and Cannock, Nottingham and Hackney. The scheme was extended in 2002 to include Bedford, Blackpool,
Doncaster, Torquay, Wirral, and Wrexham and Mold. By 2003, they were operational across all police services. The use of drug testing was evaluated by the Home Office (2004) which reported on the nine pilot sites. By October 2003, 17,586 tests had been conducted on 11,276 individuals. Twenty-four percent of people were tested more than once. There was a variation in the proportion of positive tests, ranging from 36% in Torquay to 65% in Hackney. Most sites had the same profile of drug use, apart from Hackney which had higher crack/cocaine use. Between 25 - 30% of detainees believed that drug testing would reduce their drug use. However at first follow-up 86% of detainees said that drug testing on charge had made no difference to whether they took drugs or not, while 10% thought that it had. Around 14% of detainees were offered Arrest Referral after the test, where this would not have been offered prior to testing. There was no evidence of an impact on seeking treatment at first follow-up; however by the second follow-up interview there was evidence to suggest that around 25% were more likely to enter treatment than those who received a negative drug test. The authors concluded that there was evidence to suggest that on-charge testing increased the number of acceptances of detainees to see arrest referral workers and that positive tests increased treatment entry rates; however there was no effect on consumption or offending behaviour.

The *Tough Choices* project consisted of the introduction of new provisions under the Drugs Act 2005 which included Testing on Arrest. This moved the point of testing from post-charge to post-arrest and also gave the police the power to require adults who had tested positive to attend an initial assessment of their drug use, rather than assessment being voluntary. Skodbo *et al.* (2007) looked at the pathways of individuals testing positive for heroin, cocaine or crack cocaine in police custody suites. Also examined was whether the implementation of *Tough Choices* from April 2006 changed the characteristics of people coming through Drug Intervention Programmes. They recruited two cohorts consisting of all positive testers in DIP intensive areas during two time periods. The ‘Testing on Charge’ cohort consisted of 7,227 individuals tested before the introduction of *Tough Choices*. The ‘Testing on Arrest’ cohort consisted 11,015 people tested after the introduction of *Tough Choices*. The cohorts were matched to PNC data, Drug Interventions Records (DIR) and the National Drug Treatment Monitoring System (NDTMS). Full criminal histories and treatment entry figures were also recorded. The study reported that offending was lower in 26% of the cohort following DIP contact than prior to DIP contact and that DIP compared favourably with previous drug arrest referral programmes with around 25% of those referred entering treatment. Comparing the two cohorts, they found that, following ‘Tough Choices’, a greater proportion of individuals had few or no proven offences, therefore concluding that the scheme identified more people with substance use problems earlier on. Also the Testing on Arrest cohort had higher rates of initial contact and assessment from a drugs worker. However, the study also reported that in 28% of the sample offending actually increased following DIP. The study failed to report any tests of statistical differences, therefore it is unclear if these two intervention programmes are effective.
2.6 Conditional cautioning

The conditional caution was introduced through the Criminal Justice Act 2003 as an alternative disposal to a charge for certain triable either way, or summary offences, (summary offences are the least serious offences and are tried in the Magistrates' Court). Summary offences involve a maximum penalty of six months imprisonment and/or a fine of up to £5,000. Triable either way offences are regarded as the middle range of crimes and include a wide variety of crimes e.g. theft, assault causing actual bodily harm. These can be tried in either the Magistrates' Court or Crown Court and are a means of tackling low-level offending. The conditions attached to the caution must be appropriate to the offence and an effective means of addressing an offender’s behaviour. One of the conditions that can be attached is referral to a DIP. Blakeborough & Pierpoint (2007) examined conditional cautioning schemes across six police service areas. During the implementation period, 221 conditional cautions were administered; 39 of these involved drug referral. With regards to compliance and successfully completing, in general 70% were completed which increased to 75% when cautions with drug referrals were included.

2.7 Other police liaison schemes

Riordan et al. (2000) reported that 0.63% of all arrests dealt with at the five police stations covered by the West Midlands Diversion at Point of Arrest scheme over a 4-year period from 1993-1997 were assessed by the Community Psychiatric Nurse (CPN) following referral by the police. Of these, 85% were found to have significant mental health problems, the more common illness was schizophrenia found in 16% of people referred. Admission to hospital was recommended in one-third of cases.

James (2000) looked at the initial thirty-one months of a new diversion scheme for offenders with mental health problems in Central London. CPNs took specific referrals, but also screened detainees in the absence of a specific referral. The process involved gathering information on the background of the case, taking a history, conducting a mental state examination, completing a semi-structured interview and completing the Global Assessment Scale. They also liaised with FMEs and AAs where available. At the end of the thirty-one month period CPNs had screened 1.1% (n = 712) of detainees. In half of these cases, the assessment was conducted within 70 minutes of initial arrest. The majority of the cases were referred by custody officers (85%; n = 605), but 4% (n = 28) were referred by FMEs and 8% (n = 57) identified by the CPNs through general screening. Of those screened, only 9% (64) were at the police station as a ‘place of safety’ or because they had been in a disturbed state or asked for help. Ninety percent of referrals (n = 642) were found to have a mental disorder. Nearly half (n = 348) of those referred had schizophrenia or mania. James (2000) found that 31% (n = 233) of referrals were subsequently admitted to a psychiatric hospital; of these 85% (n = 190) were discharged from police custody and 6% (n = 13) were given police bail. Forty-four percent of
those not admitted to hospital (n = 211) were referred to community agencies such as community mental health teams, social services or psychiatric out-patient clinics. Of those referred to CPNs, 39% (n = 278) had no further police action taken against them; 44% (n = 313) were charged; 12% (n = 85) were cautioned, and 3% (n = 21) received a formal warning. Those referred to the police station diversion scheme (n = 228) were compared to those referred to a local court diversion scheme (n = 253) over the same period of time. It was found that the police scheme diverted significantly more women and white Europeans. The court group had a significantly higher incidence of drug use. Those identified by the police scheme were significantly more likely to be receiving current psychiatric care, be allocated a social worker/CPN and be registered with a GP. Those diverted from court generally had more criminal convictions and were significantly more likely to have been convicted of a serious offences. The court diversion scheme referred significantly more offenders to hospital, whereas the police diversion scheme referred significantly more to community agencies. James (2000) concluded that the CPN diversion scheme increased the number of requests to social services for mental health assessments at police stations. The author also concluded that the scheme had been well received by police and FMEs as, in addition to assessing detainees, the CPNs were also able to provide training and advice for police officers. It was also argued that it was not a costly exercise, as in this scheme there was only one CPN covering three police stations for the first year; this then increased to two. It was felt that the number of detainees assessed fitted in with the approximated prevalence of detainees with mental health problems.

Vaughan et al. (2001) examined the working practices of four custody suites in Hampshire in relation to mentally disordered offenders (MDOs) and diversion services. A consecutive sample of 50 individuals detained in cells and not identified by police as having a mental disorder were screened for the presence of such a disorder and their suitability for diversion. Custody and detention staff were observed and interviewed to elicit their views and working practices in relation to MDOs. The findings revealed that in custody suites with diversion schemes an average of 7% of the sample of detained individuals had mental disorders and were suitable for diversion; however they remained undetected by the police. In the custody suite without a diversion scheme, this figure was 14%. They found that in around two-thirds of cases (63%) where police did make referrals to diversion schemes no further action was taken and many referrals were for people who were simply emotionally distressed. The effectiveness of screening processes by custody staff was variable; they were likely to identify people with schizophrenia but missed people with clinical depression. Facilities in the custody suites were not suitable for carrying out assessments and delays in obtaining mental health assessments caused considerable concern for police officers and prolonged the discomfort of vulnerable individuals. They concluded that further training was needed for custody staff to improve screening procedures. Reception and detention facilities for mentally disordered individuals should be reviewed and response times for Approved Social Workers (ASWs) and psychiatrists would benefit from improvement.
In Powys, Wales, there is a diversion scheme for offenders identified as having mental health needs aimed at minimising the number of offenders with complex needs who are placed in the CJS without adequate support (Mental Health & Learning Disabilities Directorate, 2004). Custody Sergeants can refer detainees to the scheme and CPNs then assess offenders and make recommendations or give evidence in court. Offenders can be diverted under the scheme to hospitals, housing schemes, bail hostels or support at home (either from Community Mental Health Teams (CMHTs) or voluntary sector). The details of the scheme are explained to detainees before they are referred. The Mental Health & Learning Disabilities Directorate (2004) is a descriptive report of the referral scheme in Powys and therefore it was not possible to identify how frequently the scheme is used, or to formally evaluate effectiveness in the absence of substantive information on costs, re-offending rates and other outcomes.

McGilloway & Donnelly (2004) looked at an inter-agency police liaison scheme established in Belfast. The scheme consisted of two CMHNS, supported by forensic psychiatry services. The CMHNs worked with police officers, FMEs, court officers, probation officers as well as other health and social services. All detainees’ custody records were screened by CMHNS for history of mental health problems or learning disabilities, crimes thought to be ‘odd’, and/or violent crime or unusual behaviour that led to referral by the police. Any detainees who met at least one of these criteria were asked to participate in an assessment. Following the assessment a psychiatric report was prepared and made available to anyone involved in the detainee’s prosecution. McGilloway & Donnelly (2004) found that in 18 months, 16% (n = 787) of detainees met at least one of the criteria; of this group 48% (n = 382) were assessed (the remainder were not assessed because there was either no CMHN available or the detainee declined). Of those assessed, 15% (n = 59) were assessed more than once, thus totalling 470 assessments. Almost half of the assessments (48%; n = 226) were undertaken following the results of the CMHN screening, rather than referral from FMEs or custody officers. Of those assessed, 91% (n = 348) were judged to have a mental illness (with the most common being clinical depression in 41%; n = 155). McGilloway & Donnelly (2004) found that only 10% (n = 37) of those identified as having a mental illness were currently receiving mental health services. Only 5% (n = 20) of cases were diverted (either released without charge or released to report at the police station) as a result of the CMHNS’ recommendations. A further 4% (n = 11) were remanded to custody in prison hospitals or were admitted to psychiatric hospitals.
3 Courts

People brought before the courts can present with a range of health and social care needs. These needs often go unrecognised and unmet. This means that people may not receive the most effective disposal, especially in relation to mental health problems. Offenders may receive a custodial sentence when a hospital order or a community order with treatment might be more appropriate (DH, 2007).

3.1 Health of offenders at court

A defendant’s health information is usually transferred from police custody to court staff through the Prisoner Escort Record (PER). This is designed to share information on the key risks which have been identified in police custody, including drug and alcohol abuse, physical and mental health issues and risk of self harm. Where the person is seen by a healthcare professional any confidential information gathered will be attached to the form in a sealed envelope and is only opened in an emergency. If the person is sent to prison then the PER form should follow. However the usefulness of the PER in relation to health issues is dependant upon the strength of the information gathering processes at the police station; frequently the PER form is unable to effectively inform court staff and is frequently lost (Revolving Doors, 2006).

3.1.1 Prevalence

There are currently few studies that have looked at the prevalence of health problems of offenders while attending court.

Greenhalgh et al. (1996) conducted a three-month pilot mental health assessment in a magistrates’ court in Leeds. Each assessment was completed by one of four psychiatrists. During the three-months 57 people were assessed; four were re-referred and interviewed twice. The vast majority seen were male (89%), median age was 26 years (range 22-47 years) and 82% were unemployed. They reported that 77% of attendees were found to be suffering from a psychiatric disorder, notably schizophrenia (7%); bipolar disorder (7%); and personality disorder (12%) Almost half of the sample was suffering from alcohol or drug dependence or misuse. The psychiatrists made a recommendation in 37 (61%) of the cases. In three cases the psychiatrists recommended admission but there were no beds available, in the majority of cases psychiatrists recommended psychiatric outpatient treatments. In terms of criminal proceedings most were found not guilty (43%) or given a custodial sentence (30%). The authors conclude that there were several issues impacting on the effectiveness of the diversion scheme, these included a lack of psychiatric
beds and also a lack of suitable accommodation in the community especially approved premises specialising in care for psychiatric problems. This meant that some prisoners, who would be suitable for bail, were remanded in custody. The results of this study are based on a small sample size of attendees in one urban court setting and work involving larger numbers of people across a number of courts would be required to validate the findings.

Fiander & Bartlett (1997) aimed to identify levels of ‘missed cases’ in an ‘in-custody’ population at a London Magistrates’ court, between May and July 1994. A researcher attended the court cell block on 2-3 days each week to carry out semi-structured interviews with individuals detained at the court. A random sample (n = 100) of all those in custody on each interview day was selected for interview. During the interviews brief demographic and brief psychiatric and medical history information was collected. Individuals also completed the Brief Michigan Alcohol Screening Test or MAST and were asked about their previous and present use of illicit drugs. Thirty-five individuals were identified as alcoholics by their Brief MAST score. Nine reported currently using heroin, cocaine or amphetamines everyday, 25 reported a history of deliberate self-harm. In total, eight of the 100 interviewees were referred to the ‘duty psychiatrist’ scheme. Only two of the 27 individuals who were currently using illicit drugs were referred and none of the 35 alcoholics were referred. Only one of the seven individuals who had committed an act of deliberate self-harm in prison was referred. The authors state that in view of the possible physical, psychological and social problems that may stem from such drug and alcohol use, they would argue that these individuals would benefit from a psychiatric assessment.

Shaw et al. (1999) undertook a study in Manchester Magistrates’ Court to examine the prevalence of serious psychiatric disorder, the proportion of defendants requiring diversion and whether defendants with serious mental illness were reliably detected by court personnel and referred to psychiatric staff operating the onsite court diversion scheme. The sample was taken from Manchester Magistrates’ Court which has six daily criminal courts, serving a total population of 500,000. The study included defendants appearing in court for the first time in relation to their index offence. Some attended from the community and others had been remanded in police custody overnight. The study’s definition of serious psychiatric disorder included schizophrenia, mania, other psychoses and depressive or other severe disorders (e.g. including suicidal ideas). They found that the frequency of serious psychiatric disorder was 1.31% among defendants appearing in court direct from the community and 6.57% among those held in custody overnight. Of the 99 individuals with serious psychiatric disorder, 34 (34%) had schizophrenia and other psychoses and 55 (55%) had depressive disorders. Forty-two (76%) of the 55 individuals with depressive disorders had suicidal ideas, which were recorded on the first-phase screening procedure in many cases. Only 14 of 96 (14.5%) defendants from overnight custody with serious psychiatric disorder were routinely detected by court staff and subsequently referred to the court diversion programme. They concluded that there was a substantial rate of psychiatric disorder in the court population, which was not satisfactorily detected within the
current system. Brief screening questionnaires and training of court staff in mental health issues were recommended.

Little research has been conducted on the prevalence of learning disabilities in the court system. Purchase, McCallum & Kennedy (1996) evaluated a scheme at Tottenham Magistrates’ Court over an eighteen –month period. Between July 1993 and December 1994, 104 defendants were seen and data on 89 people are reported. Of these, two defendants were identified as having learning disabilities. Data from ‘No One Knows’ (Talbot & Riley, 2007) based on interviews with 11 people with learning disabilities who have had contact with the criminal justice system reported that the most common issues faced in courts were not being able to understand words used, not understanding what was happening during their court appearance and what the outcome of their court appearance might be.

### 3.1.2 Court liaison and diversion schemes

Currently there are approximately 130 court diversion schemes in operation to serve the 650 Crown, County and Magistrates’ Courts in the UK. The Reed report (Home Office & DH, 1992) recommended a nationwide network of schemes, however these are still far from complete (Birmingham, 2001). There have been numerous studies that have investigated individual diversion schemes.

James & Hamilton (1991) aimed to assess the efficacy of psychiatric liaison schemes to Magistrates’ Courts in shortening the period that mentally ill people spend in custody between arrest, the provision of psychiatric reports and finally admission to hospital, and to establish the direct cost of setting up the schemes. They conducted a nine month prospective study of 80 remand prisoners receiving psychiatric assessment through a liaison scheme in London and compared them with 50 remand prisoners placed on hospital orders by Magistrates’ Courts after being remanded in custody for reports. The mean time from arrest to appearance in court with a completed psychiatric report was 33.7 days and from arrest to admission to hospital 50.8 days, compared with those in the liaison scheme of 5.4 days and 8.7 days respectively. In all, 1.9% of offenders appearing before the Clerkenwell scheme were referred to the liaison scheme, and 0.96% admitted to hospital. This was a fourfold increase on the 12 months before the scheme began. The additional direct costs of the scheme were reported as being negligible. The authors concluded that psychiatric liaison services to Magistrates’ Courts can greatly reduce the length of time offenders with mental disorders spend in custody. Such schemes may increase recognition of offenders suitable for admission to hospital. A scheme could be established in some areas within existing service provision.

Blumenthal & Weedely (1992) aimed to assess the extent and nature of psychiatric assessment schemes based at magistrates’ courts. A postal survey of probation services, petty sessional divisions, mental health
provider units, and district purchasing authorities across England and Wales was sent out. Data were obtained from every magistrate’s court. Forty-eight psychiatric assessment schemes were identified as currently in operation, with another 31 under development. The schemes reported problems such as a lack of adequate transport arrangements for transporting offenders to hospital once diverted from custody. There were also difficulties reported with hospital admissions, and overdependence on key people, noting that if the key person left then the scheme would probably not continue. They found that there was little liaison between health, social services, and members of the criminal justice system. They concluded that schemes to divert mentally disordered offenders from the criminal justice system were often hampered by lack of resources. They stated that when diversion is necessary, the commonest obstacle cited by the NHS is lack of resources. However, they stated that the probation service frequently cites lack of interest by mental health services as a barrier to further developments. They concluded that it remains to be seen whether lack of resources or interest is the real obstacle to the future development of services.

Exworthy & Parrott (1993), reported on the preliminary analysis of a consecutive series of 150 defendants referred by a court for a psychiatric opinion. Overall, 77% of the referrals were seen in custody, of which 64% were diverted. Over 50% of cases were wholly dealt with on the day of the assessment and within 21 days three-quarters of cases had been disposed of. Twenty-three people were admitted to hospital, constituting 15% of all referrals. Most received psychiatric treatment on a voluntary basis in the community. Evaluation of the scheme concluded that a psychiatric assessment service could be provided to a number of courts within a catchment area with minimal impact on the overall number of admissions in the receiving hospital.

Joseph & Potter (1993a) aimed to reduce the frequency and length of custodial medical remands by providing a psychiatric assessment service at a magistrates’ court. Two inner-London magistrates’ courts were chosen due to the high number of homeless mentally disordered defendants who appeared there. Over eighteen months, 201 referrals were made for 185 individuals. Those referred were predominantly male, single, and of no fixed abode. They had high rates of previous psychiatric contact and many had received previous in-patient treatment, frequently as detained patients. Many were repeat offenders committing minor offences. Only 6% had ever received a prison sentence of over a year. Over a third (n = 79; 39%) had a primary diagnosis of schizophrenia. Following initial assessment, 25% were admitted to hospital, 50% were released, and 25% returned to custody. The Crown Prosecution Service discontinued 29% of cases. For those admitted directly to hospital, the mean time from arrest to hospital admission was 5.8 (SD = 6.8) days, significantly quicker than with prison-based assessments. The scheme was successful in reducing the length of time spent in custody or avoiding it altogether, by shifting the psychiatric assessment from the prison to the magistrates’ court. The benefits to the courts and the prison were considerable in reducing workload and making the procedure more efficient. For those acutely psychotic defendants
admitted directly to hospital, a lengthy remand in custody was avoided. The authors stated that although the two courts had unique catchment areas, it is probable that many of the findings were applicable to other inner-city magistrates' courts dealing with mentally disordered homeless defendants and that diversion from custody did not necessarily result in increased rates of admission to hospital.

In a second report, Joseph & Potter (1993b) followed up the 201 referrals to assess the effect of the scheme on hospital and prison resources. For the 65 hospital admissions, hospital summaries were obtained for all admissions and information on length of admission, problems in management, diagnosis, mode of discharge, accommodation on discharge, and details of out-patient follow-up. An assessment was also made of the benefit derived by the patients from hospital admission. This was based on their progress in hospital, for example changes in mental state, response to and compliance with medication and the effect of rehabilitative measures. Also included were any absconding, self-discharge, or discharge due to unacceptable behaviour, also important was the social circumstances of patients after discharge and their continued contact with psychiatric services. Of the 65 hospital admissions, 50 (77%) derived some or marked benefit from psychiatric treatment. Those who did badly were more likely to be of no fixed abode, and had higher rates of criminality and previous compulsory admission to hospital. Twelve months after admission, all patients except one had been discharged. Ten people (15%) had had more than one hospital admission. The scheme generated an extra 21 (64%) hospital admissions per annum from the two courts, compared with the three years before its introduction. For those admitted to hospital, the average time from arrest to admission was ten days, compared to 50 days reported in a previous study, therefore within the scheme 40 days of remand time was saved. Completing a psychiatric assessment at the magistrates' court did place an extra burden on hospital resources in terms of both beds and staff, but created savings in prison resources. However, the overall shift from prison to hospital is small, in most cases. They suggested that in order to provide alternative psychiatric facilities there would need to be acute locked psychiatric wards providing psychiatric evaluations and reports on defendants remanded by the courts for such a purpose. There would need to be compulsory treatment for defendants remanded to custody and for those defendants currently remanded to prison who do not require compulsory hospital admission, their assessment could take place at specialist community-based bail hostels, managed by the probation service, with access to psychiatric consultation. Currently both these hospital and community based provisions either did not exist or were in short supply.

Babbins & Travers (1994) attempted to evaluate the amount of mental disorder that existing court diversion schemes fail to identify. They interviewed 136 defendants who had been detained by the police prior to their first appearance in Liverpool Magistrates' Court for their current alleged offence. The majority were male (87.5%), Caucasian (90.4%), with an average age of 26 years. Almost a third were in stable relationships and
settled accommodation, with only 7.5% were homeless, in squats or hostels. Most were unemployed (83.8%), 91.9% had previous convictions and 93% were registered with a GP. They found very little mental illness but high levels of drug and alcohol misuse. In 84 subjects (62.2%) no diagnosis was made. Thirty (8%) had a diagnosis of drug abuse and 14 (6%) of alcohol abuse. Five (2%) has a diagnosis of neurosis, five (4%) personality disorder and three (1%) with depression. They stated that Merseyside police policy advocated diversion at the earliest possible point and local general psychiatry services were willing to assess and treat offenders. They argued that defendants with drug and alcohol problems were neglected by current initiatives aimed at this group. Addressing this need in a population which might not otherwise come to the attention of services could have an impact on personal and public health as well as on offending behaviour.

Rowlands et al. (1996) examined the Rotherham psychiatric court diversion scheme which began assessing patients in May 1993. They present data on the scheme’s first year of operation with follow-up at mean of 12 months. Over the first 12 months, 1,223 defendants were held in police cells overnight. Using the screening criteria (whether the individual has appeared depressed or psychotic, talked of or committed self-harm, appeared to have drink or drug problems, or has committed a bizarre offence) 158 (13%) were identified as requiring further assessment. A clinical interview identified approximately half of these as not mentally disordered and they were not seen further. Of those detained overnight, 82 (7%) were identified initially as mentally disordered by the court diversion nurse. These 82 were followed-up for a mean of 11.9 months (range 6-18 months). Sixty of these 82 (73%) were seen for review by a psychiatrist. The majority were male (69; 84%), unemployed (67; 81%), and white (81; 99.8%). The mean age was 29.8 years (range 16-73). At the time of arrest, 14 (17%) were either of no fixed abode or in short-term accommodation. Thirty-five (43%) had had no previous contact with psychiatric services. The most common diagnosis was substance dependence, accounting for 28 (34%) referrals. There were 19 (23%) referrals for people who had psychotic illnesses. Ten (13%) had a diagnosis of schizophrenia or schizoaffective disorder and 5 (7%) a diagnosis of bipolar disorder or psychotic depression. Of the 19 (32%) with psychotic disorders, 6 had no previous contact with psychiatric services. Of those assessed, 19 had non-psychotic mental illnesses or learning disabilities, with depressive disorders being most common (17 cases, 23%). Six (7%) had borderline personality disorder and the remaining 10 (13%) had other personality disorders, adjustment reactions or no psychiatric diagnosis. An assessment was made of the benefit from the interventions using a similar method as Joseph and Potter (1993b). They found that 31 (38%) gained no benefit from interventions at the court: they either absconded from hospital within a few days of admission or did not attend as out-patients. Re-offending occurred in 18% of cases. Those who were admitted to hospital were more likely to benefit than those who were not. They concluded that further research was required to examine patient outcomes in more detail and to determine the impact on local psychiatric service over time.
Purchase et al. (1996) evaluated a scheme at Tottenham Magistrates’ Court over an eighteen–month period, between July 1993 and December 1994. There were 104 defendants seen during this period. Data on 89 people are reported. The mean age was 33.1 (SD 10.9) years; 80 (90%) were men. Schizophrenia was the most common diagnosis, in 29 (34%) people, followed by major affective disorders, mostly mania, in 22 (26%) people; organic mental illness; mostly alcohol related disorder in 13 (15%) people; eight (9%) had neurotic disorders and two (2%) had learning difficulties. Fifteen (17%) had no mental illness. In addition, 12 (14%) people misused alcohol alone and nine (10%) cannabis, while 29 (34%) people misused several substances. Nineteen (21%) of the 89 were unknown to psychiatric services and, despite their vulnerability, none of those previously known to the local services was receiving ongoing care and few were receiving intermittent care. They concluded that better formalisation of multidisciplinary care plans and supervision registers and close monitoring by community supervision may result in a substantial improvement in the health and social functioning of this group.

Greenhalgh et al. (1996) conducted a three-month pilot of a diversion scheme in a magistrate’s court in Leeds. They reported that the number of people with psychotic illnesses was small compared to previously reported data from London courts. They postulated that these differences may be partly due to the earlier diversion of acutely mentally ill prisoners from police custody into the health care services in Leeds. Similarly, the low rate of psychiatric admission from the pilot scheme was thought to be largely due to earlier diversion, although in four cases admission was recommended by the assessing psychiatrist but hampered by a lack of regional secure beds. Other problems identified by those involved in the scheme were the need for the provision of bail hostels specialising in the care of those with psychiatric difficulties. In some cases when suitable bail accommodation was not available people were remanded in custody despite the fact that the duty psychiatrist had identified psychiatric problems which could be more appropriately tackled on a community or out-patient basis. The authors also suggested the need for the involvement of community psychiatric nurses within the assessment and diversion scheme.

Evans & Tomison (1997) attempted to judge the perceived need for a psychiatric service in Bristol Magistrates court and whether such a service could reduce the number of individuals remanded in custody. Questionnaires for the bench, defence solicitors and bail information officers were distributed for all those appearing in a magistrates' court following overnight detention in police custody. Responses were received regarding 223 individuals. An immediate psychiatric report was considered necessary for 4.9% of cases. In 2.2% of cases it was thought that remand in custody could have been avoided if such an opinion had been available. In 8% of cases it was thought that remand in custody could have been avoided if specialist bail provision were available. They concluded that there was a perceived need for a specialist bail provision which, if available, could lead to a greater number of diversions from custody than a provision of a psychiatric liaison scheme.
James (1999) conducted a review of all published and unpublished literature on court diversion schemes, including published editorials, surveys and audits since 1990. He concluded that court diversion can be highly effective in the identification and acceleration into hospital of mentally disordered offenders, however most court diversion services were inadequately planned, organised, or resourced, and were therefore of limited effect. The study suggested the need for a central strategy, with properly designed and adequately supported court services incorporated into mainstream local psychiatric provision.

Chambers & Rix (1999) compared assessments of prisoners by doctors and nurses in a magistrates' court mental health assessment and diversion scheme. They conducted a study over three separate 3-month phases, a ‘control’ phase, during which no assessments were performed; a ‘doctors’ phase’ and a ‘nurses’ phase. The cohort consisted of people arrested and remanded in custody overnight prior to initial appearance in court. Prisoners were identified for assessment by Probation Service Bail Information Officers (BIOs). During the control phase, BIOs saw 384 of 1246 overnight prisoners and identified 94 as in need of assessment. During the doctors’ phase, BIOs saw 401 out of 1263 prisoners and 99 were referred, and in the nurses’ phase, BIOs saw 534 out of 1392 prisoners and 91 were referred. BIOs referred fewer prisoners to nurses than to the doctors, and also fewer than they would have in the control phase had assessments been available. In both the doctors’ and nurses’ phase and substance misuse was relatively common (24, 33%; 16, 31%) and psychosis uncommon (1, 1.4%; 2, 4%) in the prisoners referred. Assessment by doctors enabled magistrates to reduce remands in custody of persons suspected of suffering from mental disorder and to grant bail in more cases. Only a small proportion (0.8%) of prisoners was admitted to hospital and, although doctors and nurses recommended out-patient treatment in many cases, the subsequent attendance rate was low. Doctors were more likely than nurses to identify prisoners with medical needs which needed to be brought to the attention of the prison healthcare services, and also were more likely to recommend out-patient psychiatric treatment and identify relevant medico-legal issues. Prisoners assessed by nurses were less likely than those assessed by doctors to attend alcohol or drug treatment services if recommended to do so. Prisoners who were admitted to hospital after a remand in custody spent longer on remand if assessed by nurses compared with those assessed by doctors. They concluded that the study results provided some justification for magistrates’ court mental health assessment and diversion schemes. The assessments enabled the magistrates to avoid remanding in custody prisoners suspected of suffering from mental illness and to grant bail to more individuals.

Chung et al. (1999) aimed to investigate offenders’ living patterns, quality of life, types of aftercare received and psychological well-being following their diversion from one court diversion scheme in the UK. Offenders completed the Diversion Interview Schedule which was a self-constructed questionnaire developed by the research team. The aim was to gather information about offenders’ present living situation, employment,
education and involvement with health and social services. They also completed that Life Experiences Checklist which gave scores on home, leisure, relationships, freedom and opportunities as indicators of quality of life. Finally they completed the General Health Questionnaire (GHQ), which is a screening instrument to estimate the likelihood of respondents being judged as a psychiatric case at interview. During the six-month study period 961 offenders were arrested and held overnight to appear in court the next day. Of these 189 (20%) were screened and interviewed by the CPNs. They were then followed up at six and twelve months. After six months only 65 (34%) could be traced and at one year only 22 (35%) could be followed up. At the six-month interview, four (18%) were employed on a part-time basis, at 1 year two of the four of that group had lost their jobs, and one offender who was not working at six-months was employed. Results of the life experience checklist and the GHQ showed that life had improved between six and twelve month follow-ups, but this was not statistically different. Only half of offenders had regular contact with a GP at both six and twelve-month follow-ups. At six months 38% were living at their own home but at the twelve month follow up only around half of these were still living at home. They concluded that an outreach programme which aimed to improve offenders’ quality of life whilst important was extremely difficult to do and that programmes needed to be flexible.

James & Harlow (2000) evaluated a new concentrated model of a psychiatric diversion scheme at a magistrates' court in Inner London covering a population of 500,000. This model involved a fully staffed team of two consultant psychiatrists, an ASW, a full-time administrator and a research worker. The model also had direct access to open and secure beds. They conducted a one-year prospective study of 264 consecutive referrals to the scheme, with concurrent examination of police station custody records, magistrates' court returns, hospital admission data and remand prison transfer records. Of the 264 cases, 60% were admitted to hospital, meaning that this single scheme originated 12.8% of all the unrestricted hospital orders in England under section 37 of the Mental Health Act 1983, 4.2% of section 35 orders, and 6.4% of section 48 and 48/49 remand prisoner transfers. Of all arrests in the central London area, 0.46% were referred to the scheme, with 0.28% being admitted. The seriousness of the charge did not have a significant effect on whether or not hospital admission was achieved. It was concluded that the new model was a powerful intervention in the assessment and diversion of mentally disordered offenders and that similar supra-district diversion centres may have a role to play in other areas, complementing other local diversion exercises, some of which might better be relocated to the police station.

Vaughan (2004) reported on a Hampshire Magistrates' Court where magistrates could seek information on mentally disordered defendants from local mental health workers instead of requesting a full psychiatric report. The scheme was evaluated by examining 48 case files of mentally-disordered defendants referred between 1 January 2003 and 31 December 2003. It was found that its use had significantly reduced the time taken
from first appearance to disposal from a mean of 189 days to 69 days and also significantly reduced inappropriate referrals to consultant psychiatrists. In many cases, defendants were spared repeated bail adjournments and lengthy remands in prison.

In 2005, Nacro published findings of a 2004 survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales. The survey did not evaluate the effectiveness of the schemes, but aimed to gain better understanding of which areas of England and Wales had some form of diversion/liaison scheme. A questionnaire was sent out in November 2004 to the 143 contacts associated with court diversion held on Nacro’s database following and earlier survey in 2003 and 64 were returned. The key findings were that all schemes felt confident that courts followed their recommendations to divert people to hospital but were less likely to accept recommendations for community treatment. A quarter of the schemes said that they had seen a decrease in staffing levels in the previous year. A third of respondents cited staffing issues as a barrier to their scheme operating. Half of the schemes had no sessional input from a psychiatrist or psychologist and 41% said they had trouble obtaining psychiatric reports. Seventy-two percent of schemes cited a lack of beds as a barrier to their scheme operating successfully. Seventy-eight percent of schemes collected statistics, however half of schemes that were collecting statistics did not collect data on ethnicity and 42% did not collect data on gender (Nacro, 2005).

Also in 2005, The Centre for Public Innovation published a brief review of ten court liaison and diversion schemes. A sample of current schemes was selected from the Nacro database of all diversion schemes. The sample was carefully selected by Nacro to cover a range of characteristics; virtual vs. actual teams; urban vs. rural; medical model vs. non-medical model; peripatetic vs. court based; multi-disciplinary vs. single staffed teams; reactive vs. proactive approaches; Monday – Friday services vs. once/twice weekly services; successful vs. less successful (based on Nacro’s experience). They completed on-site visits of each scheme selected and conducted interviews with staff using a semi-structured questionnaire. Also any relevant information was collected including protocols, statistics and annual reports. They concluded that the schemes were providing a service to a group of individuals who might otherwise not be accessing appropriate mental and social care and they were regarded as invaluable in providing support. However, there is wide variety in the quality, practice and funding for schemes. The success of the schemes were heavily dependent upon the energy and commitment of the individuals involved. The majority of the schemes did not have clear aims, objectives or targets and there was no performance management in place. Schemes had clear identified pathways for referral but the majority had poor or weak integration with local mental health services. The court liaison and diversion schemes were disconnected from court psychiatric report arrangements. The sample of schemes visited was fairly small. The review also did not have the scope to carry out a needs assessment or evaluate the prevalence of health and social care.
needs in each locality, therefore making it difficult to draw conclusions about the effectiveness of the different models in meeting local clients’ needs. Data and information was difficult to obtain. It was possible to identify what the schemes did operationally but it was less easy to identify outcomes and success. The authors suggested that the review supported the need for improved local needs assessments and performance management and monitoring. There also needed to be better matching of resources to high volume courts and improvements to management and integration within NHS primary and mental health services.

Kingham & Corfe, (2005) examined the activity of the East Sussex Court Assessment and Diversion Scheme over a three year period from 1st January 2000 to 31st December 2002. During this period there were 1830 referrals to the scheme, predominantly referred by the police (71%). Twenty percent of referrals were individuals remanded by the court on bail and 8% were from individuals remanded by the court in custody in prison. The majority were men (1607 individuals; 88%). Six percent of referrals were of people from an ethnic minority. The most common primary diagnosis in people referred were drug misuse (19%), alcohol misuse (12%), schizophrenia (11%) and personality disorder (9%). In a fifth of the total referrals the individuals were assessed as having a secondary diagnosis; the majority (12%) had additional substance misuse problems. Two percent of total referrals also had a co-morbid personality disorder. Following assessment, for just over half of individuals there was no recommendation regarding diversion or liaison. The majority (43%) were referred to community interventions, 7% were admitted to hospital. They concluded that the results of this study show similar high rates of alcohol and drug misuses to other liaison schemes but that the proportion of people diagnosed with a major mental illness varied greatly between studies. They state that in this study, referring agencies generally recognised the presence of mental disorder reasonably accurately in the people they referred, so that 70% of those referred warranted a diagnosis. However, it is not known how many people with mental disorder were unrecognised as such and not referred to the scheme. Court liaison and diversion in East Sussex successfully directs defendants with mental disorders to appropriate resources. However the expansion of in-patient secure services needs to continue to accommodate increased demand.
4 Probation

Offenders in the community find it difficult to access appropriate care services. Health needs often go unmet or are met through inappropriate means (DH, 2007).

4.1 Health of offenders on probation

A summary version of an offender's health information will be documented using the Offender Assessment System (OASys), either by Prison Service staff on discharge or by Probation staff if in the community. With regard to health matters, OASys asks questions about suicide, self harm, childhood behaviour problems, head injuries, mental health problems, psychiatric treatment and emotional wellbeing. Probation staff will not have direct access to offenders’ NHS information, either those held in the community or prison based clinical records.

4.1.1 Prevalence

Huckle et al. (1996) investigated a psychiatric clinic based in a probation service in South Wales. One hundred clients were referred over three years between April 1992 and April 1995. Ninety-two were men and eight were women with a mean age of 31.4 years. Forty-nine percent of the clients had a previous psychiatric history. At current assessment, 35% were diagnosed with personality disorder, 10% with schizophrenia, 11% with substance misuse, 9% with post-traumatic stress disorder, 6% with affective disorder and 7% with learning difficulties. A range of interventions were offered to the clients, including individual cognitive and psychodynamic therapy, psychotropic medication, grief counselling and alcohol/drug counselling. Three cases were admitted to hospital and a further three to District Psychiatric Services. Thirty-one per cent were offered out-patient psychiatric treatment as a condition of a probation order. Seventeen out of the 31 successfully completed the order and have since been discharged; the other 14 are still subject to an order. With regard to attendance at the psychiatric probation clinic, all clients referred attended their first appointment, but 13.3% did not attend for subsequent appointments. They state that psychiatric probation clinics have been criticised because relatively few clients are referred. The probation clients in this survey found the setting of the clinics acceptable to them and found it easier to disclose personal information in a setting to which they were accustomed. This may partly explain the low levels of non-attendance. In the survey the psychiatric probation order proved a useful way of accessing appropriate health care for people who were at serious risk of a custodial sentence, and psychiatric clinics based in probation offices were deemed to be a success as far as the probation staff and clients were concerned.
Mair & May (1997) interviewed 1213 offenders on probation with regards to health problems and almost half (49%) said that they currently had or expected to have certain long-term health problems or disabilities. Common problems were musculoskeletal, respiratory and mental health problems. The proportion of offenders on probation reporting health problems was similar to that reported by offenders in prison and higher than found in the general population. Nearly a third said that health problems limited the work they could do. With regard to drug use, 42% reported using cannabis in the previous 12 months, 24% had used amphetamines, 15% Temazepam, 14% LSD, 12% Ecstasy, 10% Magic Mushrooms, 8% heroin, cocaine and methadone, and 5% crack cocaine. Rates of drug use were higher than those reported in the British Crime Survey. Ten percent of the sample reported having a drink problem. Health needs, drugs and alcohol played a significant role in the lives of respondents and therefore needed to be taken into account by probation officers in their work with offenders both at the assessment stage and as part of supervision.

Cohen et al. (1999) examined the first 30 months of a mental health worker scheme in Wandsworth during which time 83 assessments were conducted involving 76 individuals, representing 3% of the annual probation caseload. The majority of those assessed were male (n=76; 92%) and the overall mean age was 32 (SD = 8.8) years. Over half (59%) of the people assessed were white, 36% black, 1% Asian and 4% from other ethnic backgrounds. Nearly half (47%) had one previous psychiatric diagnosis and 19% had multiple diagnoses. Forty (48%) were receiving psychiatric treatment at the time of the assessment. Seventy-one percent had a history of substance misuse. A mental health need was identified in 76 cases (92%). Over a third (37%) were identified as having unmet mental health needs and were incorporated into a Continuing Care Group (CCG). A further 28% were referred to the Community Mental Health Team, 18% were referred to forensic psychiatric services, 16% to a mental health hostel, 14% to a housing department, 13% to social services, 5% were registered with GPs, and 13% refused intervention or were impossible to engage. Of those who were incorporated into a CCG, 22% failed to attend their appointments. The mental health worker assisted probation officers in assessing and supporting clients with mental health problems. They also helped to bridge the gap between criminal justice and mental health systems by facilitating contact between probationers and psychiatric services.

Hearnden (2000) interviewed 278 drug-misusing offenders supervised by the Inner London Probation Service under either a probation or combination order. The majority of the offenders were male, white, with an average age of 31. Two-thirds were unemployed, and a further fifth were in receipt of incapacity benefit. Over 75% had some previous experience of treatment services. Most of the sample began illicit drug use in their mid-teens, and started injecting in their early twenties. Thirty percent stated that relationship problems/personal problems had caused them to start drugs; a further 28% said that they started using through associating with other drug takers. The study reported large (self-reported) reductions in drug use.
and crime, especially for those whose probation order included a condition of treatment. There was also strong evidence of effective working partnerships between the probation service and the specialist drug services which helped bring these reductions about. The majority of probationers spoke positively of the assistance offered by their supervising officer. Probationers did feel that probation officers would benefit from increased drug awareness and training.

Moore (2007) examined data from the self-assessment questionnaire within OASys. The sample consisted of 101,240 self-assessment questionnaires from 42 probation areas and 126 prison establishments. Around a quarter said that drinking too much alcohol and/or taking drugs was a problem for them and between 16% and 19% said that it was linked to their offending. Thirty-five percent said that feeling depressed was a problem for them and 12% said that this was linked to their offending. The study included self-assessment questionnaires from people in prison, therefore is not a truly representative sample of community offenders, however it does show the high rates of health problems and how they are related to offending.

Newbury-Birch (2008) studied the prevalence of alcohol abuse amongst 715 offenders in the probation and prison systems in the North East of England and identified that 69% of men and 53% of women in contact with probation were classed as having an alcohol misuse disorder compared to 59% and 63% respectively of detained men and women. An analysis of 120,000 OASys assessments across 41 probation areas found that 37% of offenders had a current problem with alcohol use; 37% with binge drinking; 32% attributed violent behaviour to their alcohol use; and 38% were found to have a criminogenic need relating to alcohol misuse, potentially linked to their risk of reconviction. Fifty-six per cent of offenders stated that they were likely to re-offend, with 27% referring to drugs as the main factor explaining their likelihood of further offending (Moore, 2007; NOMS, 2006).

### 4.1.2 Learning disability

Mason & Murphy (2002a) aimed to examine the numbers of people with an intellectual disability on probation in one probation office in south-east Kent. Probation officers were interviewed and probationers screened to detect those likely to have intellectual disabilities. Psychometric testing was used with those identified as at risk of having an intellectual disability, to establish the actual numbers of people with a learning disability and their characteristics, compared to others on probation. Eight probation officers were interviewed and as many of the clients of the probation officers were seen, in total 70 participated. The probation officers were interviewed to assess the extent to which they felt those with intellectual disabilities were represented within their caseloads. They were also asked about clients they supervised who they suspected had an intellectual disability or who had reading, writing or communication problems. Probationers were asked questions about their psychiatric history, ‘learning difficulties’, reading problems and/or attendance at a special school. There was also a
probationer assessment which consisted of basic numerical skills and a basic word reading test. Of the 70 probationers included, 89% were male; the median age was in the 21-30 year age band, with the majority of the sample (67%) unemployed. The mean reading age equivalent and numeracy of the sample was 12.0 years (SD = 50.8 months) and 10.0 years (SD = 40.5 months), respectively. In total, 16 probationers were identified as being at risk of having intellectual disabilities. These 16 were then compared to 16 randomly selected probationers. Participants completed that Wechsler Adult Intelligence Scale, revised version (WAIS-R), used to measure cognitive ability. The Vineland Adaptive Behaviour Scales (VABSs) was used to assess the level of social functioning. There were significant differences between the two groups on all of the measures, with the probationers being at risk of having a learning disability scoring worse on all measures. None of those within the ‘impaired’ range on all assessments were located in the control group, indicating that the screening tools were relatively effective in discriminating between those who have and who do not have an intellectual disability. The authors stated that other researchers have argued that people scoring in the bottom 5% of the general population are likely to have many of the support needs that those with an IQ in the intellectual disability range are likely to have. Using this criterion, 11.4% of the sample fell into this group. They stated that this raises issues in relation to probation staff training and the supervision of the probationers. People with intellectual disabilities may have problems in understanding formal contacts or letters used by the probation service or have problems in undertaking group work and time keeping.

Mason & Murphy (2002b) examined intellectual disability in 90 people on probation in south-east England. They were screened using the Learning Disabilities in the Probation Service (LIPS) screening tool. The LIPS includes two measures of cognitive functioning, as well as some questions about day-to-day coping skills, self-report questions relating to education, intellectual disability and mental health needs, and demographic information. The measures of cognitive functioning are the Quick Test (QT), which measures verbal skills using a word-picture association paradigm; and the Clock Drawing Test (CDT) a non-verbal test. The majority of the sample (86%) was male and the mean age of the subjects was 32.3 years. The majority were Caucasian (97%). Sixty-eight percent of the sample was unemployed; of the remainder 8% were employed part-time and 24% were in full-time employment. The mean age participants left education was 15.5 years. The mean QT IQ was 89.9 (SD = 11.7), with scores ranging from 60 to 110. The mean score on the CDT was 13.5 (SD = 1.8). Using the scores from the QT and CDT they identified the presence or absence categorised participants as having or not having an intellectual disability. They found that participants with intellectual disability were significantly younger and had an earlier age of first conviction. They also more likely to offend with peers, and less able to carry out some of the tasks which are likely to be essential to a successful outcome, such as ability to keep appointments and follow the probation service rules.
Mason & Murphy (2002c) also aimed to develop a screening tool to detect those on probation who may have intellectual disabilities or borderline intellectual disabilities, and which probation officers themselves can use. They recruited 88 participants, 40 from a local unemployment project (Mean age 37.4 years, 88% male) and 40 from a local learning disability day service (Mean age = 43.7 years, 70% male). The screening measure was developed using the data reported in Mason and Murphy (2002a). A discriminant function analysis was used to identify variables that could reliably distinguish those with intellectual disabilities from those whose IQ and social functioning fell within the normal range. Those variables were then included in the screening measure. The final form included demographics, self report questions (have they had a learning disability or been to a 'special school' and have they ever required help for a mental health problem) previous contact with learning disability service, type of residence, coping skills, a vocabulary test and a clock drawing test. The results suggested that the screening measure demonstrated good concurrent validity as the vocabulary and clock drawing test accounted for nearly 80% of the variance in WAIS-R scores. Of those who fell below the cut-off on the screening measure, 87% also scored below IQ 75 on the WAIS-R. Therefore the tool may be useful in screening for people with intellectual disabilities in the probation service.

4.1.3 Approved Premises

Geelan et al. (2000) completed an evaluation of Elliot House, a specialised approved bail and probation hostel for mentally disordered men in the UK. Social and psychiatric data were collected on all residents between August 1994 and April 1996. A total of 83 people were assessed. Of the 83, 45 (54%) were of no fixed abode immediately prior to admission. Sixty three (76%) were Caucasian, 14 (17%) African-Caribbean and 6 (7%) Asian. Seventy-one (86%) were single, and all but one person was unemployed. Fifty-eight percent (n=48) had previous alcohol abuse or dependence and a similar proportion (52%; n = 4), had misused drugs. Thirty-eight percent (n = 32) had a known history of deliberate self-harm. At the time of referral, one third were seeing a psychiatrist, 13% were involved with the probation service and 6% with social services. Current International Classification of Diseases-10 (ICD-10) diagnoses were made for 67 men. Twenty-five (30%) had a diagnosis of schizophrenia; 24 (29%) alcohol abuse/dependence; 15 (18%) with personality disorder; 8 (10%) drug abuse/dependence. Only nine people (11%) had no mental health disorder. For thirty four residents, their behaviour eventually resulted, in the conditions of their residence being breached, and therefore having to leave the hostel, often to go back into custody. Reasons for breaches were more or less equally divided between ‘failure to reside’ (n=16) and breaching of the hostel rules (n=18). Data collected by the probation service demonstrated that the rate of breaches at Elliott House was comparable with other bail hostels in the West Midlands. Analysis of characteristics of those on bail revealed that those on a current charge for an acquisitive
offence were more likely to breach the conditions of their residence (odds ratio 4.02). Elliott House was established as an approved hostel to provide accommodation and specialist mental health input for mentally disordered offenders. Based on the level of psychiatric morbidity amongst the residents studied, this would suggest that the process of screening referrals was working satisfactorily for the most part, although it often became apparent that a resident’s behaviour was more disturbed than hostel staff had been led to believe.

Hatfield et al. (2004) reported on a 12 month cohort study of mental disorder among residents of approved premises within Greater Manchester. They stated that accurate figures for the number of people with mental disorders in probation and the courts are difficult to obtain, partly because criminal justice staff are not trained to identify and assess psychiatric problems. Participants completed the GHQ and the Health of the Nation Outcome Scales (HoNOS). Just over a quarter of the residents had a known psychiatric diagnosis, with 41% of these having a known secondary diagnosis. Five percent had a diagnosis of psychotic mental illness. In addition 9.4% had literacy problems, 18.8% had one or more physical health problem, 4.9% had a Learning Disability, 30% had a problem with alcohol misuse and 34.3% a problem with drug misuse. Men known to have a history of mental illness were directed into specialist premises; however others were placed in non-specialist services. Depression and substance misuse were significant problem areas for residents. The study raised two areas for future research: an exploration of self-harm, in terms of its prevalence, types, links with mental disorder, staff responses and associated training needs. Also the study reported that black and minority ethnic communities were under-represented in the group with mental disorders. It would be interesting to establish why and ensure that it is not the result of under-identification.

4.1.4 Death of offenders on probation

Research suggests that people on probation and recently released from prison are at greater risk of suicide than the general population. Pritchard et al. (1997) explored the mortality rates of a six-year cohort of male probationers (1990-1995) and compared death rates with males in the general population. Of 7,546 men on probation 28 died within the study period. Nine deaths were as a result of suicide, 13 died from ‘external’ causes (eight of which involved overdoses) ['external’ includes all forms of ‘violent’ death (e.g. road and other transport deaths, accidental poisonings, homicide, drowning and undetermined deaths) but, in this study excluded suicide deaths], four died following accidents, one was murdered, six died of natural causes, four of which were from malignant diseases. In comparison with the general population, the suicide rate of men on probation was almost nine times greater. Those probationers aged 35-44 and 45-54 year old had 35 times the rate of suicide than general population males of their age. These results highlight the vulnerability of these men, also these results are likely to be an underestimation of the actual numbers as they
could only be traced if they were still in contact with the probation service. There is a case for increasing Probation Officers’ psychiatric training, along psychiatric social work lines, and at the same time improving mental health social work training for social services. Furthermore, the links between health and crime should be highlighted for GPs to assist them to reach out more effectively.

Sattar (2001) collected data on offenders who died between 1996 and 1997 while under community supervision or in prison, covering 1267 community deaths and 236 deaths in prison. Of the community offenders, 20% were the result of natural causes, 22% suicide, 33% accident/misadventure, 17% other drug and alcohol related, 6% homicide, and 1% other violent death. Community offenders were less likely to die from natural causes and suicide than prisoners but had higher rates of death for all other causes. All deaths involving drugs or alcohol were combined and these accounted for 46% of all deaths in the community and 3% in prison. Deaths among ex-prisoners happened soon after release. By 4 weeks, a quarter of all deaths had already occurred, by 12 weeks over half and by 24 weeks just fewer than three quarters. Overall the mortality rate for community offenders was about double that of prisoners and four times than of the male general population. Sattar concluded that it was important that ex-prisoners continued their drug treatment when released into the community and it was vital that this occurred immediately after release. There are developments under way to provide drug treatment through-care for newly released prisoners in specially designed hostels in the community. A consequence of this service could be a reduction in the number of ex-prisoners dying from drug-related deaths, during what is a particularly vulnerable period. These findings also have implications for the Probation Service and other organisations that work with offenders in the community.

The Probation Service does not have the same duty-of-care as the Prison Service (i.e., that prisoners are held in conditions that are safe and promote their well being); however, the Probation Service is committed to suicide and self-harm prevention, despite receiving no guidelines. Unlike the Prison Service, the Probation Service does not have a policy unit responsible for the self-harm and suicide of offenders in the community. If such a policy unit was set up it would be possible to develop a strategy on the awareness of violent death amongst offenders being supervised by the Probation Service.

Pratt et al. (2006) investigated suicide rates in recently released prisoners. From a cohort of 244,988 released prisoners 382 suicides were identified within 1 year or release. Seventy nine (21%) suicides took place within the first 28 days of release and 195 (51%) within the first 4 months. In comparison to the general population male recently released prisoners were eight times and women 36 times more likely to die by suicide within 1 year of release from prison. These findings highlighted the need for shared responsibility between all agencies involved with offenders both before and after release from prison. Effective resettlement is vital and should be a multidisciplinary function addressing the full range of resettlement needs. Individual care plans should be developed and monitored by
multidisciplinary teams. The team would be responsible for a structured assessment of prisoners’ risk of suicide on their release and for ensuring that those identified as being at risk of suicide are provided with regular and routine contact with community mental health professionals.

**4.2 Evaluation of community orders**

**4.2.1 Drug treatment**

DTTOs were introduced as a community sentence on 1st October 2000 under the Crime and Disorder Act 1998 but have recently been phased out in favour of the Drug Rehabilitation Requirement (DRR), introduced in April 2005 as a result of the provisions in the Criminal Justice Act 2003.

Turner (2004) looked at a sample of 59 offenders who had completed a both pre-DTTO and 6 month post-DTTO questionnaire. It should however be noted that generally half of all offenders stop attending by the 14th week and only 27% were still attending at 6 months. Heroin usage was down from 84% to 26%, weekly spend was down from a median pre-DTTO of £200 to £25 post-DTTO, however the number of offenders spending £0-50 had gone up from 3 to 23, suggesting that although it appears to reduce, drug use does not stop completely and may move towards the use of ‘softer’ drugs such as cannabis as well as alcohol and illicit methadone. The findings of this report suggest that offenders attending the DTTO for at least six months can make significant improvements, in terms of reducing drug use and drug-related criminal activity, and in terms of improving their health and social situation. Maintaining motivation, learning new skills, and changing the way offenders think and/or feel were most important but were the very things that offenders thought was difficult about attending the programme. Reviewing the current strategies and/or interventions in use to assist offenders to work positively with maintaining motivation, learning new skills, and changing the way they think and/or feel would provide the first steps in ensuring that such support is in place.

Ramsden (2007) looked at a sample of 117 offenders sentenced to a DTTO or DRR between April 2003 and August 2006. As found by Turner (2004) heroin was the main drug of choice with 66.1% of offenders describing heroin use as ‘all the time’. Half way into their order this dropped to 2.8% and again to 0% on completion. Again results in terms of weekly spending on drugs were similar to Turner (2004); the mean weekly drug spend at the initial stage was £192.00, falling to £47 per week halfway into the order and to £25 at the end of the order. Again spending between £0-50 went up. In terms of criminal activity, prior to commencing DTTO/DRR offenders estimated committing 7 crimes per month; halfway through the order this reduced to 1 crime per offender and at the end of the order 1 crime every 2 months. The results suggest that there may be a link between completion figures and the content of the DTTO/DRR programme. It appears that programmes providing more activities seemed to have more completions. This would need to be investigated further.
Keene et al. (2007) studied a DIP team between 2004 and 2005. Offenders were tested when charged and referred to the DIP team. One hundred and eighty offenders were offered the scheme; 103 (57%) successfully engaged and 59 (32%) stayed for 6 weeks or more. The majority of referrals were for heroin and 45% also reported crack use. Qualitative analysis of 40 interviews suggested that clients believed that drug use itself was interlinked with social, economic and psychological problems. They highlighted that the link between drug-use and offending was not straight forward and that opiate medication alone would necessarily reduce offending, but they stated an additional need for comprehensive ‘wrap-around services’ and help with housing and employment. The authors stated that it would be interesting to see whether it would be more efficient and effective in terms of crime reduction to invest money in developing and expanding generic harm-minimisation services with no criminal justice involvement.

4.2.2 Mental Health Treatment Requirement

In 2005, the Community Order became the new generic community sentence available to the courts as an alternative to prison. The Community Order gives a choice of twelve different requirements these include unpaid work, supervision by an offender manager or probation officer, accredited programmes, drug and alcohol treatments, mental health treatment, residence at approved accommodation, specified activity, prohibited activity, exclusion for certain areas, electronic curfew, or attendance centre.

The Mental Health Treatment Requirement (MHTR) can be issued to offenders who have an identified mental health problem, where treatment is readily available and the offender has given their consent to engage with services. The requirement can be set for up to three years. The order must be managed by an offender manager, and it must be conducted under the direction of an appropriate medical practitioner. Seymour & Rutherford (2008) conducted a review of the use of Community Orders specifically focusing on the MHRT. During 2006 121,690 Community Orders were issued in England and Wales, 85% of Orders comprised one or two requirements. The two most frequently used requirements were Supervision (37%) and Unpaid Work (31%). They found that only 19 of the 60,253 single-requirement orders issued in 2006 were MHTRs. Seventy-two percent of all MHTRs used with a Community Order were combined with Supervision. The authors stated that there were a number of reasons which have hindered the use of MHTRs, including problems deciding on the seriousness of the mental illness, difficulty in accessing psychiatric assessments and problems with people with dual diagnosis.

More recently Khanom, Samele & Rutherford (2009) conducted research to explore the MHTR, its usage, delivery and impact across nine London boroughs. Sixty-seven professionals from the courts, probation and health services, including voluntary sector agencies and court diversion and liaison services were approached and 56 agreed to participate. The interviews
revealed that lack of awareness of the MHTR. Few of the professionals had any direct involvement, or understood the processes involved such as when and how a MHTR should be used. Of all the professionals interviewed, court and probation professionals were the most likely to have heard of the MHTR, but most had no direct experience of the MHTR. Awareness of the MHTR was lower among health care staff. The interviews also revealed a lack of knowledge of mental health. Court and probation professionals varied widely in their knowledge of mental health issues and their confidence in dealing with them. Judges were the most likely to say they had sufficient knowledge of mental health for their job. Magistrates felt that the training they received was minimal. Probation officers gave less of a clear picture of their understanding of mental health issues. Some probation officers said they were not so confident in managing cases where offenders have mental health problems and that there is not enough training on mental health. Issues around responsibility for mental health were raised. Many of the court professionals interviewed felt that mental health was not the business of the CJS. The authors conclude that the MHTR needs substantial reinvigoration and reinvention as a recognised and utilised non-custodial option for people who would otherwise be imprisoned on short sentences. They recommend that criminal justice and health professional be provided with practical guidance on how to use and manage an MHTR. Protocols at a local level need to be developed between the courts, probation and health services to enable the appropriate use of the MHTR. There also needs to be better mental health training for all criminal justice professionals.
5 Research priorities

Healthcare services for offenders should be designed and developed on evidence based best practice. In order to do this, a knowledge base needs to be developed, identifying what is already known, and what knowledge gaps exist. The preceding scoping review goes some way to identify the current published literature relating to the UK. Overall, our knowledge of the health needs of prisoners is greater than our knowledge of the needs of people in contact with all other parts of the CJS.

Priorities for future research need to be identified by combining research knowledge (what is already known) with the views of key stakeholders about which parts of their service delivery are not necessarily evidence based (what we would like to know). To compliment the review of existing literature and gain this stakeholder knowledge, individual interviews were conducted with a number of key stakeholders and an interactive session hosted at the Offender Health Research Conference in January 2008. This knowledge base and knowledge of key stakeholder have been combined to identify Offender Health research priorities.

5.1 Research priorities for police custody

There have been few prevalence studies of mental illness, learning disability, physical health and drug and alcohol use of detainees in police custody. Those that have been undertaken have tended to relatively small scale studies, focused on very specific health problems. These studies do not amount to a national picture of the health of people in contact with the police and in police custody. It is also very difficult to use data from these studies as a basis for any accurate extrapolation of the numbers of people with serious mental illness that could benefit from being diverted from the CJS. While there is some, limited, research on mental health and learning disability, there is currently only one study looking at the general healthcare of people in police custody and how it is managed which is due for publication this year. The study is small scale and London based, therefore there remains the need for a national scale study. Key stakeholders raised the point that the population of people detained in police custody is dynamic and therefore research needs to be continually conducted if it is to usefully inform training and service provision. For example stakeholders highlighted the fact that over recent years there has been a change in the types of drugs detainees use; in the past opiates were the major drug of choice, however stimulant use has become more common. This therefore impacts on the care and treatment required in police custody and the training needs of police officers, custody nurses and FMEs.
Alongside up to date research on prevalence, research focussing on healthcare needs, and the feasibility of different models of delivering effective screening and assessment in police custody is required. There is currently little consistent/effective screening for physical and mental health problems within police custody, the amount of health information collected currently within police custody is small, not standardised across services and information is infrequently/inconstantly passed on to other agencies. Diverting the mentally ill from the CJS at the earliest opportunity is a Department of Health priority, although many of the key stakeholders interviewed raised the problem that currently police custody suites are not physically conducive to conducting health assessments.

The models of care within police custody are diverse. Currently there is little research around the efficacy of any particular model of care. In order to improve the healthcare offenders receive while in custody, we need to know which aspects work best.

During the interviews key stakeholders raised several issues with the current models of care. Some raised the issue of in-possession medication, highlighting the confusion among custody staff over prisoners having access to medication and also around custody officers giving out medication. Many raised the problem of the cost of current private healthcare services, and also that there was no standardised level of care, in some cases grave concerns were expressed over the level of care that was given. There were also issues around the provision of weekend care. One key stakeholder said that, in the last three years, they had not made any onward referrals as they did not know who to liaise with. Alongside this problem some police officers raised the issue that they were not sure what they could do with any health information they obtained, unsure about issues of around confidentiality. Also the issues around specific populations within police custody, such as the under 18s and pregnant women were raised. During the conference the issue of offenders “in crisis” was raised in relation to what could be done with them if they were ‘ill’ but not ill enough so as to warrant sectioning. This was often encountered in the context of people detained under Section 136.

Previous research has shown that there needs to be improved training for FMEs in providing care in custodial settings. This was echoed by stakeholders concerned that many of FMEs were retired GPs and may not be receiving up to date information both on the types of detainees in police custody and in new techniques and procedures. The key stakeholders also raised the issue of lack of health training for the custody staff, including more training for custody nurses.
5.2 Research priorities for courts

There has been limited research focusing on the prevalence of health problems in people attending court. The most recent study was published in 1999. Therefore, up to date prevalence data are required. During the conference, delegates suggested that there was a need for prevalence studies to focus specifically on Attention Deficit Hyperactive Disorder and Learning Disability.

There have been numerous studies on court diversion schemes; however many are small scale descriptive studies, focussing more on describing service delivery models at individual schemes, rather than undertaking a formal evaluation of health, criminal or economic outcomes. Many key stakeholders were frustrated that court diversion schemes had seemingly not moved on since their conception, in spite of the number of schemes in operation and their potential contribution to the correct placement of individuals. Developments in court diversion practices and efficacy would thus be enhanced by studies critically examining best practice models, combined with examinations of both short and longer term outcomes. Improved knowledge of the value of diversion is linked to the need identified by stakeholders to examine the feasibility and value of mental health and drugs courts and the efficacy of community orders with mental health treatment requirements.

A common theme raised by key stakeholders and conference delegates was that of staff training, not only for court staff, but also judges, magistrates and the Crown Prosecution Service.
5.3 Research priorities for probation

There is limited work on the prevalence of health problems in the community, therefore more needs to be done. The key stakeholders raised sexual health, alcohol and gambling as three specific areas in which there was a lack of current research knowledge. Many of the key stakeholders said that the current system of collating health information through OASys was not sufficient to gather health information, and that ways of improving the gathering of routine data should be examined, to thus increase the usefulness of such data.

Key stakeholders raised the issue of the need for more research into ‘what works’. Particular concerns were expressed that a large amount of money had been invested in drug intervention programme, but with no corresponding evaluative element. They also stated that they only ran programmes that had been accredited, but that there may be alternatives which were more effective, shorter and cheaper to deliver. They also expressed the need to examine the best ways of delivering services to people with lower level mental health problems, rather than focussing solely on the severely mentally ill.

Delegates at the conference suggested that there should be more research into how to motivate people to engage with services, especially the potential value of peer support schemes. As with court-based staff, those working in probation identified the need for research on the efficacy of mental health treatment orders, as the literature review above suggests currently they are used infrequently.

Again, in common with other staff, the need to examine the training implications of delivering more efficient or new types of services was regarded as vital; in particular the issue of ensuring adequate risk management training was noted.
5.4 Knowledge gaps across the criminal justice system

The following table (Table 1) represents a synthesis of opinion gathered through key stakeholder interviews and the interactive session at the OHRN conference which reveals areas of knowledge gaps across the criminal justice system.

There was significant overlap in needs and gaps across the whole criminal justice system. This knowledge can be gained through a variety of types of research or allied techniques e.g. audit, service evaluation, needs assessment. The items in the table are presented in order of the frequency with which they were mentioned, with the most frequently identified needs first.
<table>
<thead>
<tr>
<th>No.</th>
<th>Research Priorities</th>
<th>Importance to sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health needs assessment including the identification of health problems through implementation of effective screening tools</td>
<td>Court, Police, Probation, Community/Resettlement</td>
</tr>
<tr>
<td>2</td>
<td>Improved multi-agency working within and across sectors through communication, networks, improved IT systems</td>
<td>Court, Police, Probation</td>
</tr>
<tr>
<td>3</td>
<td>Improved continuity of care across sectors and an established pathways of care</td>
<td>Court, Probation, Community/Resettlement</td>
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<tr>
<td>4</td>
<td>Mental health as a health problem including identification, links to offending and mental health services and providers</td>
<td>Court, Probation, Community/Resettlement</td>
</tr>
<tr>
<td>5</td>
<td>Substance and alcohol misuse relating to identification, base rates, services and links to offending</td>
<td>Court, Probation, Community/Resettlement</td>
</tr>
<tr>
<td>6</td>
<td>Community, linked to continuity of care, social needs and the links to offending</td>
<td>Court, Community/Resettlement</td>
</tr>
<tr>
<td>7</td>
<td>Staff training to develop greater awareness and improved skills e.g. mental health training for GPs and awareness of own and others roles</td>
<td>Court, Community/Resettlement</td>
</tr>
<tr>
<td>8</td>
<td>Service user perspectives including gaining insight into their experiences, expectations and awareness of own illnesses</td>
<td>Probation, Community/Resettlement</td>
</tr>
<tr>
<td>9</td>
<td>Access to services including problems of availability, motivation and strict referral systems</td>
<td>Police, Court, Probation</td>
</tr>
<tr>
<td>10</td>
<td>Interventions and implementing research findings</td>
<td>Court, Probation</td>
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<tr>
<td>11</td>
<td>Evaluation of available services</td>
<td>Court, Probation</td>
</tr>
<tr>
<td>12</td>
<td>Problems in delivery and provision of services</td>
<td>Police, Probation</td>
</tr>
<tr>
<td>13</td>
<td>Meeting the needs of those on short sentences and ensuring continuity of care</td>
<td>Court, Community/Resettlement</td>
</tr>
<tr>
<td>14</td>
<td>Problems of variation in the delivery and management of services</td>
<td>Police, Court, Probation</td>
</tr>
<tr>
<td>15</td>
<td>Tailoring services to the needs of young people</td>
<td>Court, Community/Resettlement</td>
</tr>
<tr>
<td>16</td>
<td>Tailoring services to the needs of women, including researching preventative measures</td>
<td>Police, Community/Resettlement</td>
</tr>
<tr>
<td>17</td>
<td>Tailoring services to the needs of the elderly</td>
<td>Court, Probation</td>
</tr>
<tr>
<td>18</td>
<td>Tapping the user experience</td>
<td>Community/Resettlement</td>
</tr>
<tr>
<td>19</td>
<td>Autistic spectrum disorders- services and a pathway to meet assessed needs</td>
<td>Court, Community/Resettlement</td>
</tr>
<tr>
<td>20</td>
<td>Evaluation of the impact of health initiatives and lifestyle in relation to complex needs</td>
<td>Community/Resettlement</td>
</tr>
</tbody>
</table>
6 Conclusion

As Donald Rumsfeld, former US Secretary of State for Defense rather tortuously expressed in another context, “there are things that we know we don’t know” (Department of Defense, 2002). In the current context, this is true of the state of our knowledge about the health needs of those in contact with the criminal justice system.

The state of research knowledge about prevalence of mental disorder and chronic physical disease among prisoners is good in the UK and elsewhere, but less is known of the prevalence of all types of health issues in other areas of the CJS. However, more pressingly, the quantity and quality of evidence which could directly and positively influence actual service delivery models to ensure that they accurately meet clinical need and guide staff in providing the most current and effective modes of treatment, is much less advanced. Work concentrating on how best to deliver services to this health-compromised group must be the main focus of future research.

In order to be able to deliver sufficient appropriate healthcare services it is necessary to have comprehensive, accurate information not only about the prevalence of physical and mental disorders along the whole offender pathway, but, most importantly, how this translates into identifying needs for particular services. Only then can those charged with commissioning and providing services for these groups hope to do so effectively through collaboration with clinicians and researchers focusing on developing best practice models of care delivery. The development of new services then needs to be accompanied by effective evaluation programmes of both clinical efficacy and acceptability to users. The development of new services will have implications for workforce development in terms of embracing new ways of working and the need for additional and innovative training opportunities. Central to any service developments will be the need to establish effective multi-agency partnership across all spectrums of the criminal justice, health and social care systems. These partnerships will need to be sustained at individual practitioner level, local and regional management level and additionally within and across central government departments.

It is indeed true that healthcare delivery is not the main purpose of criminal justice agencies, and this was a factor in the shift such that healthcare in prisons as well as in the community be chiefly provided by the NHS rather than by prison authorities. In terms of the current government, policy and clinical interest in, and emphasis on, improving diversion from custody and developing a cross-agency health and social care strategy across the wider CJS, there are exciting times ahead for all.
7 References


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