

# **The mental health of offenders and ex-offenders**

## **Call for Evidence Responses**

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**Sent:** 28 April 2017 14:52

**To:** Healthcommittee@london.gov.uk

**Subject:** Mental Health questions

To whom it may concern,

I have provided answers to the questions and wanted to know if I could be emailed the final report into this issue as this relates to the work that I am involved in.

The Health committee will be looking at these key questions:

1. What are the main mental health challenges faced by prisoners and ex-offenders in London? For me the main issue is thinking about the past and reliving the past as everyone from an area will know the person and that makes it hard for the person to turn their lives around, as it seems like everyone is watching them. Another issue is when the person with mental health problems feels that people are out to get them even though people are not. Once the person who has been to prison takes in negative ideas, they have the tendency to become real, depending on their level of criminality. Lastly if the person who has a mental health problem is unaware of what triggers them, they will repeat the same mistakes without really understanding that they are the ones who have the problem as they will blame society for all of their problems, rather than to take responsibility.
2. What measures are in place to prevent people with mental health needs entering the criminal justice system and how are they supported through prison, probation and release? Are these measures sufficient? I am not aware of the support that is available for people who have mental health problems and how they are being supported through the criminal justice system.
3. Which groups within the offender population are specifically at-risk of developing mental health problems? Anyone that is involved in serious crime and has the tendency to follow their friends who may also be involved in criminal activity. Also, anyone who holds onto secrets may find it harder to continue holding on to them when they realise that other people are quick to let go of their secrets at the drop of a hat.
4. What steps could mental health service providers take to make their services more accessible for ex-offenders? They could provide information to people who are leaving prison so that they can be aware of the support that is available to them. Probation services could also do more to signpost people to relevant services so that people can access support before it becomes too late.
5. How effective are programmes that aim to support continuity of mental health support when people have returned to their communities following prison? Again not aware of the services that are available for this.
6. How do issues such as housing and unemployment affect the mental wellbeing of offenders and ex-offenders? Both housing and the job situation will affect a person's mental health leading them to want to block out their problems rather than facing them. Society provides so many distractions to get away from self but when one has a mental health problem, one has to go into self in order to be able to deal with it.
7. What examples of good practice are there in London and further afield? There are good mental health services in Sussex where there is a lot of partnership work happening with services across the county.
8. What can the Mayor and the London Assembly do to support better mental health for this group? It would be nice to have self supporting support groups set up where people can

discuss their mental health with other people who have problems as once people realise that others are managing to live with their mental health problems then hopefully other people will see that it is possible to do so.

As I said before this is a very live area for me now as I am a person who has been to prison who got released in 2005 and had my first mental health problem in 2015. I do some work in prison's which means that I can now realise how many other people are managing their own mental health problems which seems like a huge issue, especially for men as on the whole, they have not been raised to talk about their feelings.

I am happy to stay involved in this project in anyway that I can so please do keep me updated.

All the best

**Sent:** 02 May 2017 13:06

**To:** Healthcommittee@london.gov.uk

**Subject:** Re: Mental Health of Offenders and Ex-Offenders Inquiry

Dear Chair,

For your consideration, information.

#### Reports

Refer attached x 3 [Young Minds report, [Same Old](#)...the experiences of young offenders with mental health needs. Criminal Justice Alliance report, '[Crowded out?](#) The impact of prison overcrowding on rehabilitation'. Clinks report, '[Navigating the health landscape in England](#)'.]  
<http://www.clinks.org/criminal-justice-influencing-criminal-justice-policy-reducing-reoffending-third-sector-advisory/rr-0>  
and attached report  
[<https://www.rcpsych.ac.uk/pdf/OffendersPositivePracticeGuide2009.pdf>].

#### NHS

Refer [NHS Confederation](#) report

#### JSNA

Tower Hamlets, refer [attached](#)  
Other Local Authorities JSNA, EqlA, IA, Risk, Health..... impact assessments from the city of London and other LA's might wish to be considered as informational evidence?  
Wandsworth CCG, [refer attached](#)

#### Prison Statistics

<https://www.gov.uk/government/statistics/prison-population-figures-2015>  
<http://inquest.org.uk/statistics/deaths-in-prison>  
<http://www.prisonreformtrust.org.uk/PressPolicy/News/Deathsincustody>  
<http://www.ppo.gov.uk/document/fii-report/>

#### Charitable Support

<http://lambethandsouthwarkmind.org.uk/directory-group/anyone-in-the-criminal-justice-system/>

The committee might wish to further investigate the use of Local Authorities paid through the Local Government Finance Settlement, e.g Supporting people grant, the use and social return in investment?

#### Charitable Support

<http://www.clinks.org/funding-for-offenders>

#### Government

<https://www.gov.uk/government/news/funding-boost-for-programmes-that-reduce-reoffending>  
<https://www.gov.uk/government/publications/rehabilitation-social-action-fund-faqs>

#### Parliament

Refer attached x 2 [House of Commons Work and Pensions Committee [Support for ex-offenders, Penal Reform Trust submission](#) to Work and Pensions Committee]

<https://www.parliament.uk/business/committees/committees-a-z/commons-select/work-and-pensions-committee/inquiries/parliament-2015/ex-offenders-15-16/>

<https://www.parliament.uk/business/committees/committees-a-z/commons-select/work-and-pensions-committee/news-parliament-2015/ex-offenders-launch-15-16/>

<https://www.publications.parliament.uk/pa/cm201617/cmselect/cmworpen/1044/104402.htm>

<https://www.publications.parliament.uk/pa/cm201617/cmselect/cmworpen/58/5803.htm>

#### Publications

Refer [attached](#)

#### Local Authorities

<http://www.haringey.gov.uk/social-care-and-health/health/joint-strategic-needs-assessment/other-factors-affecting-health/crime>

Refer [attached](#) Lewisham

#### EqIA and Risk Assessments

[Tower Hamlets](#) (outdated)

[Harrow background](#).....

#### London Councils

Information published but not accessible to public, might wish to seek further information on their publications

#### Facts and Figures

Refer attached [summer briefing](#) 2016

#### MoJ IA

Refer [attached laspo](#).....

#### Home Office IA

Refer attached EIA.....

#### Government

<https://www.gov.uk/government/publications/dbs-sample-policy-on-the-recruitment-of-ex-offenders/sample-policy-on-the-recruitment-of-ex-offenders>

[Refer attached](#)

#### Parliament

Refer [SN02989](#)

#### CPS

[http://www.cps.gov.uk/publications/research/offenders\\_with\\_mental\\_health\\_problems.html](http://www.cps.gov.uk/publications/research/offenders_with_mental_health_problems.html)

#### Health Needs Assessments

Refer attached [part 1](#) and [part 2](#)

<https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>

<http://www.chimat.org.uk/yj/hwbna> and

<http://www.chimat.org.uk/yj/na/template> and <http://www.chimat.org.uk/yj/na/aboutHWBNA/def>

<http://docplayer.net/34004191-Offenders-and-ex-offenders-needs-assessment.html>

Blogs

<https://www.mentalhealth.org.uk/blog/mental-health-prisons-lets-stop-and-think>

Bradley Report

<http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth/TroubledInside/BradleyReport>

<https://www.basw.co.uk/resource/?id=3116>

Refer [attached](#)

<https://www.centreformentalhealth.org.uk/bradley-and-the-cj-workforce>

<https://www.centreformentalhealth.org.uk/the-bradley-report-five-years-on>

Thank you.

**Sent:** 21 April 2017 14:39

**To:** Healthcommittee@london.gov.uk

**Subject:** FW: London Assembly Health Committee - access to mental health services for offenders

Hello Lucy,

in light of your consultation exercise, the Prisons and Probation Ombudsman thought you might find the attached publications of interest.

Best wishes,

Kimberley

Kimberley Bingham  
Deputy Ombudsman

[publications attached were the '[Learning from PPO investigations Prisoner mental health](#)' report (January 2016) and the '[Learning lessons bulletin, Fatal incidents investigations](#), Issue 11 (July 2016), both published by the Prisons and Probation Ombudsman

3 May 2017

Health Committee  
London Assembly  
City Hall  
The Queens Walk  
London  
SE1 2AA

**Investigation into the mental health needs of offenders and ex-offenders**

The Howard League for Penal Reform welcomes the opportunity to submit evidence to the investigation into the mental health needs of people in the criminal justice system in London.

Founded in 1866, the Howard League is the oldest penal reform charity in the world. We have some 10,000 members, including lawyers, politicians, business leaders, practitioners, prisoners and their families and top academics. The Howard League has consultative status with both the United Nations and the Council of Europe. It is an independent charity and accepts no grant funding from the UK government.

The Howard League works for less crime, safer communities and fewer people in prison. We aim to achieve these objectives through conducting and commissioning research and investigations aimed at revealing underlying problems and discovering new solutions to issues of public concern. The Howard League's objectives and principles underlie and inform the charity's parliamentary work, research, legal and participation work as well as its projects.

Since 2002 the Howard League for Penal Reform has provided the only legal service dedicated to representing children and young people in custody. We have drawn upon our lawyers' experience in practice and our expertise in this policy area in this response.

**The main mental health challenges faced by prisoners**

Prisons are violent, dangerous and unhealthy places. The high rates of suicide and self-harm in prisons are indicators of the level of mental distress. On average a prisoner dies by suicide every three days. Last year 119 prisoners died by suicide, the highest number since current recording practices began in 1978.

The rise in prison suicides and self harm incidents has coincided with cuts to prison staffing and budgets and a rise in the number of people in prison, resulting in overcrowding. Data from the Ministry of Justice show that two London prisons, Wandsworth and Brixton are among the ten most overcrowded prisons in England and Wales. Many prisoners are spending hours locked in their cells each day with little to occupy themselves. They are being deprived of basic coping mechanisms, including physical activity and social contact, often at a time when they most need it. Her Majesty's Inspectorate of Prisons (HMIP) found that in Isis prison the regime had been punitively restricted for years and prisoners could not access activities, showers and telephones every day.

There has been an increase in prison violence and a deterioration in prison safety. An HMIP report on Pentonville prison in 2015 found *'levels of violence were high, and prisoners reported high levels of victimisation from staff and other prisoners. The number of violent incidents had also almost doubled since the previous inspection and they were becoming more serious'*.

The use of punishments in prisons has increased. Difficult or challenging behaviour in prisons can be indicators of mental distress but often results in punishment or segregation. In 2015 the Supreme Court heard evidence that prolonged solitary confinement of adults can have an "extremely damaging effect on ... mental, somatic and social health" and "some of the harmful psychological effects of isolation can become irreversible". The effects of solitary confinement can continue to impact on mental wellbeing after release.

The Ministry of Justice does not national publish data on the use of segregation in prisons. The Howard League has assisted and represented many prisoners who have been held in segregation or solitary confinement. In April, the Howard League for Penal Reform brought a judicial review on behalf of a boy who had been held in prolonged solitary confinement in a London prison. For long periods of his time in Feltham prison, the boy, identified only as AB in court documents, had been locked alone in his cell for 23 and a half hours a day. The court heard that staff would turn off his electricity leaving him in darkness whilst he could hear other boys associating and that a photocopy of a worksheet was pushed under his door as the only education provision. The charity's legal team has been contacted by other children in Feltham prison who have also been placed in solitary conditions for extended periods.

The Howard League is concerned about proposals to pilot a secure school in London. Secure Training Centres were opened 20 years ago and, just like secure schools, were intended to provide training and education to meet children's needs. Indeed, it is difficult to see how a 'secure school' would be different to an STC.

The Howard League warned about systemic problems in STCs for years. The on-going degrading treatment of children in Medway secure training centre was exposed in January 2016 by the BBC's *Panorama* programme. Its undercover investigation revealed child abuse, coercion and the falsification of records at Medway STC and has been the subject of police investigation and prosecutions. An Ofsted inspection report on Rainsbrook STC in 2015 found children had been



subjected to degrading treatment and racist insults. Howard League lawyers have represented children who have been injured by staff during violent restraints in STCs.

Reinventing and renaming prisons for children is not the answer and is not in the best interests of London's children.

### **Accessibility of mental health services in prisons**

In a report published by the Howard League and Centre for Mental Health (2017), health care staff described how patients frequently missed their health care appointments because there was no staff member to escort them.

HMP Pentonville Independent Monitoring Board reported that one to one mental health treatment sessions were taking place on a landing or at an open cell door. The IMB reported,

*'Worst still, however, is the problem of prisoners not being unlocked at all which is attributed mainly to a shortage of custodial staff. It is bound to be detrimental, and is, in any case, wholly inappropriate, that mental health assessment and therapeutic support should have to take place through the locked doors of cells'.*

The health committee must consider the whole prison environment when investigating the mental health needs of prisoners. It is not sufficient to ensure that every prisoner is able to have the occasional appointment with a mental health professional or psychiatrist if the prisoner is terrified, isolated, locked in their cell for hours on end or drug-addled. Mental health service providers cannot deliver an effective service when prisoners are locked behind their cell doors. Mental health services will have minimal or no impact on improving the mental wellbeing of prisoners when the whole prison environment is detrimental to mental health.

I would be happy to provide further information on the points I have raised. I have attached a copy of our report on preventing prison suicides.

Yours sincerely,

Frances Crook

[attached alongside the submission was the [Howard League's briefing on preventing prison suicides](#)



## **London Assembly Call for Evidence – Mental Health of Offenders and Ex-offenders**

St Giles Trust is a charity helping ex-offenders and people experiencing other forms of serious disadvantage to turn their lives around.

We work with people affected by prison, homelessness, long-term unemployment, addiction and poverty. We help them overcome any issue which might be holding them back from moving their lives forward.

We have a proud track record of working with over 20,000 people per year across England and Wales through services in prison and in the community. We close the gaps left by state services and help some of the most vulnerable people in our society access them. Our work is not about ticking boxes – we are led by the needs of the people who need our support.

Underpinning all of our work is a belief that change is best achieved when those with lived experience are at the heart of the solution. We achieve this through our Peer Advisor Programme. This offers those who have experienced barriers themselves the opportunity to follow a programme of training and voluntary placements, leading to a Level 3 qualification in Advice and Guidance.

St Giles Trust has won multiple awards for our work and in 2017 was included in the 100 Best Companies to Work For list in the not-for-profit category for the ninth consecutive year. We are a leading employer of ex-offenders who currently comprise 33% of St Giles Trust's workforce.

We passionately believe everyone is capable of positive change if they are given the right support.

We have undertaken a number of external evaluations into our services:

- In 2016 PwC undertook a study into our peer support service for prison leavers in Yorkshire which used Peer Advisors to help them successfully resettlement in the community by overcoming multiple barriers such as housing, addictions and long term unemployment. It concluded that £8.54 in societal value was generated for every £1 invested in the service. These were benefits to both the Peer Advisors personally and the prison leavers they supported. (*PwC Creating Social Value and Building Social Capital 2017*)
- Our SOS Project uses specially trained ex-offenders to help high risk young people caught up in gangs and multiple offending. A 2013 evaluation found that 87% of the clients stated that it had changed their attitudes to offending and 73% felt it was important that their caseworker was an ex-offender as they could relate to them and felt inspired to turn their lives around. (*An Evaluation of St Giles Trust's SOS Project, The Social Innovation Partnership, 2013*)

- A 2012 evaluation into a peer-support project for highly vulnerable women leaving prison who were frequent re-offenders found that their re-offending rate halved for the 12 months after engaging with the project compared to the 12 months prior. (*An Evaluation of WIRE, The Social Innovation Partnership 2012*)
- A 2010 cost-benefit analysis into a London-based service using ex-offenders to offer meet at the gate support for medium to high risk offenders found that it delivered £10 in cost benefits to the public purse for every £1 invested in the service through savings on criminal justice costs alone. (*St Giles Trust's Through the Gates – An Analysis of Economic Impact, 2009*)

All the above services worked with individuals who were difficult to engage with support services due to their high levels of need and challenging behaviour. This included backgrounds of multiple offending, long-term unemployment, homelessness and rough sleeping, substance misuse problems and mental health issues. The evaluations offer a snapshot into their potential wide-ranging benefits which can be felt by all of society.

### **What are the main mental health challenges faced by prisoners and ex-offenders in London?**

The experience of prison itself can be a contributory factor. The stress and isolation of being held in prison without access to support structures such as family can worsen existing mental health conditions or possibly be a trigger factor for them. Furthermore, for people experiencing certain conditions the noise, crowded conditions and harsh lighting can worsen this. People with mental health problems are particularly vulnerable to being bullied and may have difficulty disclosing this to staff.

There is a lack of understanding on the issue amongst staff coupled with a lack of training on it in the criminal justice sector. Furthermore, cuts to the criminal justice sector and mental health services mean everyone is being asked to do more for less.

Lack of joined up practice between custody and community mean services do not follow the individual. Information is often not shared 'through the gate' which can lead to people being released without support or access to medications. Recently, St Giles Trust received a request to support a highly vulnerable female prison leaver who had served a six week sentence. She had not received any medication during her sentence and as she was so unwell when released we could not get her registered with a GP. The prison did not provide any supporting documents to help her get linked into services. Her condition worsened to the extent that she disengaged with the service and has since disappeared. We are still trying to locate her whereabouts to continue our work with her.

Many people have dual diagnosis e.g. mental health and substance misuse issues which leads to self-medication. These individuals are stuck in the 'dual diagnosis' loop. They are unable to access mental health support to help prevent their offending as they need to address their addiction first. The recent NICE guidelines detailing how mental health services should work with dual diagnosis clients are paradoxical. They state agencies should only work with clients who have a 'formal diagnosis' of dual diagnosis which, in itself, is very tricky to get due to services not working with them in the first place.

Some mental health services are perceived as inaccessible by the people who need them. Vulnerable people can be unwilling to engage with mental health support services due to fear of unknown, worries over medications and feeling embarrassed.

1.

**What measures are in place to prevent people with mental health needs entering the criminal justice system and how are they supported through prison, probation and release? Are these measures sufficient?**

The Court Diversion scheme provided by Together, which is a mental health organisation are able to provide specialist support to those who meet the Liaison and Diversion scheme, however there is evidence that in some cases courts and CMHT will recommend men and women with mental health issues are held in custody so that the prisons can cover the cost of having a person access mental health services. The problem with this is that mental health assessments do not happen in a timely fashion in custody. For those on short custodial sentences, the mental health teams will decide that it is not worth assessing in custody and will therefore recommend that they access CMHT. With no joined up system men and women often slip through the gap.

No provision is not sufficient, there always feels like there is a lot of 'passing the buck'. No one seems to want to take responsibility, this is especially significant for those with dual diagnosis or not formal mental health diagnosis.

What we need are early interventions in appropriate settings such as mental health, homelessness, long-term unemployment services. Make services accessible through going to locations frequented by those in need of the support and involve former service users to make them more 'friendly'. Offer holistic support so people have a single point of contact with one individual who can help with a range of issues rather than expecting a vulnerable person to maintain engagement with multiple agencies without any added support.

2.

**Which groups within the offender population are specifically at-risk of developing mental health problems?**

People who are homeless, those that have come through the care system, those from disadvantaged backgrounds, those who have suffered past trauma and abuse which can go diagnosed and present in other ways such as substance misuse or offending. Those on short sentences are not in custody for long enough to access inreach services.

3.

**What steps could mental health service providers take to make their services more accessible for ex-offenders?**

Ideally, use specially trained ex-offenders in their service delivery. This will break down barriers and bring the experience of the service user into service delivery. Ensure that staff working in mental health services are trained in issues such as disclosure, gangs, leaving prison. Listen to charities and other support agencies who have experience of working with this client group and the barriers that we face.

4.

**How effective are programmes that aim to support continuity of mental health support when people have returned to their communities following prison?**

Good support offered in prison is not always followed through into the community and people who stabilise in custody often break down once they are released into the community, setting up a cycle of relapse and re-offending (see above example in answer to first question). Support with needs such as housing often only happens very close to release meaning vulnerable people can be released homeless further exacerbating their conditions. Frequent use of short sentences for people with mental health needs – who often can be involved in low-level, survivalist, repeat offending – can make this even more problematic. Often, the sentence can be managed in the community instead. Cuts exacerbate this problem and services are often only kept together by frontline staff from all sectors going over and above their jobs.

5.

**How do issues such as housing and unemployment affect the mental wellbeing of offenders and ex-offenders?**

Housing is particularly important. Lack of housing or unstable housing for anyone will exacerbate stress and worry. Housing is a big need amongst people leaving prison and affordable housing in London is particularly in short supply. We frequently need to relocate people away from their support networks and family in order for them to secure housing. Those with more serious mental health needs often need supported housing which can be difficult to access.

Only a minority of people with complex needs are in employment. Many have been reliant on welfare benefits for most of their lives, poverty is universal and mental health needs are another complicating factor. People with criminal records already face barriers when they look for employment and those with mental health issues can struggle further. Not only are they more likely to be lacking skills and experience, they frequently face discrimination from employers who are reluctant to employ people with convictions and mental health issues.

However, with a patient, peer-led approach individuals can eventually progress towards employment. St Giles Trust trains former service users known as Peer Advisors to offer employment support to this group. One of the individuals we recently helped was number one on the MAPPA list for the borough he came from. He was diagnosed with

multiple personality disorder and substance misuse issues. Our Peer Advisors collaborated closely with probation, drug and alcohol agencies to offer extra support to him. As a result of this he was able to engage much more effectively with statutory services and eventually his situation stabilised to the point where employment was a realistic prospect for him. He secured a job and we continued our support for him during the early stages of this. He has now been employed for almost two years. We believe this result is an example of good communication with other agencies, long-term consistent support, access to resources within appropriate time and considerable patience.

6.

### **What examples of good practice are there in London and further afield?**

Our Footsteps Project helps women prison leavers returning to London who have mental health issues and complex needs. Taking a multi-agency approach, Footsteps aims to stabilise their lives and help them resettlement in the community. It works with women leaving HMPs [Bronzefield](#), [Downview](#) and [Send](#) and also accepts referrals from some community-based partner agencies and London-based Community Mental Health teams. The nature of the support is driven by the needs of the client. It offers 'meet at gate' help to provide women with the practical support they need on their first day out and then works with them in the longer term to address underlying issues which might be driving their offending. Footstep's Team Leader is highly experienced in supporting vulnerable women with complex needs and previously led a specialist project working with women in the criminal justice system who have Autism Spectrum Disorder and personality disorder. Alongside offering support for clients, she has also offered training for other frontline professionals in prisons and similar settings.

St Giles Trust is delivering a multi-partnership project called Peer Circles. It is aimed at heavily disadvantaged adults who have experienced issues such as homelessness, substance misuse issues, mental health problems, time in prison and long-term unemployment. Peer Circles puts former service users at the centre of this service through training them to a Level 3 Advice and Guidance qualification. As part of the vocational element of this course they undertake supported voluntary placements helping people who are currently being supported through Peer Circles. The majority of clients supported through Peer Circles have experienced both mental health issues and/or time spent in prison. This peer-led approach means that levels of engagement with the project are high – service users feel like they are being supported by someone who has truly 'walked in their shoes'. Ultimately, Peer Circles aims at helping service users access employment opportunities but it will help address any other issue which might be hampering them from achieving this e.g. housing, debts. Support is both practical and emotional. Locations are flexible and the team work in partnership with a wide range of other agencies to deliver support sessions in places such as secure units, community-based mental health settings and drug and alcohol support providers. Peer Circles is funded over three years thanks to the European Social Fund and Big Lottery Fund. This long-term funding recognises the fact that it takes time to work with vulnerable adults and that positive progressions will not take place overnight.

**What can the Mayor and the London Assembly do to support better mental health for this group?**

We would call on the Mayor and the Assembly to encourage statutory providers to listen to voluntary agencies who can add value to their work and act as a bridge between them and some of the more vulnerable ex-offenders with mental health needs. This group can be challenging to work with and take up a lot of precious time and resources for statutory agencies. By working with us and sharing information, we can help relieve some of this pressure.

We would also call for commissioners to not simply race to the bottom and commission the cheapest services in this area. Effective, sustainable change in vulnerable takes time to achieve and needs funding – especially in the early days of working with someone when their behaviour can be most challenging.

Along with wider work being done to address affordable housing shortages in the capital we would also recommend that this group are not left out of the equation. Encouraging local authorities to accept them as priority needs would be a very welcome measure alongside provision of some supported housing for this group if possible.

**Sent:** 30 May 2017 16:20

**To:** 'healthcommittee@london.gov.uk'

**Subject:** The mental health of offenders and ex-offenders; London City Hall

Dear Sir/Madam

In response to the London Assembly Health Committee investigation into the mental health needs of offenders and ex-offenders, please find below responses to the questions posed.

Step Together works with offenders across London, helping them re-integrate into the community through volunteering. You can find out more about our work here: <http://www.step-together.org.uk/supporting-rehabilitation-ex-offenders>.

**1. What are the main mental health challenges faced by prisoners and ex-offenders in London?**

Lack of support and understanding/knowledge from staff, prisoners are given anti-depressants as soon as they arrive in prison without proper consultation/diagnosis, no support given on release. Some people do not realise they have a mental health issue and don't seek treatment – they may just feel “down and upset” having been sent to prison but this can manifest into depression.

There is sporadic screening for when the person first enter the system, and often people are misdiagnosed because the Health Service is completely overwhelmed. There is a woeful lack of medicines in the prisons, and the Health Providers won't prescribe strong opiates because of the black market for prescribed medicines is enormous. Many of the people who have mental health issues self-medicate with drugs or alcohol and are put on the de-tox wing, where their mental health issue is over shadowed by their addiction issues. These people are often cleaned up and sent out without any proper diagnosis and little or no support service provided on release.

People with convictions are unfortunately only seen as people who have created victims, never as victims themselves. As a result they are not given help to come to terms with physical and mental and sexual abuse or neglect that they may have suffered as they were growing up. If support were given to help people with these issues whilst in custody, then maybe people's mental health can be helped to improve.

**2. What measures are in place to prevent people with mental health needs entering the criminal justice system and how are they supported through prison, probation and release? Are these measures sufficient?**

From our experience, very few measures are in place unless someone is seriously ill, even when the client is diagnosed before they go in. There is no support or referrals for when a person first goes into the system from their mental health provider, or communication from the prison to the persons' mental health team externally. In extreme cases, the client can contact their mental health team and they will contact the prison, but that is very rare. Many develop their illness whilst inside and a significant proportion of the clients we work with at Step Together are suffering with their mental health on release.

**3. Which groups within the offender population are specifically at-risk of developing mental health problems?**



Hard to separate out, as all are at risk. However, specific groups would include women separated from their children, foreign nationals, sex offenders, first time offenders, young men. Prison is extremely traumatic, not just going in, but coming out as well. Most people don't think about what happens to the client when they are released, they need a huge amount of support and time to re-adjust. Many go out onto ESA because of their mental state.

4. What steps could mental health service providers take to make their services more accessible for ex-offenders?

Basic screening for all going into prison. Open door policy for the Mental Health team. Provide support whilst in prison, ensure a care package is in place on release with monitoring.

Clients' being allowed to self-refer. Stronger medication than just paracetamol or ibuprofen, but carefully monitored. Provide the facilities for AA, NA and self- help groups, with professional facilitators.

5. How effective are programmes that aim to support continuity of mental health support when people have returned to their communities following prison?

In our experience, there is little support and many of our clients are left to find it themselves and don't know where to go.

6. How do issues such as housing and unemployment affect the mental wellbeing of offenders and ex-offenders?

These are huge issues – it is a vicious cycle of having no money to pay for accommodation/food/family etc so they turn back to crime to pay for it. Unemployment affects them financially as well as personally – low self-esteem, no confidence, loathing of own self, unable to move forward and make changes, seen as “not worthy” of been given a job, lack of motivation when told “no” all the time - all of these issues affect personal mental health.

A 2003 survey by NACRO stated that for every 5 men coming out of prisons at that time in London, there was only one available hostel space. We have seen men deliberately get an extended sentence because they can't cope with finding somewhere to live when they are due for release. The anxiety and stress over this is phenomenal. The housing teams in the prisons now only try to save peoples' properties, rather than trying to find them accommodation. They also hand out lists for first night stays. There is a project in London called: <http://www.nosecondnightout.org.uk/>, which helps people on release, but is only for people who are homeless for the first time.

Unfortunately, we do work with some local councils which refuse to house people who coming out of prison, saying that they have made themselves intentionally homeless, despite them often having lived in the area for years. This adds a huge barrier to people moving on with their lives and can have serious consequences for mental wellbeing.

7. What examples of good practice are there in London and further afield?

We have struggled to find good practices – the majority of our clients state they have mental health issues and it has been up to the Step Together team/probation etc to try and refer them to an organisation for help on release.

MIND is a good organisation, and has impact on clients' in the community, but not sure to what extent.

8. What can the Mayor and the London Assembly do to support better mental health for this group?

- A joined up service between the mental health teams both internally and externally.
- Money needs to be given to the NHS and mental health charities to help the ever growing population of offenders suffering with mental health issues.
- Mental health teams based inside prisons, need to be a priority.
- Provide SOS bracelets/necklaces with the clients' details, so the prison team can access external notes and be able to take appropriate action, or bring in certified experts.

Please do not hesitate to contact me should you require any further information or clarification.

Yours sincerely

Mike Silvey

Mike Silvey  
Chief Executive, Step Together Volunteering

### **BMA response to the Greater London Assembly, Health Committee review into mental health for offenders and ex-offenders in London**

#### **About the BMA**

The British Medical Association (BMA) is a professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

#### **Executive Summary**

This BMA response to the Greater London Assembly, Health Committee review into mental health for offenders and ex-offenders in London, encompasses expertise from across our membership, and focusses on the mental health needs of offenders and ex-offenders in London. It seeks to address those consultation questions which we consider to be within our members' scope of expertise.

The BMA welcomes this review and believes that given the above average number of offenders who have experienced mental ill health, it is imperative that action is taken to offer appropriate support when people first come into contact with the criminal justice system. It is crucial to ensure that all offenders receive healthcare equivalent to that in the community, and where particularly vulnerable people are concerned that there is greater exploration of alternative treatment routes outside of the secure estate.

Key points contained within this submission are:

- Prisoners have a right to a standard of healthcare equivalent to that available in the community, but the clinical reality of providing care in prisons can make this difficult to achieve. Greater investment in staffing and healthcare is required to make equivalence of care a reality.
- Specific targets to reduce deaths, particularly self-inflicted deaths should be introduced at the earliest possible opportunity in the secure estate.
- Health provision should feature more prominently in the commissioning, leadership and governance of prisons.
- Prisons in London should be issued with guidance and supported to introduce a minimum standard of delivery for key mental health services.
- In line with the BMA report *Young Lives Behind Bars*<sup>1</sup> and the *Taylor Review of the Youth Justice System in England and Wales*<sup>2</sup>, there is a need for further exploration of how health services can play a key role in diverting children and young people from custody.
- Learning should be taken from liaison and diversion services, which are being used successfully in some areas to divert those in need of medical support away from the prison service.

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<sup>1</sup> BMA Young Lives Behind Bars, <https://www.bma.org.uk/collective-voice/policy-and-research/equality/young-lives-behind-bars>

<sup>2</sup> Ministry of Justice, Review of the youth justice system, <https://www.gov.uk/government/publications/review-of-the-youth-justice-system>

- Information sharing strategies should be established between prison and the community health services, to improve assessment of mental health needs and to aid in prescribing on arrival to the secure estate and to support an individual's return to the community.
- The Health and Justice Information Service (HJIS) Project should be prioritised and a new IT system facilitating electronic information sharing rolled out without further delay.
- There should be overall recognition by government and prison commissioners of the value of promoting effective healthcare to improve outcomes for prisoner wellbeing, such as supporting substance misuse services to operate uniformly within the secure estate.
- Clear policy and monitoring procedures should be developed for the use of segregation and restraint within the secure estate, with particular regard to safeguards for use on vulnerable individuals, including those with mental ill health.
- Pre-registration with a GP should be available to all prisoners ahead of their release, and where an individual is released unexpectedly they should be able to seek immediate health support, ensuring existing treatment is never interrupted through a lack of registration or provision.
- Different health agencies supporting an individual in the secure estate should work together to form a healthcare plan. This plan, with the prisoner's permission, should, upon release, also be shared with future healthcare providers and community support organisations.

## **1. What are the main mental health challenges faced by prisoners and ex-offenders in London?**

- 1.1 Providing healthcare of an equivalent standard to that of the community in a secure environment is one of the key challenges in meeting the mental health needs of offenders. Our members report that access to mental health support and treatment, such as CBT (cognitive behavioural therapy) which is used to treat a wide range of mental health conditions, including PTSD (post-traumatic stress disorder), is very limited or, more frequently, not available at all within the secure estate in London. We believe that more focus should be placed on commissioning these mental health services inside the secure estate in the same way that other services such as primary care and IDTS (integrated drug treatment system) are commissioned.
- 1.2 In the community, where primary care would be unable to meet a patient's needs, it would be appropriate to refer a patient to a specialist. In the prison setting, however, where they do not have the appropriate health support/treatment, it is complicated to refer someone to an external specialist due to security and resource considerations. Escorts to external services and appointments are insufficient to meet the level of need in UK prisons. The consequence of this is that patients have to be triaged, with escorts reserved only for the most urgent of cases, which our members report is rarely, if ever, reserved for those experiencing mental ill health. Therefore, individuals experiencing a serious mental health crisis may often be placed on bed watch, with a member of prison staff there to observe, but unable to provide therapeutic or clinical support. We believe that because of this, improvements in healthcare cannot be achieved without greater investment in ancillary staff.
- 1.3 Problems in ensuring equivalence of care can be particularly acute for patients who have a mental health disorder so severe that, if living in the community, they would be sectioned. In England, prisons, including healthcare wings, are specifically excluded as places where patients can be given compulsory treatment under the Mental Health Act 1983. In order for this to happen they must be referred to an external psychiatric hospital, a process that can take, in some cases, many months. This can be a particularly difficult position for the prison doctor, who will be limited in what they can do to prevent a patient's mental health from deteriorating further in the meantime.
- 1.4 We note with concern the rising number of instances of self-harm and suicides in prisons in England and Wales. In the 12 months to March 2017 there were 113 self-inflicted deaths, up

11% on the previous year and more than double the number since 2013.<sup>3</sup> Instances of self harm increased by 24% on the previous year, reaching a record high of 40,161 incidents in the 12 months to December 2016.<sup>4</sup> It is clear more needs to be done to ensure better mental health support for offenders, and we believe specific targets to reduce deaths should be introduced in the secure estate. Specifically, we believe that there is a need for health provision to feature more prominently in the commissioning, leadership and governance of prisons and if there is opportunity prisons in London should seek to act as trailblazers in this respect.

1.5 Facilities in the secure estate also contribute towards the risk for self harm and suicide, and there is a need to modernise facilities in many London prisons. While CCTV and ACCT (Assessment, Care in Custody and Teamwork) observations are useful tools in preventing self harm and suicide, we are concerned by reports from doctors working in prisons that monitoring patients in this manner has the perverse incentive of reducing active engagement and face-to-face interaction with these vulnerable prisoners. We believe that all prison staff need to work together to prevent self harm and suicide, and recommend increased suicide awareness training, communication and shared working with healthcare staff to facilitate this. It would also be useful for prisons in London to be issued with guidance and to introduce a minimum standard of delivery for key mental health services. Facilities should be incentivised to sign up to the Royal College of Psychiatrists, College Centre for Quality Improvement Quality Network for Prison Mental Health Services<sup>5</sup>. This network aims to raise the standards of mental healthcare given in prisons by reviewing the services each prison offers, against published specialist standards for prison mental health, to identify areas which need improvement.

1.6 In addition to supporting mental health needs, we believe that the secure estate also presents an opportunity to offer help to those with related health problems such as substance misuse. This includes novel psychoactive substances (NPS), which the Royal College of Psychiatrists emphasises can have a significant impact on a person's mental health,<sup>6</sup> and which have been reported in some instances as a trigger for self-harm.<sup>7</sup> Members report that in some London prisons there is minimal support to address the root causes of offenders' addictions. More must be done to facilitate substance misuse support services which operate uniformly within the secure estate. One way that this could be promoted is by building on the success of the Justice Data Lab pilot<sup>8</sup>, which gives organisations working with offenders' access to central reoffending data in order to help them assess the impact of their work on reducing reoffending. Such an approach will further support prison managers in their commissioning of inpatient services, and organisations working with offenders in the London area should be encouraged to participate in the scheme.

## **2. What measures are in place to prevent people with mental health needs entering the criminal justice system and how are they supported through prison, probation and release? Are these measures sufficient?**

2.1 We support the use of liaison and diversion services which are being used successfully in some areas to divert those in need of medical support away from the prison system. We believe that this approach should be further explored and we welcome the intention to roll out services

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<sup>3</sup> Ministry of Justice, Safety in Custody Statistics Bulletin, England and Wales, Deaths in prison custody to March 2017, Assaults and Self-Harm to December 2016 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/611187/safety-in-custody-statistics-q4-2016.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/611187/safety-in-custody-statistics-q4-2016.pdf)

<sup>4</sup> Ibid

<sup>5</sup> Royal College of Psychiatrists, Quality Network for Prison Mental Health Services

<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqip/projects/prisonmentalhealth.aspx>

<sup>6</sup> Royal College of Psychiatrists – legal highs

<sup>7</sup> Prison and Probation Ombudsman report self harm, 2015, [http://www.ppo.gov.uk/wp-content/uploads/2015/07/LLB\\_FII-Issue-9\\_NPS\\_Final.pdf#view=FitH](http://www.ppo.gov.uk/wp-content/uploads/2015/07/LLB_FII-Issue-9_NPS_Final.pdf#view=FitH)

<sup>8</sup> Justice Data Lab Statistics, February 2017 <https://www.gov.uk/government/statistics/justice-data-lab-february-2017>

across the country by 2021. Local liaison and diversion services will also provide details of areas of unmet health need by recording where they are unable to divert vulnerable individuals from the justice system to appropriate health support. They could, therefore, be instrumental in understanding need and how services across London can be reconfigured to best support vulnerable individuals who come into contact with the justice system.

- 2.2 The BMA's report [\*Young lives Behind Bars\*](#) showed that over a third of young people in custody had been diagnosed with a mental health disorder.<sup>9</sup> It is crucial that appropriate and effective support is offered as soon as possible after a young person first comes into contact with the criminal justice system. This approach, we believe, will reduce reoffending rates and improve wellbeing. We also welcome the publication of the *Taylor Review of the Youth Justice System in England and Wales*<sup>10</sup>, and would like to see further consideration of its recommendation that health services should play a key role in diverting children and young people from custody.
- 2.3 To improve on the overall assessment of vulnerable prisoners it is crucial that there is improved information sharing with agencies which have previously interacted with the individual. Members in London report that many prisoners will arrive in detention with no accompanying medical history. The effect of this is to slow down and reduce the accuracy of the health assessment, meaning that this first opportunity to provide someone with the type of support they need may be missed. Additionally, without access to medical records, prison GPs are in effect prescribing without any information about the patient's history of pre-existing conditions or drug use, including whether they have a history of overdose. To address this we recommend establishing information sharing strategies and systems between prison and the community, to improve assessment of mental health needs and to aid in prescribing.
- 2.4 Information sharing should work both ways to ensure that offenders leaving prison are supported to receive continuous support both for mental health, substance misuse and other long term conditions. Members report that this is particularly an issue for 'unplanned releases' where an individual is released immediately after a court appearance. In these cases they are unlikely to have arranged community care either by pre-registering with a GP or by being linked to mental health or substance misuse support services, such as community pharmacy drug teams. Another issue highlighted by a member working in a London prison is that community teams are often not able to access patient notes, which would enable them to give optimum care upon release. The BMA believes that it is crucial that the Health and Justice Information Service (HJIS) Project, which has been tasked with improving the electronic flow of information between the secure estate and community settings is prioritised and a new IT system facilitating electronic information sharing is rolled out without further delay.

### **3. Which groups within the offender population are specifically at-risk of developing mental health problems?**

- 3.1 Offenders and ex-offenders as a cohort should be considered to have a higher risk of mental ill health. However, we recognise that within this cohort there are certain vulnerable groups and isolated individuals who are particularly underserved in prisons and are more likely to experience, or be at risk of developing, mental ill health. These vulnerable groups and individuals can include, but are not limited to: young offenders, transgender prisoners, those with language barriers, veterans, female prisoners who have experienced past abuse or previous mental ill health and those with existing physical health conditions. Limited access to education, social interaction, exercise, clinic appointments and language interpreters can seriously impact these

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<sup>9</sup> BMA, *Young Lives Behind Bars*, <https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/improving%20health/vulnerable%20people/po-younglivesbehindbars-31-10-2014.pdf?la=en>

<sup>10</sup> Ministry of Justice, *Review of the youth justice system* <https://www.gov.uk/government/publications/review-of-the-youth-justice-system>

groups and exaggerate pre-existing health inequalities, particularly those related to mental health.

- 3.2 Children and young people are still developing mentally and socially, and so can be particularly vulnerable to poor mental health. The BMA, therefore, recommends that they receive appropriate support for existing mental ill health and are treated in such a way as to minimize future harm. The use of segregation and restraint on vulnerable children and young people in the secure estate can be particularly damaging. Lord Carlile's review described conditions of segregation units as "inducements to suicide" and also expressed concern over their use on children with mental health problems<sup>11</sup>. Clear policy and monitoring procedures should be developed for the use of segregation with regard to safeguards for use on both young people and other vulnerable offenders, particularly those experiencing mental ill health. We recommend that where segregation does occur, it should be administered for the shortest time possible and carefully monitored. Crucially, they should still have access to a healthcare worker during this period. Similarly, restraint should be used only where absolutely necessary, and be removed at the earliest opportunity. As a preventative measure, all children and young people should be offered the opportunity to be seen by a member of the healthcare team after any restraint incident, rather than being left alone, as this may avoid negative impact on the individual's mental or physical health.
- 3.3 Female offenders are more likely than their male contemporaries to have been identified with indicators or diagnosis of mental ill health prior to entering prison, with 30% of female offenders having previously had a psychiatric admission before they entered prison and 46% reporting an attempted suicide at some point in their lives<sup>12</sup>. This group is particularly vulnerable. Better information sharing between community services and prison GPs would allow for an earlier identification of these prisoners, allowing them to be appropriately supported in the secure estate.
- 3.4 Female prisoners are also more likely than male offenders to have previously been victims of abuse. It is deeply concerning that 46% of women in prison report having suffered domestic violence and 53% report having experienced emotional, physical or sexual abuse during childhood<sup>13</sup>. These experiences are likely to have a long lasting impact on mental health and would make this group particularly vulnerable. Where an individual is known to have been the victim of abuse that they should receive appropriate support within the secure estate, and where appropriate, continued support upon release.
- 3.5 Currently veterans represent between 4% and 5% of the UK prison population<sup>14</sup>. We recognise that this cohort can be particularly vulnerable in terms of their mental health. The BMA has called more widely for appropriate and sustained long term funding of the Defence Medical Services to ensure appropriate medical, psychiatric, psychological, physical and prosthetic support for veterans upon their return to the UK and we believe such investment could potentially reduce the small number of veterans who do go on to become offenders. Within the secure estate it is crucial that those supporting veterans are aware of their potential vulnerabilities and that healthcare workers are supported to use specific guidance on veterans' healthcare needs, such as that produced by the RCGP<sup>15</sup>.
- 4. What steps could mental health service providers take to make their services more accessible for ex-offenders? / How effective are programmes that aim to support continuity of mental health support when people have returned to their communities following prison?**

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<sup>11</sup>An independent inquiry into the use of physical restraint, solitary confinement and forcible strip searching of children in prisons, secure training

centres and local authority secure children's homes, <http://howardleague.org/wp-content/uploads/2016/03/Carlile-Report-pdf.pdf>

<sup>12</sup> Prison Reform Trust, Mental Health Care in prisons, <http://www.prisonreformtrust.org.uk/projectsresearch/mentalhealth>

<sup>13</sup> Women in Prisons factsheet, <http://www.womeninprison.org.uk/research/key-facts.php>

<sup>14</sup> Guardian, 18 March 2017, <https://www.theguardian.com/uk-news/2017/mar/18/uk-armed-forces-veterans-prison-population-mental-health-issues>

<sup>15</sup> Royal College of GPs, Veterans' Healthcare Needs Guidance <http://www.rcgp.org.uk/policy/rcgp-policy-areas/veterans-healthcare-needs.aspx>



- 4.1 Pre-registration with a GP enables offenders to register in advance with a GP in the area in which they will be living on release. Such an approach increases the chance of continuity of care and can be particularly valuable for those with long term conditions. This can include ongoing treatment for issues such as mental health and related issues such as substance dependency, and ensuring the availability of prescriptions for methadone, where an offender was already receiving treatment in detention.
- 4.2 As outlined earlier in this response, where an offender is released without notice it is not possible to arrange pre-registration and this may be to the detriment of the individual's future healthcare. Members working in London report that pre-registration is not always used as a matter of course, even where release without notice is not an issue. We believe that this approach should be available to all prisoners ahead of their release, and that where an individual is released unexpectedly they are able to seek immediate support, and that they are never in a situation where their existing treatment is interrupted through a lack of registration or provision.
- 4.3 In the secure environment where commissioned support services are available it is not unusual for prisons to commission different agencies to support prisoners with different aspects of their health. While in principle this is not an issue, the BMA does consider it crucial that these different agencies engage with each other and that there is continuity formalised in the shape of a healthcare plan. For example, a single prison may have general practice, mental health provision and addiction services all operating simultaneously but not necessarily in conjuncture with each other and prison staff. We recommend exploring how, with the prisoner's permission, these plans can be shared with future healthcare providers and support organisations they engage with in the community.
- 4.4 We also believe that if this multi-agency approach continues to be taken in prisons it would improve continuity of care if some of the commissioned support services were also available upon release. Prisons should then want to prioritise, as part of the commissioning process, organisations which can offer continued support to offenders upon their release.
- 4.5 Community mental health support should be funded and made widely available, in a way that is tailored to ex-offenders with a mental health problem. They should be supported in their transition to the community. Similar services such as addiction and substance misuse services should be made known to those who would benefit from them.

## **5. How do issues such as housing and unemployment affect the mental wellbeing of offenders and ex-offenders?**

- 5.1 Offenders of no fixed abode (NFA) are one of the most underserved prison populations. One member working in a London prison described this group as the most 'set up to fail'. The reason for this is an overall shortage of accommodation for this group to go to upon release. Without accommodation this group is less able to access ongoing health support once they leave prison and is more likely to return to prison<sup>16</sup>. We recommend that the Greater London Assembly and the Mayor explore how they can best ensure NFA ex-offenders are supported into sustainable long-term housing.

## **6. What can the Mayor and the London Assembly do to support better mental health for this group?**

- 6.1 The Mayor and the London Assembly should do all they can to encourage the speedy adoption of London based liaison and diversion services. Once this roll out has been completed, and where the liaison and diversion services demonstrate areas of unmet health need in the community, they should work with local providers and community services to fill these gaps in provision. This approach would allow for resources to be targeted at community support which can prevent

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<sup>16</sup> Howard League for Penal Reform, No fixed abode: The implications for homeless people in the criminal justice system, [http://howardleague.org/wp-content/uploads/2016/04/no-fixed-abode\\_web.pdf](http://howardleague.org/wp-content/uploads/2016/04/no-fixed-abode_web.pdf)



vulnerable individuals being sent to prison. It may also be instrumental in reducing the likelihood of future offending and subsequently reduce future burden on the secure estate.

- 6.2 There is a role for the Mayor and Assembly to explore how they can best support community services already commissioned to provide services within the secure estate, to provide ongoing support once someone is released. Where this is not possible they should explore what health services offenders are most in need of to ensure continuity of care, or to address unmet health need from their time in the secure estate. This provision should then be arranged pre-release, so that ex-offenders do not fall through the cracks and end up in a cycle of ill health.

**May 2017**

## **London Health Committee review into mental health for offenders and ex-offenders in London**

### **About Revolving Doors Agency**

Revolving Doors Agency is a charity working to change systems and improve services for people who face multiple and complex needs, including poor mental health, and come into repeated contact with the police and criminal justice system. We work with policymakers, commissioners, local decision-makers, and frontline professionals to share evidence, demonstrate effective solutions, and change policy, while involving people with direct experience of the problem in all our work through our London Service User Forum. Our work in London is supported by Trust for London.

### **About this response**

As Revolving Doors Agency is neither an accommodation provider or a membership organisation, we have limited this response to questions and matters that appear to be of direct relevance to our population of interest.

### **The revolving doors group**

Too many Londoners still face entrenched social and economic exclusion linked to a range of problems, including: poverty; poor mental health; homelessness; substance misuse issues; repeat victimisation; and offending. For the most disadvantaged people, these problems overlap and they become caught in a negative 'revolving door' cycle of crisis and crime.

Evidence from one national study<sup>17</sup> suggests there are at least 7,000 individuals experiencing a combination of substance misuse, offending, and homelessness across London each year. There are a further 32,000 facing two of these needs at once. People in this group also face a range of additional problems, including:

- poor mental health - 55% of those facing all 3 needs above had an identified mental health problem
- high levels of unemployment and poverty - over half of those experiencing all 3 needs had been reliant on welfare benefits for most of their adult lives
- histories of trauma - 85% had traumatic experiences in childhood.

A conservative estimate suggests that the repeated demand generated by this combined group results in a combined cost of at least £760 million per year to London's public services. The 7,000 people facing all three needs generate at least £160 million of this total. However, these figures are likely to underestimate the cost of multiple needs across London. Research in some London

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<sup>17</sup> <http://lankellychase.org.uk/multiple-disadvantage/publications/hard-edges/>

boroughs suggest that those facing the most complex needs can typically generate higher individual costs to local services of around £30,000- £50,000 per year.

### **Revolving Doors Agency's London Together manifesto**

In 2016, Revolving Doors published the report *London Together – Transforming services for the most excluded in the capita*<sup>18</sup>, along with an accompanying manifesto.<sup>19</sup> Both the report and the manifesto were based on our engagement with people with lived experience, services and other stakeholders, and on analysis of the best publically available evidence about need and service responses. The report and manifesto were sent to all main mayoral candidates, including the current Mayor, ahead of the May 2016 election.

We highlighted a number of areas of opportunity, including devolution, all of which have some relevance to the Committee's review:

1. Earlier intervention in people's problems – developing improved systems and tools to identify those at risk of falling into a negative 'revolving door' cycle wherever they come into contact with the system, and link them into appropriate co-ordinated support.
2. Greater access to targeted and intensive support for those facing the most complex needs – ensuring there are links into intensive and co-ordinated support for those facing severe complex needs in every borough, including gender specific responses for women and girls facing complex needs.
3. Co-ordinated rehabilitation for offenders facing multiple needs – ensuring criminal justice responses are tailored to work more effectively and reduce 'revolving door' offending.
4. Improved health and wellbeing for the most excluded adults – reducing the health inequalities experienced by those facing multiple and complex needs, and targeting improved access to healthcare for the most excluded groups.
5. Creating a system that supports long-term recovery – building a system that takes account of the recovery journey, does not remove support too quickly, and helps to build resilience and networks for the most excluded individuals.
6. Greater user involvement in the design and delivery of services – service users should be involved in the design and delivery of services, coproducing their own support and being involved in the commissioning process. A multiple needs strategy should be coproduced with input from those with 'lived experience' to help set outcomes and advise on delivery.

### **Review questions**

#### **1. What are the main mental health challenges faced by prisoners and ex-offenders in London?**

Our recent report *Rebalancing Act*<sup>20</sup> highlighted some of the combinations of needs faced by those in contact with the criminal justice system, some examples relating to mental health are set out below. Two important points must be emphasised. Firstly, Revolving Doors was using data on prison health which date from a time when the size and composition of the prison population was very different. Secondly, the data on the probation population is more recent, but is mostly based on studies of single areas, which may not be representative of the probation population in London.

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<sup>18</sup> <http://www.revolving-doors.org.uk/file/1854/download?token=4Y807jtO>

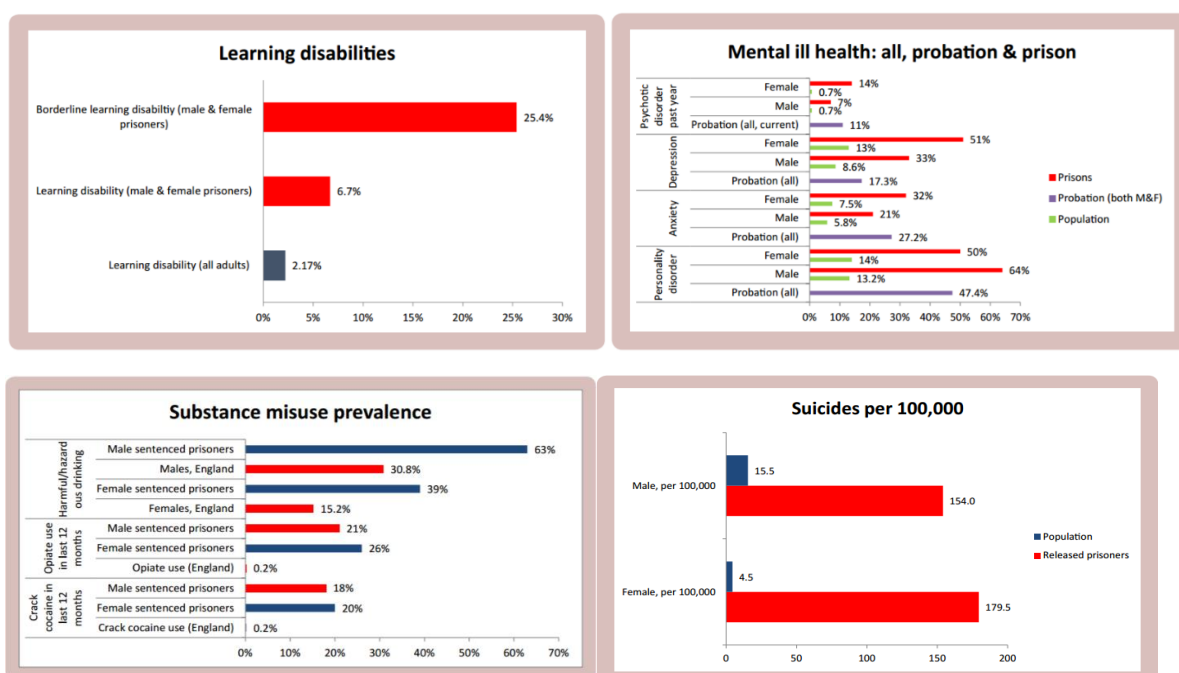
<sup>19</sup> <http://www.revolving-doors.org.uk/file/1852/download?token=W8axXjWF>

<sup>20</sup> <http://www.revolving-doors.org.uk/blog/rebalancing-act>

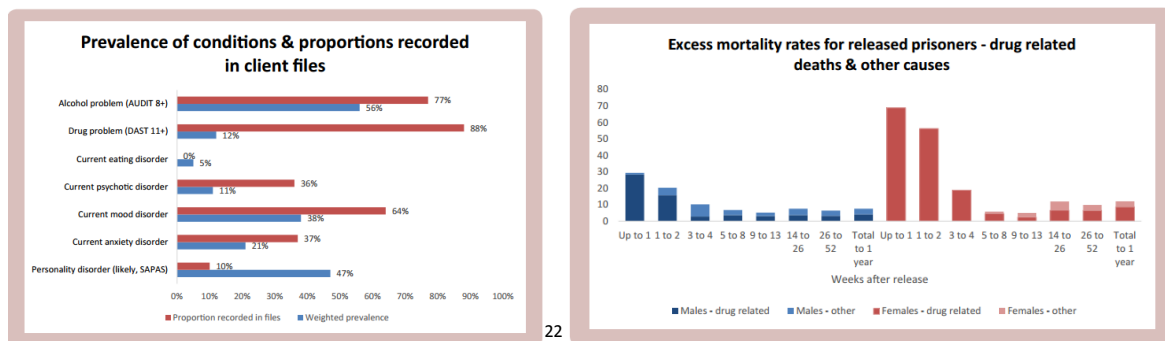
Additionally, the Transforming Rehabilitation reforms will have resulted in a different probation population, with short sentence prisoners receiving probation support for the first time as a matter of routine.

A further observation is that many more people come into contact with the CJS than are sentenced to immediate custody. At the time of drafting *Rebalancing Act*, we found that while the police in England had dealt with 1.7 million people, resulting in 1.25 million sentences, there were only 140,000 probation starts and 88,500 sentenced to immediate custody. Further, there is good evidence that the population in contact with the CJS doesn't divide neatly into perpetrators and victims. Perpetrators of crimes themselves face an increased likelihood of victimisation, and the reality is that personal identities – victim and perpetrator – can often be fluid. Consequently, when considering offender mental health and access to mental health treatment, support and care, it is essential to consider the wider population in contact with the criminal justice system, and not just those who are in or have been through the prison system.

There is one further factor that the committee might want to consider. In addition to people who come into contact with victims of, witnesses to or suspected perpetrators of crime, the Metropolitan Police respond to thousands of mental health crises each year – almost 3,700 in 2015-16.<sup>21</sup> It is important to note that many or most of these people will not be offenders, although as people with likely mental health needs that come into contact with the police, the Committee may want to give some consideration to them.



<sup>21</sup> <http://www.npcc.police.uk/documents/S136%20Data%202015%2016.pdf>



Where data is available, there is often a marked disparity between male and female offenders, with women often exhibiting more needs, and/or higher levels of need. There are distinct disparities of vulnerability and risk among the prison population, with the rate of instances of self-harm per 1,000 prisoners being approximately five times higher for women than men. The rate of self-inflicted deaths is twice as high for women than men, at 2.6 per 1,000 prisoners compared to 1.3, both rates being the highest since at least 2008.<sup>23</sup>

In addition to these selected headline measures, people in contact with the criminal justice system face elevated mortality rates, are disproportionately likely to have worse physical health, higher prevalence of blood-borne viruses, low educational attainment. Pre-conviction homelessness rates are high, as is the need for housing support to prisoners on release, and care-leavers are grossly over-represented across the CJS. People in prison are also likely to have additional vulnerabilities, or to have experienced additional adverse experiences, including being in care (31% f, 24% m), or having experienced emotional, physical and/or sexual abuse (53% f, 27% m).

## 2. What measures are in place to prevent people with mental health needs entering the criminal justice system and how are they supported through prison, probation and release? Are these measures sufficient?

In a broad sense, the measures and systems that are (or could be) put in place need to focus on ensuring that mental health needs are identified and met, that the appropriate course through or diversion out of the CJS is chosen, and that risk factors for reoffending are addressed.

The primary mechanism for doing the above in the community is Liaison and Diversion, for which Revolving Doors provides lived experience support to NHS commissioners, and co-produced the national operating model. With national roll-out following the publication of the 2009 Bradley Report,<sup>24</sup> Liaison and Diversion builds on previous, local diversion schemes, and on the track record of national initiatives such as the Drug Interventions Programme (DIP). Aiming to identify and initiate responses to a range of vulnerabilities such as, mental health, learning disability, substance misuse, housing, education, Liaison and Diversion is nominally broader in scope than previous initiatives. Improved access to healthcare and support services for vulnerable individuals through effective liaison with appropriate services.

Liaison and diversion aims to achieve:

- The diversion of individuals into health or other supportive services
- Diversion out of the youth or criminal justice system (where appropriate)

<sup>22</sup> This *Rebalancing Act* chart is based on a study of a single former probation trust.

<sup>23</sup> <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2016--2>

<sup>24</sup> <https://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>

- A reduction in re-offending
- A reduction of health inequalities
- A reduction of first time entrants to the CJS

The continued roll-out of Liaison and Diversion is very welcome. To genuinely succeed, however, Liaison and Diversion services must be thoroughly integrated with local community services and be supported by effective flows of data within the criminal justice system. While thresholds to and waiting times for some services, such as substance misuse, might mean that they are readily accessible, this may be less the case with access to mental health service. A corollary of this is that for some services and some needs, there are no rapidly available referral routes. In some respects, Liaison and Diversion has conceptually more in common with an intervention that a service, with only very limited case holding and management envisaged. Discussions with expert stakeholders suggests that in reality Liaison and Diversion services are, in effect, assuming something of a case management role. This may be better than an individual receiving no support at all, but it is a suboptimal situation in several respects.

With regard to prison services, mental health in-reach and substance misuse services are available in every establishment; sometimes provided by the same provider in an integrated system, or by separate providers working, at least in theory, in close partnership. Recent reports by HM Chief Inspector of Prisons have highlighted the triple problems of mental health, drugs and violence in prisons, compounded by overcrowding, poor physical environments, and understaffing. The latter also includes prison officers, where reduced numbers<sup>25</sup> appear to have led to more use of restrictive regimes, and have impeded the ability of prisoners to attend activities and healthcare appointments. There are further concerns around the availability of beds in forensic mental health units that ill prisoners can be moved to, and whether ACCT is fit for purpose and/or delivered effectively as a suicide prevention tool.<sup>26</sup>

Through the gate initiatives, propagated in connection with the Transforming Rehabilitation reforms, although not part of them, are an essential component in supporting the safe and effective resettlement of a person leaving prison. TTG services aim (as the name suggests) to provide a continuous, or at least seamless, package of support including meeting needs around housing, employment, and health, including substance misuse and mental health. A recent Criminal Justice Joint Inspection by HM Inspectorate of Prisons and HM Inspectorate of Probation<sup>27</sup> found that ‘services were poor and there was little to commend. Too many prisoners reached their release date without their immediate resettlement needs having been met or even recognised.’ The Inspectorates found that out of 86 male cases reviewed, 22 had mental health needs prior to incarceration, and that only in 1 case had sufficient work to meet these needs been done prior to release. The corresponding figures for women were 24 cases reviewed, 12 with mental health needs, and 5 with sufficient work done prior to release. While needs went unmet across both male and female cases reviewed, the gaps between needs identified and met was particularly stark for male prisoners across the spectrum of needs considered.

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<sup>25</sup> Numbers have fallen nationally by approximately 25%, although Ministry of Justice has announced a recruitment drive which should partially offset this fall, although presumably at the cost of replacing departing experienced officers with inexperienced recruits.

<sup>26</sup> [http://www.ppo.gov.uk/wp-content/uploads/2014/07/ACCT\\_thematic\\_final\\_web.pdf](http://www.ppo.gov.uk/wp-content/uploads/2014/07/ACCT_thematic_final_web.pdf)

<sup>27</sup> <https://www.justiceinspectors.gov.uk/ciji/wp-content/uploads/sites/2/2016/09/Through-the-Gate.pdf>

A recent HM Inspectorate of Probation review of services in North London<sup>28</sup> raised a number of concerns in respect of the Community Rehabilitation Company (CRC) and, to a lesser extent, the National Probation Service (NPS) that deals with offenders assessed as being higher risk. While the CRC had adopted a cohort model, including a mental health and intellectual disabilities cohort, the Inspectorate found that this raised practical challenges. To a large extent, probation services will be reliant on NHS community and/or forensic mental health service provision and, as referred to elsewhere and widely acknowledged, accessing these services can be challenging. This can often be the case with the revolving door cohort, many of whom may have illnesses or conditions that are sub-threshold for routine service access, but that cumulatively result in a significant impairment.

### **3. Which groups within the offender population are specifically at-risk of developing mental health problems?**

As illustrated by the *Rebalancing Act* charts above, mental ill health is highly prevalent across the CJS pathway. The associations between mental ill health and offending are complex, and often compounded by aggravating factors such as substance misuse housing problems, and a range of excluding factors. Comorbidity of conditions, and coexistence of mental ill health with non-medical needs is commonplace, with substance misuse being a clear case in point, where comorbidity could arguably be considered the norm (at least for common mental illnesses) rather than the exception. This is particularly the case with the revolving door group, where persistent (but often relatively low level) offending can be indicative of multiple needs, including mental ill health.

There is evidence that prison is detrimental to an individual's mental ill health and can have a traumatising effect. People in prison are exposed to high levels of criminal activity (such as violent crimes and drug-dealing) and social isolation. The exposure to crime and isolation can lead to increased levels of mental health problems and institutionalisation, in the long-run leading to increased re-offending rates. As above, rates of suicide, self-harm and mortality more generally are higher for prisoners and released prisoners.

There is ample evidence that, for many offenders and types of offence, community sentences are more effective in reducing reoffending, and more cost effective than prison. Despite this, the use of community sentences has, with little exaggeration, dropped off a cliff, falling by half over the course of the last ten years. Further, requirements included in community sentence orders may not match need, with only 0.4% to 0.7% of community or suspended sentence orders including a mental health treatment requirement, despite the level of mental health need among the offender population being substantially higher. A recent review<sup>29</sup> found that community sentences were being used in a way that paid little heed to evidence around reducing reoffending, that they had limited impact in turning lives around, and had lost the confidence of sentencers.

A factor that the Committee may want to consider, although with some circumspection, is the effects that childhood experiences, including adverse childhood experiences (ACEs) can have on the likelihood of a child having increased risks of experiencing mental ill health, and of coming into contact with the criminal justice system. As we highlighted in *Rebalancing Act*, risk factors include socioeconomic factors such as familial and neighbourhood deprivation but also parental characteristics such as parental offending, substance misuse and mental ill health, and relationship factors such as abuse, discord and inconsistent or neglectful parenting. A recent and large Welsh

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<sup>28</sup> <https://www.justiceinspectors.gov.uk/hmiprobation/wp-content/uploads/sites/5/2016/12/North-of-London-QI-Report.pdf>

<sup>29</sup> <http://crestadvisory.com/wp-content/uploads/2017/04/community-sentences-report-where-did-it-all-go-wrong.pdf>

study concluded that if no child had been exposed to ACEs, the Welsh prison population might be almost 2/3 smaller.<sup>30</sup>

#### **4. What steps could mental health service providers take to make their services more accessible for ex-offenders?**

Access to mental health services is problematic across the spectrum of provision. There are many explanations for this. Inevitably, resourcing will be a factor. While there are now waiting time standards,<sup>31</sup> access to mental health services in the community is often problematic, as is access to a hospital place in an emergency. The same applies to child and adolescent mental health services (CAMHS), with the unfortunate consequence that for many people transitioning into adulthood, there may effectively be no community mental health provision available.

Engagement with experts by experience also suggests that service thresholds may also form barriers. This may manifest in at least two ways: people with multiple and complex needs may have needs which are, individually, below usual service or clinical thresholds, while cumulatively having a significant impact on the individual's life. Conversely, people with multiple and complex needs, can be perceived as chaotic and/or higher risk, and thus difficult for community services to cope with. A further complication in the case of coexisting substance misuse and mental ill health is the risk of falling between two stools – that mental health services will refuse to treat someone until their substance misuse needs have been addressed or, less commonly, that substance misuse services will decline to treat until the person's mental health needs have been met. NHS England and Public Health England will be publishing a revised good practice guide later this year, although it should be noted that previous attempts to improve provision and practice in this area had limited impact.

In addition to capacity, resources and thresholds, there are some specific shortages of services in London compared to other large UK cities, women's centres being a case in point. While these are not specifically mental health services, they are services that have a great deal to contribute in meeting women's mental health needs.

Also in addition to resources, capacity and thresholds, mental health services need to engage with the inequities of access, experience and outcomes of their services, particularly where these intersect with criminal justice pathways. For example, certain ethnic and (perhaps) religious minority (principally the Black and Muslim) groups experience higher prevalence of severe and enduring mental ill-health, higher rates of both detention and Community Treatment Orders under the Mental Health Act and lower rates of referral from primary care; they are also disproportionately represented in both the criminal justice systems and in the diversion from court into secondary mental health services. These groups also show both lower satisfaction and higher distrust of mental health services and the greater reluctance to re-engage with the services. Similarly, one of the largest health inequalities for men, suicide, suggests a degree of unmet need that mental health services currently struggle to engage with. Mental health services need to engage in true coproduction with communities to design services in appropriate places, that connect with people at appropriate times and engage their trust over extended treatment times.

#### **5. How effective are programmes that aim to support continuity of mental health support when people have returned to their communities following prison?**

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<sup>30</sup> *Rebalancing Act*

<sup>31</sup> <https://www.england.nhs.uk/mental-health/resources/access-waiting-time/>



Following from the above, ensuring continuity of access to generalist and specialist health services must be prioritised. The London GP Registration for Offenders Scheme points to one means of doing this, and the Health and Justice Information Service should ensure smoother movement of records through the system. Ultimately, however, much depends on the individual in need of treatment. As an example, the pick-up rate between prison and community substance misuse treatment in London is 20.1%,<sup>32</sup> a rate that is well under half that of the highest performing region, the North East. Discussion with expert stakeholders suggests that generally, pick up rates with substance misuse treatment are likely to be higher than for other specialist services. If this is the case, it seems likely that there will be a significant level of unmet need, both nationally and in London.

The restructuring of the make prison estate to include resettlement prisons is, in some respects, a welcome move. Where it is possible to resettle someone relatively locally (with a key caveat being the fragmented provision of services based on borough boundaries in London), one would hope that TTG and other resettlement services would find it easier to work effectively than when resettling someone a considerable distance. With a limited number of women's prisons, the resettlement prison model has always seemed less convincing. Now that there are no female prisons at all in London, following the closure of HMP Holloway, this situation may be exacerbated.

## **6. How do issues such as housing and unemployment affect the mental wellbeing of offenders and ex-offenders?**

Many who have themselves used services for people with complex needs, including ex-prisoners, are keen to 'give something back' or to create a new identity for themselves through employment. Through work, people can have the chance to work and to benefit from the improved financial resilience, self-esteem and new social networks employment can bring. Good quality, appropriate work can also be supportive of health,<sup>33</sup> although there is evidence that not only do poor quality jobs not provide the same health benefits as good jobs,<sup>34</sup> but also that some aspects of poorer quality jobs may cause some common mental health problems, such as depression.<sup>35</sup>

Research by the Home Office suggests that employment is associated with significantly reduced rates of reoffending, although some caution is needed in extrapolating the results from this modelling to the entire prison population; people given non-custodial sentences are excluded entirely. Nevertheless, given the substantial reductions, the relatively buoyant current job market and the relatively low unit cost of labour market interventions, supporting ex-offenders into employment seems likely to achieve reduced rates of reoffending, alongside economic value of almost £15k achieved.<sup>36</sup>

However, many people with histories of offending (or of related factors such as substance misuse) are highly disadvantaged in the job market, despite the (patchy) provision of specialist labour market programmes, and the success of initiatives such as Business In The Community's *Ban the Box* campaign.<sup>37</sup> Given that alongside the evidence around reducing reoffending and health and wellbeing, employment is also associated with improved outcomes from substance misuse

<sup>32</sup> <http://www.nta.nhs.uk/uploads/secure-setting-statistics-from-the-national-drug-treatment-monitoring-system-2015-2016.pdf>

<sup>33</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/214326/hwwb-is-work-good-for-you.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf)

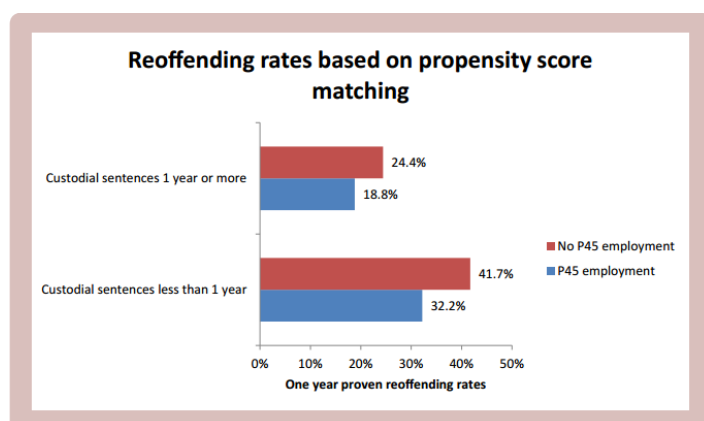
<sup>34</sup> <http://oem.bmj.com/content/68/11/806>

<sup>35</sup> <http://oem.bmj.com/content/74/4/301>

<sup>36</sup> <http://www.neweconomymanchester.com/media/1446/3316-150327-unit-cost-database-v1-4.xlsx>

<sup>37</sup> <http://www.bitc.org.uk/programmes/ban-box/why-should-we-ban-box>

treatment,<sup>38</sup> there are clearly opportunities to make and lock in progress against a number of different priorities.



With regard to homelessness, UK Government research frequently cited<sup>39</sup> suggests that stable accommodation can reduce reoffending by a fifth. It is difficult to be sure of the quality of this particular research as it remains unpublished and, as with other data cited, it is an old study. Nevertheless, a study from 2012 found that 15% of prisoners had been homeless immediately prior to custody, compared to a lifetime experience of homelessness of 3.5% in the wider population. More than three-quarters of prisoners (79%) who reported being homeless before custody were reconvicted in the first year after release, compared with less than half (47%) of those who did not report being homeless before custody. 37% of prisoners felt they would need help to find accommodation on release, with almost all of them (84%) thinking they would need a lot of help.<sup>40</sup>

With this high level of need and, on the other hand, such high prevalence of mental ill health, substance misuse and histories of offending on the part of people who sleep rough in London,<sup>41</sup> it would stand to reason that there should be a significant gain in reducing reoffending where stable accommodation is secured. It goes almost without saying that there are strong associations between homelessness and mental ill health, which can be both a cause and a consequence of homelessness.

As the Committee will know, London has particularly severe problems with homelessness in any case, including rough sleeping, applications, use of temporary accommodation and so on. Reports such as the report into TTG services referred to above, and a recent HM Inspectorate of Prisons report into HMP Wormwood Scrubs<sup>42</sup> where the proportion of prisoners recorded by the prison as having accommodation on discharge had fallen from 95.3% (April 2015) to 59.4% (October 2015) may not be, in themselves, proof of a crisis, but nor are they reassuring.

## 7. What examples of good practice are there in London and further afield?

Several examples of positive practice have been highlighted in *Rebalancing Act*, and we hope to accompany that later this year with a review of co-commissioning and co-delivery of services.

<sup>38</sup> <https://www.gov.uk/government/publications/drug-misuse-treatment-in-england-evidence-review-of-outcomes>

<sup>39</sup> [http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/cabinetoffice/social\\_exclusion\\_task\\_force/assets/publications\\_1997\\_to\\_2006/reducing\\_summary.pdf](http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/reducing_summary.pdf)

<sup>40</sup> *Rebalancing Act*

<sup>41</sup> <https://files.datapress.com/london/dataset/chain-reports/2016-06-29T11:14:50/Greater%20London%20full%202015-16.pdf>

<sup>42</sup> <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2016/04/Wormwood-Scrubs-web2015.pdf>

Revolving Doors has recently concluded a project in the London boroughs of Wandsworth and Barking & Dagenham. In which we investigated possible ways of improving the service experience of people with mental health problems and multiple complex needs – individuals who very often feel excluded and let down by the system – across the two boroughs.

Our team needed to understand the everyday reality experienced by vulnerable people who are very often unwilling to discuss issues with those they see ‘in authority’. Our approach was to use trained experts by experience – people with direct experience of being failed by the system – to explore the issues with those currently facing problems.

Our approach involved:

- Recruiting, training and supporting 29 service users – our experts by experience – to conduct six peer-led research programmes over three years with 118 offenders and ex-offenders about their experience of current services. These insights were pivotal in identifying opportunities to look at familiar problems in new ways.
- Organising and supporting user groups who could meet directly with commissioners from health, housing, social care and criminal justice agencies.
- Users then collaborating with these professionals to influence local commissioning processes, producing more effective joined-up responses to those with multiple and complex needs across areas including needs assessment, evaluation of existing services, design of new service models and pathways, procurement of new services and monitoring quality

The programme has addressed a number of priority areas for commissioning, including:

- Male ex-offenders’ experience of mental health support in the criminal justice system
- Women’s experiences of the criminal justice system
- Experience of service users in substance misuse provision around how domestic abuse and violence are addressed
- Women’s involvement with Integrated Offender Management schemes
- Experience of housing support and homelessness
- Experience of mandatory substance misuse assessment appointments and experiences of transition to voluntary engagement.

The programme achieved impact because of the commitment of both the peer research groups and the commissioners involved. To date, as a result of our lived experience input, a service in Wandsworth has been decommissioned and a new mental health service funded in its place.

## **8. What can the Mayor and the London Assembly do to support better mental health for this group?**

To some extent, the precise details of how the Assembly and Mayor can support better mental health for offenders, ex-offenders and others in contact with the CJS will depend upon the scale and scope of the forthcoming devolution agreement, particularly with regard to the criminal justice and health systems. That said, the following may be worthy of consideration:

- The design of the Transforming Rehabilitation reforms, and specifically the incentives incorporated into the payment by results mechanism, have been identified by multiple stakeholders as not driving CRC behaviour in the desired ways. More must be done to ensure that resettlement, including accommodation, employment support needs and health needs, is addressed. The Committee will be aware that there are multiple reviews of probation taking place at the Ministry of Justice; engaging in that process may also be prudent, given the reported shortcomings in London. Given the failure of differential incentive payments to influence

provider behaviour in the DWP Work Programme to the extent originally envisaged, a more interventionist approach than varying incentives may be worth considering.

- The Mayor may be able to use his profile to increase the use of community sentences where appropriate. This may best be done through partnership work with London boroughs to ensure that community services with appropriate pathways are not only in place, but are seen to be in place. Working with the representative and/or membership bodies of sentencers may also be worth considering.
- As we argue above, the quality of a job is important, with good quality jobs being associated with improved health and wellbeing, and growing evidence that poor quality jobs are associated with and may cause worse mental health and wellbeing. The Mayor should ensure that the recommendations in the Trust for London/Centre for Economic and Social Inclusion<sup>43</sup> report *Work in Progress*<sup>44</sup> are embedded in employment support programmes in London, and with employers via the London Enterprise Panel.
- London already benefits from *Working Capital*, a specialist labour market programme for disadvantaged jobseekers. The Work Programme is due to be replaced by the Work and Health Programme from early 2018, with the latter being co-designed and co-commissioned in London. The Work and Health Programme is intended specifically for disadvantaged jobseekers, including those with disability and health related barriers to work, and the very long-term unemployed. While some ex-offenders and others with multiple and complex needs will fall into one or both of those categories, others will not, and measures to ensure that those with offending and/or mental health related barriers to work are not overlooked would be welcome.
- Homelessness in all its forms continues to be a problem in London, and continues to worsen. We acknowledge and appreciate the measures that the Assembly, Mayor and individual London boroughs are already taking to tackle homelessness, but there is much left to do. As above, ensuring that resettlement in the broadest sense is a priority for all involved is likely to be one part of the solution; another is likely to be in improving homelessness services more generally. We suggest that the Mayor and Assembly take note of the many housing first initiatives, and consider the viability of increasing that sort of provision in London.

Finally, in *Rebalancing Act*, we argued that leadership is crucial. While written with an audience of Police and Crime Commissioners, Directors of Public Health and similar in mind, we were agnostic about where that leadership should come from. The office of the Mayor, as one of the most powerful and high profile directly elected politicians in the country, is supremely placed to provide that leadership.

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<sup>43</sup> Now the Learning and Work Institute

<sup>44</sup> <https://www.trustforlondon.org.uk/research/publication/work-in-progress-low-pay-and-progression-in-london-and-the-uk/>

## Mental Health and the Criminal Justice System

The London Assembly Health committee has called for evidence and views on this subject.

The consultancies contributing to the views here work in the health, social care and justice fields and regularly assist public, commercial and non-profit organisations to improve their practice. The comments here are our views on what works (best practice) and what should be done to tackle the issue.

We will address these issues (in the same order):

1. What are the main mental health challenges faced by prisoners and ex-offenders in London?
2. What measures are in place to prevent people with mental health needs entering the criminal justice system and how are they supported through prison, probation and release? Are these measures sufficient?
3. Which groups within the offender population are specifically at-risk of developing mental health problems?
4. What steps could mental health service providers take to make their services more accessible for ex-offenders?
5. How effective are programmes that aim to support continuity of mental health support when people have returned to their communities following prison?
6. How do issues such as housing and unemployment affect the mental wellbeing of offenders and ex-offenders?
7. What examples of good practice are there in London and further afield?
8. What can the Mayor and the London Assembly do to support better mental health for this group?

We have emailed our comments to [healthcommittee@london.gov.uk](mailto:healthcommittee@london.gov.uk).

### Contributors

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### About the contributors

Contact Consulting (Oxford) Ltd and Adaptus LLP are independent consultancy and research practices working the field of health and social care. Both organisations specialise in issues relating to mental health and criminal justice. More detail about them and the contributors can be found in Appendix Two.

1. The main mental health challenge faced by prisoners/ex-offenders in London.

There are three 'truths' at the heart of this challenge:

1. People involved in justice systems have higher mental health care needs and therefore the response must be proportionate to ensure they receive the right interventions so health/social care/justice outcomes are as good as any in other (non-justice) community. Therefore the resources invested should be higher to achieve this outcome;
2. Health need should not be a reason on its own why people are involved in justice systems. Mental health, substance misuse or other illnesses that effect behaviour should be dealt with in health settings and as preventatively as possible (public health principle applies) by all agencies involved working in an integrated way;
3. Safety (for the individual and the community) and evidenced-based intervention quality is central to any future service models.

In general, the prison and wider offending population has four times more health need than the general public, in inner-city London this need is sometimes as high as seven times. Increasingly this is for serious problems. The reoffending rate (within one year after release) for those with mental health or related illnesses is the highest of any sub-group category at 60-70%. It makes sense to work with this group of vulnerable people because social impact can be high with wide and considerable benefits (and savings) to wider society.

Theresa May said at 'Care not Custody' conference July 2014:

"Nationally, around 20% of police officers time is spent dealing with people suffering from mental health problems. 35% of prison officers time is spent dealing with mental health related issues. We know that a large proportion of the prison population have mental health issues, learning disabilities or other health vulnerabilities, and that people can get locked into cycles of reoffending due to unmet health needs. In 2009 Lord Bradley's report laid bare the true scale of the issue by stating that a very high proportion of prisoners have "a range of very complex needs, including a high number who are suffering from mental health problems or learning disabilities."

Vulnerable people suffering mental crises (or any health crises) are not best served in jail; those suffering mental illness or learning difficulties should not be kept at police stations for want of somewhere else to go; and the best use of police time is not attending to people who would be much better dealt with by healthcare professionals.

The police/prisons cannot, and should not, do the job of healthcare professionals. People experiencing a mental health crisis deserve a proper healthcare setting. People with mental health issues who are arrested or held in custody, deserve a proper assessment of their needs and the appropriate care and support.

2. What measures should be in place to prevent mental health needs entering the justice system, and improve outcomes when in the justice system.

1. Place of Safety (POS) for assessment

A POS should be set up to allow for assessments of health need. A POS protocol should be in place. A POS should be a safe, secure, quiet area, where skilled health and social care staff should be available 24/7 with police input as required. It is not good practice to assess complex health/behaviour (which may result in a criminal charge or not) in a busy general healthcare setting where the individual or others are at risk. The POS should not be the prison or a police station (though as a last resort this may happen), - the best location should be in reach of urgent clinical service support.

## 2. Prevention and diversion from custody

The development of diversion from custody and 'street triage' should be in place. There is merit in some clients with mental health needs not being engaged within custody at all. Advice to police, assessment at the POS and triage response in the community needs to be available so someone's mental health is the focus. Offending is separate and should be dealt with at police stations.

In relation to plans around street triage, it is recommended that any development should be mindful of the particular characteristics of the local area. The model for a mental health nurse presence in the police car/control room may offer a helpful alternative to other 'mobile based' forms of street triage.

Courts need advice and guidance on mental health from skilled practitioners and probation staff which recommends the best way forward for sentencers with the service user. Options to use of mental health treatment requirements (as a community order) should be available.

A specific justice/health navigation intervention is recommended – this specifically supports offenders whose behaviour is due to poor mental health. This would be in the form of a Neighbourhood Outreach team. Case Management - plus intensive discharge/release planning reduces reoffending by 25%. Offender peer support can augment the professional role. Drug Rehabilitation Rehabilitation - DRR (formerly DTTO) reduces mental health custody and should be planned in alongside health interventions.

## 3. Accommodation

Housing first – stable housing can impact by a further 15% to prevent custody stays.

Therapeutic Communities – can assist for 10% for the mental health community entering prisons. Enhanced and gender-specific therapeutic communities can add a further 5%.

The issue of accommodation, with attendant supervision and support is regularly a service gap. The law governing Approved Premises in UK law applies. Residential options for offenders can be supported by court orders and conditions.

There is a potential for stigmatisation and discrimination of offenders, particularly so for those with mental health problems, where specific residential provision is concerned.

## 4. Screening

Every person entering prison should have an immediate (1<sup>st</sup> day) health screen from a skilled person. Immediate health care needs can be met, and information gained should be formed into a plan (ICP) within 72 hours. This

ICP is regularly reviewed (monthly). The screening should be updated when a release date approaches so care continuity is emphasised by passing on the information to the health organisations where the offender will return. Through-the-gate planning is required.

#### 5. Individual (personalised) focus

Managing Vulnerability and Mental Health in Prison - each person assessed as in need in the ICP must be assigned to a suitably qualified and experienced healthcare staff member who will act as their personal Custody and Rehabilitation Officer (CARO) whose responsibility it will be to build a supportive relationship with them, to oversee their security and well-being, to ensure their health, education, social care and rehabilitation needs are met, and to oversee the assessment for and delivery of their Individual Custody Plan (ICP).

This ICP should contain the Safety and Vulnerability, Risk Assessment and Support (SAVRAS) assessment, should be co-ordinated by a CARO, who will ensure that as part of this process an appropriate assessment is made by suitably qualified practitioners (properly trained in issues of youth, gender and cultural sensitivity) of any physical, social care, and mental health needs of, or other vulnerabilities and risks. These needs will include those currently covered by the ACCT (Assessment, Care in Custody and Teamwork) process.

Responsibility for prevention of self-harm and self-inflicted deaths in custody should be owned by all agencies. There should be a consistent approach throughout the criminal justice system to requesting consent to share medical information, which should happen at the first point of contact with the health services in a Criminal Justice System setting, whether that be at a police station or at a prison, and that that consent should apply to the prisoner's journey through the CJS.

#### 6. Local secure mental health facilities

A secure PICU (Psychiatric Intensive Care Unit) type inpatient service should be available within reasonable distance of the prison to take swift transfer of offenders who have acute mental health need who need more intensive care.

The PICU should be secure or escort and bed-watch staff from the prison will be needed. This would be an interim secure place for the assessment and immediate treatment of prisoners. Possible transfer to a longer term secure mental health service may result. A specific service level agreement should exist with a chosen provider to allow swift transfer.

#### 7. Prison Built Environment

The built environment of the prison and health care facility should be safe (to deter self-harming behaviour), well-equipped, modern and easily accessible with some services available on wings if at all possible, such as health promotion material, talking therapies, group work. Health kiosks and booking on wings should be planned in.

#### 8. Equity of access

Access to a primary care appointment should be within 24-48 hours and access to more specialist services should be as soon as possible and no longer than an average 6-12 weeks depending on the urgency.

Access to forensic and clinical psychology services should be within 4-6 weeks.



The forensic psychology (those specifically qualified) resource needs to improve so input to medical and nursing assessments can be augmented. Service arrangements for those individuals with personality disorder should be in place as described above.

#### 9. Capacity and expertise and multi-disciplinary working

The adult mental health service level of provision within the prison should have sufficient nurse capacity via advanced nurse practitioners, not only as a practitioner but also in the development of working practices, strategic development and liaison with other services outside the prison.

It is good practice for the mental health advance practitioners to support a mental health peer support programme which develops the role of mental health champions on each wing. This champion role is one where a trained peer offender is able to be approached by other offenders who believe they have mental health issues and they can report these approaches confidentially to the advanced nurse practitioner. Also the champion role can report concerns about fellow offenders that are picked up by the advanced nurse practitioner and carefully looked into to assess early stage risks.

#### 10. Governance

An integrated board should bring together all agencies who have an interest in justice and health. This board should govern quality, development, concerns and improving standards.

A full set of KPIs (key performance indicators) should be in place and reported on monthly to the board. Any service area that has deficits by > 10% should develop an improvement plan to get back on trajectory.

#### 11. Sharing information

As far as possible, information and recording systems should be integrated or at least access be facilitated across agencies.

Any practice of not sharing court/health reports should cease because this is not a safe practice.

An information sharing protocol be established. All offender mental health cases should be flagged for future continuity of care, plus this will enable macro-population research on trends and outcomes, which can advise of socio-economic trends and inform development.

#### 12. Training and awareness

The adult mental health service and the prison should work together with their respective training departments to review and update current mental health training. A regular and rolling programme of training should be put in place. In addition, consideration should be given to other forms of mental health awareness training and support for prisoners. Peer mentors should be trained and supervised so they are effective in their role.

#### 3. Which groups within the offender population are specifically at-risk of developing mental health problems?

All protected (vulnerable) categories have heightened needs in the justice

system especially when mental health need occurs. Immediate attention is recommended on:

Women – 5% of the prison population is female, this needs to reduce and sentencers need to consider more community options which preserve family functioning.

Youth – Screening and measures described in section 2 need to have special focus for those aged under 25.

Ex-military personnel – application of the Government's covenant to this group should be applied as well as all measures described in section 2.

Complex (multiple disadvantage) needs – this needs local integrated service delivery. (See annex)

4. What steps could mental health service providers take to make their services more accessible for ex-offenders?

An integrated approach (consortium) and full information sharing is recommended across all sectors (public, commercial and non-profit) overseen by a specific governance board. (See annex)

5. How effective are programmes that aim to support continuity of mental health support when people have returned to their communities following prison?

Through the gate release planning needs to be efficient, but for the mental health group the focus needs to be on not entering the justice system at all.

6. How do issues such as housing and unemployment affect the mental wellbeing of offenders and ex-offenders?

Having stable housing and a job is proven to reduce reoffending by 20-40% across all groups. Supply of housing should be sufficient and ear-marked for the mental health offender group and more employers encouraged to employ offenders with mental health needs. This should be via Social Value Act mechanisms to encourage local philanthropy and commercial investment to help their local communities. (See annex)

7. What examples of good practice are there in London and further afield?

See section 2.

8. What can the Mayor and the London Assembly do to support better mental health for this group?

See section 2.

Economic reasoning for best practice changes recommended here

The evidence from UK cost-utility analysis based on economic modelling found diversion plus treatment and/or aftercare programme when compared with no diversion to be dominant (that is, it resulted in lower public sector costs and reduced reoffending gain).

The cost-effectiveness of diversion for adult offenders who come into contact

with the CJS found cost-saving from the public sector perspective. Generally, in these studies the diversion resulted in higher public sector costs (by 20%) in the first 6 months but with improvements on various scales (such as the BPRS and the Wisconsin quality of life scale) resulting in a positive saving inside 1 year.

The mental health court programme is dominant for successful participants alongside using residential days, and reduced prison days as outcome measures. Drug court programmes were found to be cost-saving when compared with no such programmes in adults with substance abuse problems and mental health needs.

Street triage was cost-saving, especially when conducting Mental Health Act assessments for all Section 136 detainees, and having a link worker present at custody suites only marginally increased immediate public sector costs and made 50% savings over a 3 year period.

### In Summary

Commissioners and providers of criminal justice services and healthcare services should consider developing systems for police custody and courts custody that provide prompt access to the following: 1) the effective identification and recognition of mental health problems, 2) a comprehensive mental health assessment, and 3) advice on immediate care and management.

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

Commissioners and providers of criminal justice services and healthcare services should consider establishing joint working arrangements between healthcare, social care and police services for managing urgent and emergency mental health presentations in the community (for example, street triage). This includes 1) joint training for police, healthcare and social care staff, 2) agreed protocols for joint working developed and reviewed by a multi-agency group, 3) agreed protocols for effective communication within and between agencies, and 4) agreed referral pathways for urgent and emergency care and routine care.

Commissioners and providers of criminal justice services and healthcare services should ensure effective identification, assessment, coordination and delivery of care for all people with a mental health problem in contact with the criminal justice system. In particular, ensure that: 1. all people with complex needs/mental health problem have a designated care coordinator, 2. during transitions between services care plans are shared and agreed between all services, and 3. effective protocols are in place to support routine data sharing between health and criminal justice agencies to reduce unnecessary duplication of assessments.

31<sup>st</sup> May 2017

### Appendix One

Mental health and offending - complex needs, social impact and value for money *This discussion paper looks into the issue and suggests a structural way to develop more services.*

To properly think about really tackling complex needs (multiple disadvantage) in our communities it is worth understanding what worries service commissioners/funders (health, central/local government and justice

agencies): How to stay in budget? How to meet rising needs with reducing funds? Being innovative and achieving social impact? ALL of these? One can understand that rising social/health care needs and cuts in central and local government spending means public funds only go towards the highest priorities, emergencies and the statutory-required/highest risk services. This way commissioners stay in budget (or nearer to it)? But, there is a problem brewing - cutting spending on preventative services, rehabilitative services, and services that are not absolutely compulsory, means in the medium term unmet needs actually grow and they become more intense until they are (or the individual is) critical and they flood the priority service thresholds. In other words, it is not a wise strategy to stop funding local schemes that support social/behaviour change, to stop work on crisis- prevention, to disincentivise opportunity for self-determination, - because these services actually stop long-term future use of public services. Many service commissioners feel they'd like to do more to really effect change rather than just deal with priority floods where people connect with services too late, too distressed and take much longer get back on their feet. These commissioners can't get ahead of the themselves and seem destined to only deal with the most needy and patch them up to re-present again (it's like hospital A&E services quite literally). We need to think about how commissioners can get ahead of the game and permanently change growing demand for services that specifically focus on people with complex needs.

There is a way to resolve this issue and start to invest to save and maintain services that are more than the legally obliged, to plan longer term and to work in a more strategic way. The principle to hold in your mind to achieve this is 'social impact' logic and a wider use of the Social Value Act engaging the commercial, non- profit and public sectors as parallel investors with the commissioners. All sectors (commercial, public and non-profit) need to play ball together and will if it is packaged in the right way. Between them the sectors have more funds at their disposal and together they will be best placed to do good things (especially as Social Investment Tax Relief can make it reasonably inexpensive for commercial companies to invest). Reputations for all are enhanced too because integrated and sustainable social impact outcomes are achieved.

At a local region level all sectors/partners need to coalesce where prevention, working ahead of the curve is required to make social impact. Local partners can with others provide an excellent infrastructure body (a consortium) who can develop shared information systems, training, and integrated case management. This becomes even more powerful when the [Social Value Act](#) [SVA] (2012/3) is played into the mix. The SVA aims to transform the way money is spent on local services. It does this by requiring the people in charge of putting in place our services (commissioners) to think about more than just how to design these services and who will provide them. Public authorities must consider how the services could have an even further reaching impact on the local community. To directly quote:

*If an authority proposes to procure the provision of services, it must comply with these requirements:*

- There has been some
- (a) *how what is proposed to be procured might improve the economic, social and environmental well-being of the area, and*
  - (b) *how, in conducting the process of procurement, it might act with a view to securing that improvement*

steady SVA progress in the way commissioners think but everyone feels more needs to happen. How do commissioners deliver more real social change, prevention, more social value?

All sectors should show more can be done using the SVA at a time when the voluntary, community and social enterprise (VCSE) sector is really suffering because of spending austerity. Many charities describe how their traditional contracts and grants are drying up and they are fiercely competing for any funds (i.e. a 'race to the bottom' is created as prices are slashed making delivery and real change less likely). Once these VCSE organisations disappear it is unlikely they will return, - if we are not careful it will be a permanent loss of social value. To realise the ambition of the SVA and truly transform commissioning practice the government should do more such as mandating for Social Value progress and promoting better value for money for the taxpayer. In other words, every commission/procurement should state how much extra value it wants to see and make it a structured part of the assessment of tender offers. A very transparent way of doing this would be for the government (or any commissioner using public funds) to state the usual specification requirements of volume, cost and quality of a service being tendered out, AND in addition say how much (a 20-50% points of a contract value) should additionally flow and be ring-fenced into the hands of the local/field-related non-profit sector partners. This would be so welcome by the VCSE/Third Sector who are currently under a lot of financial pressure and sadly going-under, merging or simply withdrawing services.

The SVA has an important link to many emerging central strategies. Without doubt central government is right to seek to plan and commission services on a larger more integrated regional scale so long as the delivery is devolved and local. It makes sense to integrate health, social care, justice, employability, housing and a range of other services around a natural geographic region and decide what's in every neighbourhood/centralised to a specialist service.

If done well this will lead to greater efficiency, prevent unnecessary duplication and encourages inter-agency work. By implication the benefits to service users are they get joined-up interventions that are better coordinated for greater up-stream impact. This devolved integration should follow SVA requirements and make clear those interested in the service procurements (commissioners) have to additionally set aside a value which goes to the non-profit sector and this is part of the assessment of who wins a bid and carries on to manage the complex supply chains required.

This can be defined as the very essence of Social Value when this sort of large scale integration positively encourages the non-profit supply chain consortia associated with such integrated devolution. The commissioning method above should be hard-wired into public procurement through a section of the tender invite which is scored so as to promote it [SVA].

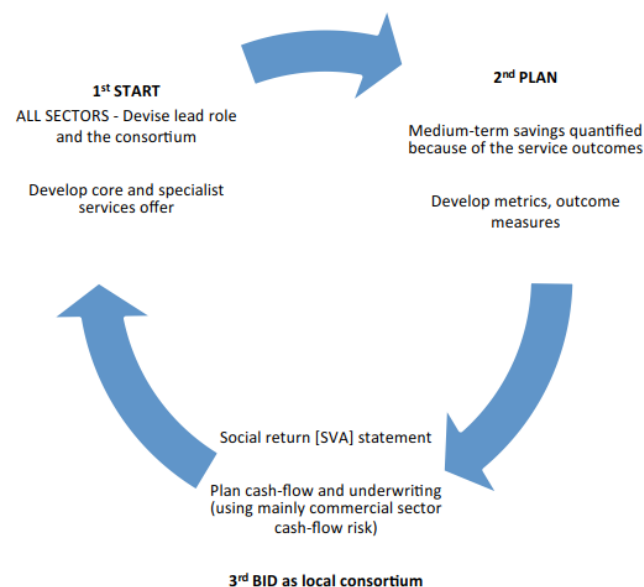
Devolved integration is likely to see the rise of the 'one-stop-shop' service, the 'service hub', best led by the Third Sector. This is financially savvy and in terms of integrated support pathways is very sensible and will be welcomed by most service users because they also see the waste of going in and out of many doors before they get anything like a real solution to what they rightly believe are their unique problems and providers see as complex.

An offender with an anti-social drug and alcohol problem may be assisted into employment but if they still live in the same poor accommodation as their dealer and their mental health/drinking problem isn't dealt with at the same time then there is little chance of a truly long term successful outcome. The RE-world beckons: – reoffending, readmission to hospital, relapse, revolving-door, re-training, etc. Commissioning is often serially inefficient (not integrated) and looks at solving one problem at a time, when in reality people are complex with multiple needs requiring simultaneous responses.

Solution method: A lead or prime (i.e. through a consortium) teams up with all sectors commercial/organisations locally to coordinate the service, overall delivery and manage infrastructure headline risks of the commission. The lead will be held to more stringent SVA requirements. This lead or prime body for efficiency/practicality reasons will want to go through a consortium to sub-contract in a wide non-profit, local third sector supply chain to achieve integrated delivery outcomes.

This form of devolved and integrated commissioning from the prime will increase across many areas over the coming years. No one charity or third sector organisation will have the skills and capabilities to do it all on their own, so the future is likely to see increasing movement towards selected, integrated supply chains with an active directory of services that in combination offers the full solution package (to any and all problems).

Diagram: Integrated service planning (example model)



All sectors have a lot of experience in building supply chains when bidding for public sector contracts. This is proven effective in aiding the modernisation of Probation Services, substance misuse delivery, DWP employment schemes and a range of other health and social care initiatives that all at their heart have personalised services for people with complex needs who want the right set of services, at the right time, local to them.

This is social impact that new consortia will build on – i.e. it prevents reoffending, readmission to hospital, reduces inability to get work/stay out of debt, etc because a unique blend of the right organisations is personally created to fit the person (not the other way round).

A managed consortium providing a range of services will help commissioners consider whole-system change and linkage across all service areas being delivered (such as social care, health, housing, and employment) and avoiding duplication. With wider application of the SVA, integration of the commercial sector with the public, and non-profit sector leadership will provide

the answer to a range of new service models (see annex examples).

The information above is what all sectors should be discussing with groups of regional commissioners to help them lever change and efficiency in their local systems. Health, social care, justice, employment, housing commissioning leads need to see their work in the round and senior provider leaders locally must see the benefits of integrated working and that all partners are there to assist the social impact vision locally and will use the SVA to guide how it does this. In this way all sectors will show local commitment as a powerful agent for change and impact.

## Appendix Two

Contact Consulting works at the intersection of health, housing and social care. We provide consultancy and research, specialist writing inputs for use by professionals, organisations and for the public, service evaluation and review, strategy development, incident investigation and good practice development. Mental health is our main area of expertise.

Steve Appleton is Managing Director of Contact Consulting.. He has thirty years experience of working in health and social care, as a practitioner, operational manager and as a senior manager in an English Strategic Health Authority. Steve has built a successful consultancy portfolio through Contact Consulting, working with the NHS and social care organisations, Government departments, housing associations and the independent sector.

Recent work has included the development of Thrive West Midlands, a population based approach to mental health following a mental health commission chaired by Norman Lamb MP. Contact Consulting project managed the commission and wrote the report, published in January 2017.

Contact Consulting is currently developing the Thrive London report, to be launched by the Mayor of London in July 2017.

Contact Consulting has worked in mental health and criminal justice over the past ten years. This has included health needs assessments of prison mental health care in various prisons across England. We have recently completed a gap analysis and service review of prison and offender mental health care for the States of Jersey government.

Adaptus is an independent consultancy partnership working across the public, private and voluntary sector. We are specialists in the Justice sector. Our combined experience spans 35 years of strategic and operational management across the public, private and third sectors.

Lee Whitehead specialises in the criminal justice, mental health and substance misuse sectors. In the last five years he has completed work for London Probation Trust (November 2012 to June 2013) as a business developer, Before this he worked with Nacro.

Contact Consulting and Adaptus have worked together over the past five years on a range of projects relating to mental health and criminal justice





## London Clinical Networks

**Please find the response for the Health Committee from the NHSE Health in Justice and Other Vulnerable Adults London Clinical Network (HiJOVA).**

**What are the main mental health challenges faced by prisoners and ex- offenders in London?**

High rates of mental disorder are found in the remand and sentenced prison population (Singleton et al 1997, Light et al 2013, Fazel et al 2016). While the UK mental illness epidemiology is now out of date and the prison population larger, there is little that suggests the picture would have improved. NICE (2017) have recommended this is revisited to inform the work of commissioners and providers. Characteristics of the offender population in the community are less well described in the research literature but as this population is drawn in part from the prison population and is otherwise socially deprived, it is likely to be fairly similar in terms of rates of mental disorder.

The prison population has high rates of major mental illness, alcohol and drug dependence and personality disorder. Mental disorders are frequently co- morbid and often have associated physical disorders. Individuals in this population often have well-documented histories of contact with mental health services but are not necessarily receiving care at the point imprisonment and in some cases their disorders are of a nature or degree that would not normally require contact with secondary care providers.

**What measures are in place to prevent people with mental health needs entering the criminal justice system and how are they supported through prison, probation and release? Are these measures sufficient?**

In addition to the estimates above of mental health problems in the offender population, recent evidence in London from individuals presenting in police cells (Forrester et al 2017) and in 24 hour prison health units (Hales et al 2015) suggest that significant numbers of



individuals have pre-existing mental health histories and that they will have multiple periods of custody. Evidence from the liaison and diversion scheme evaluation in London suggests both that those in police cells and courts who are assessed under the schemes will not infrequently have major mental illnesses such as schizophrenia. This evidence suggests both that the existing pre-prison processes to flag mental health difficulties and the care provided after imprisonment are not sufficient to prevent (re)presentation to the criminal justice system.

Investment in liaison and diversion schemes at different points in the criminal justice pathway has grown rapidly in recent years. However, these remain signposting services and their capacity to divert the individual away depends not only on the view of the police and courts but also on the individual's willingness to follow advice and the capacity of local services, mental health and other, to assist. Post prison or on a community sentence, individuals should be supported by either of the two arms of the National Probation Service depending on level of offending. Care planning pre-release should involve consideration of health and social care needs and good practice requires liaison between health practitioners inside and outside prisons and also between health and CJS practitioners within the prison. CRC pathways have been slow to develop in London. Ex-prisoners are at considerable risk on release with high rates of death in the immediate post-custody period. The cuts to drug and alcohol services following the transfer of funds to Local Authorities may be relevant as many of these deaths are drug related. Ex-prisoners continuity of care is also adversely affected by unstable accommodation, no regular GP and exclusion from generic mental health services by virtue of presenting with complex needs.

Offenders with learning disabilities can find it especially difficult to gain access to mental health services and to programmes designed to address offending behaviour. Very often people fall between all the eligibility criteria: 'not disabled enough' for learning disability services, but 'too disabled' for mental health services, substance misuse programmes and offending behaviour programmes run by prison and probation services.

Offenders with learning disabilities often need quite basic support to enable them to understand and comply with orders and to avoid re-offending. Loss of the Supporting People funding and drastic reductions in social care have significantly reduced access to such support. Research from the Tizard Centre at Kent University showed that, 10 weeks after release from prison, one-third of ex-prisoners with

learning disabilities were back in prison or in hospital.

In sum, current processes and structures are far from adequate.

### **Which groups within the offender population are specifically at-risk of developing mental health problems?**

There are subgroups within the prison population who are more likely to suffer from mental health problems. These include women prisoners, older adults and individuals from black and other minority ethnic groups (NICE 2017). Some groups may also have difficulty accessing health care by virtue of not speaking English or having Intellectual Disabilities. Prisoners with learning disabilities are at increased risk (compared to other prisoners) of experiencing mental ill health. According to the Prison Reform Trust, "Prisoners with learning disabilities or difficulties were almost three times as likely as other prisoners to have clinically significant anxiety or depression—many were both anxious and depressed" (Talbot, 2008).

### **What steps could mental health service providers take to make their services more accessible for ex-offenders?**

Most ex-offenders will be under the care of primary care only or locally commissioned mental health services or drug and alcohol services.

NHSE is bringing in clauses to the new GP contract to improve registration rates for ex-prisoners.

The doctrine of parity of esteem for mental health services is necessary because of the relatively modest resources allocated to mental health commissioning. This has a number of effects on the offender population. Offenders often present with complex needs e.g. learning difficulties and substance misuse. In practice, local mental health services are reluctant to take on individuals with a history of poor engagement and complex needs. Secure hospital services provide community support to individuals with histories of secure inpatient care but many offenders failed to meet the threshold of serious crime for such services. Both probation services and prison mental health services find their clients and patients rejected from services for these reasons, leaving them at risk of deterioration and further offending.

The health commissioning framework requires attention to improve

responses to individuals with complex mental health needs which in the case of ex-offenders includes better understanding of trauma and abuse as well as greater attention to competence to address cultural needs. The gap of lower level of offending and complex mental health needs require specific attention.

Drug and alcohol services have seen their funding reduced which has an impact on ex-offenders leaving prison or based in the community.

### **How effective are programmes that aim to support continuity of mental health support when people have returned to their communities following prison?**

Continuity of care between community and prison settings is difficult. Offenders can have erratic contact with healthcare often only on an emergency basis and a combination of temporary accommodation and no regular primary care provider complicates the receipt of information within the prison and care on release. Recent NICE guidelines (2017) have recommended more research on clinical case management systems as it is unclear what constitutes the best system for offenders.

Continuity of care for women offenders has been made more complicated by the reallocation of London women to Surrey prisons. They will often be released from prison to locations in London. The geography of confinement makes adequate continuity and care planning difficult. This issue can affect men who are not relocated to prisons in the London area prior to release.

High churn prisons are anticipated in the London area in the near future. This will be an exaggeration of the current challenge of delivering healthcare and ensuring prisoner safety when individuals may be in custody for a few days or a few weeks. It is important to bear in mind that the remand period is particularly risky in terms of ensuring safe detoxification from alcohol and drugs and ensuring full assessment of individuals for mental health difficulties as a high number of self-inflicted deaths occur in the first few weeks of custody. Rapid return of individuals to the community creates capacity issues for prison healthcare staff and this change will require additional resources.

### **How do issues such as housing and unemployment affect the mental wellbeing of offenders and ex-offenders?**

There is an extensive literature on unemployment and mental health problems. Lack of permanent or suitable housing complicates service

access.

**What examples of good practice are there in London and further**

**afield?** Holloway: complex care planning Jointly HMPS/healthcare: evaluated psychological programmes for PD (Options - now in HMP Downview): comprehensive psychological care (Allen et al 2017) On line Suicide and self harm training also delivered face to face in all CNWL sites and now to be offered via the Clinical Network to all prison and court /police cell based staff (discipline and health care). PD pathway projects providing community and in prison work.

**What can the Mayor and the London Assembly do to support better mental health for this group?**

Continuity of care through improved joint work between local health commissioners and the probation services. Critical to success in this area is the capacity for offenders to have permanent addresses and appropriate housing.

**Professor Annie Bartlett**

**Chair HiJOVA Clinical Network 31.05.17**



## **Women in Prison**

A response to the  
London Assembly Health Committee review into mental health  
for offenders and ex-offenders in London

31 May 2017

### **About Women in Prison**

Founded in 1983, Women in Prison (WIP) aims to reduce the number of women in prison and prevent the damage done to women and their families by imprisonment. Women in Prison's proposals are based on experience of delivering gender-specialist support services in prison and the community for women affected by the criminal justice system.

For more information see [www.womeninprison.org.uk](http://www.womeninprison.org.uk)

### **Introduction:**

#### **About Women in Prison (WIP):**

Women in Prison (WIP) is a women-only organisation that provides holistic gender-specialist support to women affected by the criminal justice system. We work in prisons, in the community and "through the gate", supporting women leaving prison. We run three women's centres (in Manchester, Woking and Lambeth, London) that

all incorporate liaison and diversion schemes for women involved in the criminal justice system. Our combined services provide women with support around advocacy, complex needs, domestic and sexual violence, education, training and employment, mental health, parenting and substance misuse.

We advocate for a significant reduction in prison sentences and for strengthened community support services.

Our policy and campaigns work is informed by our frontline support services for women, delivered at every stage of a woman's journey through the criminal justice system. The experience and knowledge of staff working directly with women affected by the criminal justice system enable us to see first-hand how well policy is implemented in practice.

### **About this consultation response:**

Our response to this consultation is concerned specifically with women involved in the criminal justice system.

## **1. What are the main mental health challenges faced by prisoners and ex-offenders in London?**

### Characteristics of women prisoners as a cohort

As a group, prisoners have disproportionate levels of childhood trauma, including having experienced childhood abuse and/or growing up in the care system. A majority of women in the criminal justice system also go on to experience abuse and violence in adult relationships and a disproportionate level of women in the criminal justice system have experienced sexual violence and involvement in prostitution. There is a strong link between women's experiences of trauma and mental ill health, including depression, anxiety and post-traumatic stress disorder. Official figures show that 49% of women prisoners are assessed as suffering from depression and anxiety, compared to the rate of 19% in the general population<sup>1</sup>. 25% of women in prison reported symptoms indicative of psychosis, compared to the overall rate of 4% among the general public<sup>2</sup> and 30% of women have had a previous psychiatric admission before they entered prison<sup>3</sup>. A large proportion of women in the criminal justice system also have personality disorders with 57% of sentenced women having a diagnosis<sup>4</sup>.

A majority of women involved in the criminal justice system are affected by substance misuse and there is a strong link between women's mental health issues and substance misuse issues. The relationship between addiction and mental health is complex with conflicting theories around whether dual diagnosis is the most

appropriate response or whether substance misuse is a consequence of mental health which can be reduced if addressing the root causes of mental health issues. We know from working with women that many “self-medicate” using illicit substances as a coping mechanism to deal with previous and/or current trauma. This substance misuse, in turn, has a significant negative effect on reoffending, with many women committing crimes such as theft, handling, burglary or robbery to finance their addiction.

As stated in the call for evidence document, people with mental health problems are much more likely to be a victim of crime than a perpetrator. However, the commonly assumed victim-perpetrator dichotomy is misleading; perpetrators and victims are not mutually exclusive and women who have committed crimes are disproportionately also victims of crime, as well as having poorly treated mental health.

Levels of self-harm are extremely high in women’s prisons with the rate of incidents in female establishments being 1,987 incidents per 1,000 women<sup>5</sup>. Last year there were 7,657 reported self-harm incidents across all female prisons<sup>6</sup> and there were twelve self-inflicted deaths, the highest number on record<sup>7</sup>. Self-harm and suicide prevention in prisons is outside of the scope of this investigation. However, it is worth mentioning that there are clear links between mental ill health and self-harm and suicide that apply to our client group throughout their lives. 46% of women prisoners report having attempted suicide at some point in their lives, compared to 6% of the general UK population.<sup>8</sup>

Given that women in the criminal justice system lead chaotic lives and have such complex needs, women themselves rarely prioritise their mental health. This client group only tends to engage with mental health support after continued encouragement and support from other services, so for those clients where support is lacking, mental health needs are seldomly addressed. Furthermore, women have also disclosed to our workers that even once the path way to mental health support has been initiated they are reluctant to divulge too much about themselves due to risks of confidentiality and safeguarding. Some service users have shared that they do not believe interventions such as therapy and counselling would be beneficial to them as they feel they can never fully explore their anxieties due to the risk of potential repercussions. This shows the importance of maintaining therapeutic relationships that are separated from criminal justice professionals.

## **2. What measures are in place to prevent people with mental health needs entering the criminal justice system and how are they supported through prison, probation and release? Are these measures sufficient?**

Unfortunately, despite the wealth of evidence of the prevalence of mental health issues among people at risk of entering the criminal justice system, this group has very little access to mental health support and there are few measures in place to

prevent their entry into the criminal justice system.

### Prevention and criminal justice alternatives

For those women who are already involved in the criminal justice system and who have committed a crime, mental health liaison and diversion schemes are an option. Although these have been rolled out across the country, including in London, they are far from the norm. We would like to see diversion from custody into community mental health community support for the majority of women with mental health needs, in line with the recommendations set out in Lord Bradley's 2009 report<sup>9</sup>.

There are examples of mental health liaison and diversion schemes being successfully rolled out across the country. However, not all magistrates' courts, police stations, prison or probation offices have access to these. In addition, as argued by the Prison Reform Trust, in order to work effectively, it is important that partnerships are established between liaison and diversion services and local authorities and other local services.<sup>10</sup> It is also vital that community mental health and other services are sufficiently secure in terms of commissioning and funding to ensure they remain a permanent and reliable sentencing alternative.

Initiatives such as the Women's Diversion Scheme pilot, run by Brixton Police and the Beth Centre and Transforming Women's Justice diversion pilot in Woking, are effective ways to identify individuals' needs at early stages of contact with the criminal justice system. Unfortunately these are local initiatives and not applied pan-London. However, we would like to see this model of partnership work built on and extended.

However, mental health liaison and diversion schemes are not a preventative measure but can only be applied to those who have been charged with an offence. We believe that more investment in mental health support services would help prevent many with mental health needs from entering the criminal justice system in the first place, including preventing a slippage into substance misuse. Examples of such services may include, but not be limited to, early intervention in schools, easier and quicker access to counselling through GP referrals, walk-in clinics, day centres, emergency out-of-hours support, floating support and increased opportunities for supported accommodation for vulnerable adults.

Currently, secure mental health units exist as an alternative to prison for some women. However, women tend to be transferred to these units during or after a prison sentence, following assessment by a Forensic Medical Examiner under the Mental Health Act 2007. Given the level of mental health needs in prisons compared to the very small number of women transferred to psychiatric settings, this is clearly only an option for the very few. Moreover, it is rarely an alternative to custody but more often a progression thereof and far from all women with mental health issues need to be in secure units. Under Section 136 of the Mental Health Act, psychiatric units, police stations and A & E departments can be used "places of safety" for individuals suffering from a mental disorder. However, as noted in the Bradley report, detaining someone in a police custody suite can have detrimental effects, including



criminalising people for their mental health needs and exacerbating their mental health state. The use of police custody suites is also inappropriate in terms of lack of staff expertise levels and puts women at risk<sup>11</sup>.

## Support through prison, probation and release

### Prison

Prison mental health services are under enormous strain with low staffing levels and high demand from a very complex client group.

Community mental health in-reach teams operate in prisons. However, only a small proportion of the prison population are eligible for support by the in-reach teams due to resource constraints; therefore capacity, not need, determines eligibility for mental health support in prison with many women unable to access any support at all. Prisons also have Psychological therapies team that can offer counselling and therapeutic group work. Again though, waiting lists are long and resources are scarce, meaning that many women are not able to take advantage of this service.

Moreover, short-sentenced prisoners are rarely able to take part in any activities such as training or group work as their release will inevitably be imminent. This applies also to mental health support. Women are particularly affected by this as the majority of women prisoners serve short sentences – 56% of adult women (or 4,067 women) who were given an immediate custodial sentence received a sentence of less than three months in 2016<sup>12</sup> and many serve only a few weeks.

Another group of prisoners that are rarely able to take part in activities, including mental health support, is remand prisoners. This is a significant proportion of the prison population – 45% of women enter prison on remand<sup>13</sup> and only 30% of women on remand go on to receive a custodial sentence.<sup>14</sup>

### Release

On release, some women experience issues with medication. Women should be discharged with a 7-day supply of medication (where applicable). However, far too often women are released without any medication at all or with the wrong medication. This is particularly concerning where women are released from prison without correct medication on a Friday afternoon, without any possibility of visiting a GP until the following week. Transfer of medical records can also take a very long time due to the usage of different systems across various health settings.

We would suggest that women leaving prisons have healthcare exit appointments in advance of discharge rather than on the same morning as is often the case. There must be another mechanism in place for flagging up release dates in order to arrange pre-release health assessments. It can be difficult to plan ahead for releases in prison as women are sometime released relatively suddenly on Home Detention Curfews or after parole hearings. However, more forward planning would enable

healthcare staff to prescribe accurate medication, supply women with medical notes and ensure transfer to a GP in the community. Far too many women leave prison without having a named GP in the community, not knowing how to register with a GP and without the required forms of ID to do so. There are, however, schemes in certain prisons to rectify this, for example, a project commissioned by Public Health England taking place in HMP Downview to set women up with a GP before leaving prison.

Women who are under the care of the in-reach team in prison will be transferred to community support by the CMHT on release. However, such support tends to be rather limited. For those women who are not on the in-reach caseload, their lack of care will continue into the community on release.

For women leaving prison, effective through the gate (TTG) support is paramount in achieving a smooth transition back in to the community. However, this service is limited and does not form part of probation responsibilities. Where it exists, it is primarily operated by third sector organisations who are underfunded and can only perform a partial service. Certain women, such as women on remand or women released on tag tend not to be eligible for this services due to a lack of prior knowledge about release dates and inability to plan ahead.

When it comes to housing, this should be allocated and secured whilst women are still in prison, and not left for women and support workers to deal with on release, which is the often case. It is incredibly challenging for women to come out of an establishment where there is a daily routine, “accommodation” and very little responsibilities, to re-settle without a secure place to live. Clients disclose experiencing heightened anxiety and very low moods in the period leading up to and after release. Moreover, the time it takes to allocate temporary accommodation for ex-offenders in the community is simply not acceptable. Many women are forced to find a place to stay while waiting for accommodation to materialise and this can be highly unsuitable, sometimes resulting in them instead reoffending and going back to prison.

### Probation

In terms of mental health support through probation, it is rare for a probation officer to arrange mental health support in the community, largely because there is very little on offer. Lack of resources translates into a either a complete lack of provision or a rushed service provision and women’s needs often go unrecognised and/or untreated.

### **3. Which groups within the offender population are specifically at-risk of developing mental health problems?**

As discussed above, women in prison as a group face multiple complex and

overlapping needs. While not all women in prison share the same characteristics, and some women will not face all the challenges outlined above, an overwhelming majority of women in the criminal justice system do. The number of women in prison who are *not* at risk of developing mental health problems is marginal. For the purposes of this review, it therefore makes more sense to treat women affected by the criminal justice as one single cohort. As a group, women affected by the criminal justice system have experiences of childhood trauma, abusive relationships and homelessness, all of which significantly affects self-esteem, anxiety levels and depression and can lead to post-traumatic stress disorder. PTSD is also common among the many women in prison who have been affected by prostitution, sexual abuse and coercion.

Prison itself also induces mental ill health, including depression and risk of self-harm and suicide. Therefore, it is reasonable to argue that all prisoners are at risk of developing mental health problems, or to have their existing problems further exacerbated, regardless of their individual propensity to do in a community setting.

Women as a group are also particularly affected by separation from children given that they tend to be primary carers. Women with dependants therefore face disproportionate levels of punishment and trauma from being imprisoned.

#### **4. What steps could mental health service providers take to make their services more accessible for ex-offenders?**

We advocate for specialist services for women in the criminal justice system. As a group, these women tend to lead chaotic lives, often involving homelessness, domestic abuse and substance misuse. As a result of these factors, women often miss appointments and can disengage from support for periods of time. With many services, a missed appointment or a lack of engagement usually means going back

to the end of the waiting list or being discharged. While it is understandable in general terms that services operate according to this practice, it is unrealistic to assume this way of working will be effective for this cohort. In order to make services more accessible and to maximise uptake it would make sense for services to offer more drop-in sessions. It is also important for services not to enforce a blanket exclusion for those women who fail to attend appointments but to give women a chance to come back to services when they are able to engage. NHS organisations offering mental health services need to take into account the vulnerability and sometimes chaotic lifestyles of this client group, and persist in trying to engage with them slightly more than they would normally with the average client.

Women in the criminal justice system also tend to experience personal crises and often require crisis support around mental health. Unfortunately this sort of service is not widely on offer in the community, often resulting in mental health breakdowns

and/or reoffending. This constitutes a false economy with many women currently ending up in A&E or back in prison rather than getting the preventative or ongoing care they need. Long waiting lists for mental health interventions act as a barrier for engagement; Many women agree to sign up to go on waiting lists for mental health interventions such as counselling when in a moment of crisis but by the time their appointment comes around they are unable to engage as they have disengaged from support, gone back to prison, gone back into active addiction or lost interest in the service. A proliferation of different types of services are needed in conjunction – on the one hand preventative, ongoing and long-term support services would be able to reduce the prevalence of crisis situations for many women while more mental health crisis services are also needed for women who inevitably will still be experiencing acute issues.

Understandably, many mainstream services are ill-equipped to deal with this particularly challenging group, with many staff feeling fearful and lacking the experience to deal with women who are often seen as “difficult” or intimidating. Mainstream services can be risk averse and feel they have to prioritise the well-being of staff and other service users and can therefore be unwilling to accommodate women in the criminal justice system. As a result, many women ex-prisoners are unable to use mainstream services. This is particularly the case for women with personality disorders, who are hugely over-represented among women in the criminal justice system.

Substance misuse services have also faced significant cuts in recent years, to the detriment of women in the criminal justice system. It might be helpful to offer more specialist mental health services such as counselling aimed at women with substance misuse, given the close connection between trauma, mental health and substance misuse.

Services also need to be offered more widely to all women in need, not just to those women who are under CMHT. Lack of resources have led to extremely narrow criteria to qualify for support which means many women are unable to access any support at all due to being [wrongly] deemed “not unwell enough” for support.

Services could also be made more accessible and efficient by a transparent communication and shared access to monitoring platforms for key stakeholders.

Mainstream services that come into contact with women in the criminal justice system might benefit from staff training on working with this complex client group. This point also applies to prison staff who do not have specialism in working specifically with women.

## **5. How effective are programmes that aim to support continuity of mental health support when people have returned to their communities following prison?**

Such programmes can be very effective, given appropriate allocation of resources. When such projects are not NHS funded, collaborative working is key. Also, for this cohort of people, mental health workers need to have small caseloads in order to be flexible to provide intensive support and respond effectively to crisis situations.

Unfortunately, in our experience there is insufficient continuity of care between custody and community.

Those women who are under Community Mental Health Teams (CMHT) receive an element of support in the form of home visits and support with medication as well as one-to-one support work. However, this support can be very limited and often consists of quick check-ups to ensure service users are taking their medication. Naturally, women who are street homeless or of No Fixed Abode are not able to receive floating support from their CMHT. On a practical level, therefore, in order for people to receive the support they need in their local communities, it is vital that they are adequately and appropriately housed.

For those women who are not under CMHT in prison, the situation will remain the same once back in the community.

## **6. How do issues such as housing and unemployment affect the mental wellbeing of offenders and ex-offenders?**

### Housing

Housing may not seem like a factor immediately relevant to mental health but it is of crucial importance to women in the criminal justice system and has an enormous impact on women's mental (and physical) wellbeing. A large proportion of prisoners experience a combination of mental ill health, homelessness and substance misuse and practical issues such as homelessness and insecure housing on release are significant sources of distress and anxiety for women prisoners. The housing situation in London is increasingly dire and has been getting steadily worse over the last ten years with many women knowing they will be released to street homelessness, prostitution or domestic abuse.

Homelessness is a major driver of women's offending as well as a devastating consequence of imprisonment. The link between homelessness and offending has, to date, not been given sufficient attention by policy makers who often look at the two issues in isolation. However, without an increase in available housing for vulnerable women involved in the criminal justice system, no amount of housing support from voluntary sector organisations can help solve the problem of women ending up in the criminal justice system as a direct result of lack of housing.

Housing is a major barrier to desistance for women and needs to be a cornerstone of any criminal justice strategy. Provision of housing is an extremely important factor in preventing offending for women. Many women affected by the criminal justice

system lead chaotic lives and do not have a home to go back to on release from prison or can end up in prison partially as a result of a lack of housing. Likewise, many women caught up in the criminal justice system lack a support network, whether family or suitable friends. In the event of homelessness, many women with substance misuse issues (and hence often mental health issues) are forced to stay with peers involved in substance misuse, hence seriously running the risk of relapsing if they have previously been detoxed. Some women have to choose between the “least bad” option, which may involve facing a choice between sexual exploitation and street homelessness. Similarly, many women who are in abusive relationships face choosing between homelessness and staying with abusive partners. Lack of appropriate housing therefore has a tragic direct effect on women’s mental health. Given the above, housing is also a fundamental prerequisite for the success of community sentencing as many women affected by the criminal justice system lack a safe and suitable home.

As an organisation we recognise that local councils are under immense pressure to provide housing for vulnerable people due to a lack of housing stock. Individual housing officers working for housing departments within local councils are sometimes simply unable to provide the housing needed for applicants on a day-to-day basis and are not personally responsible for the lack of provision within their boroughs. There is no doubt that national housing policy has to change in order to provide the social housing that is desperately needed in order for councils to carry out their duties. There can be no improvement to today’s dire housing situation without a significant increase in housing allocation. This has to be a conscious government decision that will have to filter down to local councils in the form of increased housing stock.

Not only do councils struggle to provide long-term, stable housing for those in need but the lack of long-term social housing also has a knock-on effect on temporary accommodation. Due to the lack of move-on accommodation, many people are stuck in short-term temporary accommodation for long periods of time, often years. This is clearly not a suitable solution for these particular tenants and is a cause of depression and other mental health issues. It also means that there is a strain on temporary accommodation for others in desperate need of emergency accommodation who are instantly turned away at the point of enquiry and hence forced to remain in a state of crisis.

Women affected by the criminal justice system are relying on supported housing more than ever due to the stricter conditions and requirements by local authorities. Many women are incredibly vulnerable and need support but are still not deemed vulnerable enough by their local council to be eligible for housing. Supported housing provides a housing option for these women and it is vital that this provision is extended. We would urge the Mayor to cement statutory duties for women with complex needs in the criminal justice system and ensure supported housing provision and funding is extended for this group. This could be linked to provision for those leaving other state institutions such as the care system so that as well as permanent housing solutions there are stepped supported housing solutions on offer.

Reunite is an example of a supported housing project run by Commonweal, Housing for Women and Women's Breakout that focuses on the needs of women leaving prison who cannot not be reunited with their children until they have a home but cannot access appropriate housing until they have their children in their care<sup>15</sup>.

## Unemployment

Unemployment is a significant barrier to resettlement for those with a criminal conviction. As with the general population, unemployment can have a detrimental effect on mental health with depression, low self-esteem and anxiety being a consequence. Women in the criminal justice system are no exception to this and many women struggle to find work and turn their lives around without success.

However, unemployment is not always the most pressing issue for many women leaving prison. Sadly many women have more urgent barriers to overcome in the first instance, such as mental ill health, homelessness, substance misuse or fleeing abuse from violent partners. Poverty and debt is a significant issue for women in the criminal justice system and access to benefits tends to be a more immediately pressing issue for women leaving prison.

## **7. What examples of good practice are there in London and further afield?**

Women in Prison runs a number of projects in London and beyond that should all be seen as examples of good practice.

We currently deliver a Mental Health through the gate project in HMP Bronzefield. Staff on this project work alongside the in-reach team in prison and support women while in prison, on release (through the gate) and on release in the community. We find the through the gate model very useful as it enables women to get the continuity of care and stability they need when moving through the criminal justice system. Like all our projects, support is holistic and tailored to individual needs, although the focus of this particular project is on mental health.

We also run a specialist complex needs project for women with personality disorders, providing holistic and tailored support in the community pan-London to a small caseload of women. This project always has a full caseload and a waiting list, despite being restricted in remit to women who are on probation license and who have committed a serious offence. There is a clear need for more projects like this and for more funding to be invested in these form of support services for women with complex needs.

In line with the Corston report,<sup>16</sup> Women in Prison advocates a network of holistic one-stop-shop women's centres that can provide holistic support to this complex client group. We run three such women's centres – the Beth Centre in Lambeth,

London, the Women's Support Centre in Woking, Surrey and Women MATTA in Manchester. There are numerous other examples of such women's centres across the country that provide excellent services to women with mental health issues and a range of other support needs and we strongly urge that this model is extended across London and beyond.

We previously ran a mental health advocacy project that operated in a similar way to our TTG project but was primarily based in the community. Unfortunately, funding restrictions often limit the remit of support organisations like us can offer and lead to many women being excluded from support services. One major benefit of this particular project was that it faced fewer funding restrictions than many other projects and could work with women based on need, including women who self-referred and women who did not have an official mental health diagnosis. We would call for many more flexible services like this which can fill gaps as they appear and meet the needs of referring agencies. However, this will require a more flexible approach to commissioning and targets.

## **8. What can the Mayor and the London Assembly do to support better mental health for this group?**

### Increase in support services

The primary challenge to mental health facing women with involved in the criminal justice system in London is a lack of support services, both in prison and in the community. Community mental health support tends to be reactive and crisis-focused and there is virtually no preventative mental health support on offer for those in need of support. We believe an increased investment in prevention and early intervention when it comes to mental health support services would have an enormous impact on public health, including for women in the criminal justice system. Such a shift in focus from crisis response to prevention would not only be hugely valuable on an individual and human level but would also have a positive societal impact on crime levels and spending on criminal justice.

Increased mental health support in the community is of utmost importance to prevent women entering the criminal justice system and to divert women with mental health issues at point of arrest into appropriate community support. Currently such provision is woefully inadequate.

Examples of support needed includes mental health advocacy, mentoring and other holistic one-to-one support for women. For women in the criminal justice system we advocate for specialist women's centre support, alongside mainstream support services, where relevant. Women in the criminal justice system tend to have multiple needs and require support around various issues such as benefits and debt, housing, domestic violence or health. Women may also need encouragement to attend appointments or advocacy in professionals meetings. In addition to practical advice and support, many women benefit from emotional support and the simple



knowledge that there is a professional available to them if they need to reach out for help.

As mentioned in question 2, we would also recommend early intervention in schools, easier and quicker access to counselling through GP referrals, walk-in clinics, day centres, emergency out-of-hours support, floating support and increased opportunities for supported accommodation for vulnerable adults.

There is also a need for more support services for women who have been separated from their children as a result of their involvement in the criminal justice system. When women are sent to prison they are separated from their children, and only 9% of children are cared for by their fathers in their mothers' absence<sup>17</sup>. Many children are taken into care and some are permanently given up for adoption. There is little support on offer for women who have gone through this ordeal. On a related point, there is a need for more specialist services for mothers with anti-social and borderline personality disorders who are deemed as posing a risk of harm or neglect to their children as it is difficult for women with a criminal record to access mainstream services maternal mental health services such as therapy.

Naturally, in order to expand community mental health support services, funding is a necessity. However, a shift in focus from criminal justice solutions to community solutions does not have to be more costly overall but would simply require a shift in existing resources. Currently, an enormous amount of public money is spent on prison, money that could be spent more wisely on preventative care in the community. Likewise, emergency services such as A&E departments are under enormous pressure and rather than adding to their burden it makes more sense to provide alternative, less crisis-driven mental health provision in the community.

### Housing

It is imperative that the housing pathway for women in the criminal justice system is reviewed. As discussed in question 6, improving the housing situation for women in the criminal justice system would have an enormous impact on women's mental health but is also a prerequisite to improving societal crime levels and community safety.

We believe the Mayor and the London Assembly should initiative a pilot scheme for women involved in the criminal justice system in London to provide secure housing, including supported housing with specialist mental health support.

### Leadership and cooperation

In order to achieve genuine results for women affected by the criminal justice system, political leadership and cooperation between central and local government are vital. Criminal justice solutions alone are not sufficient to deal with offending, nor

is the Ministry of Justice, in isolation, able to implement the changes needed to reduce (re)offending. What is required is a joined-up approach that takes into account the root causes of women's offending. This approach must encompass an understanding of the compelling opportunities for change that appropriate housing, mental health support, Violence against Women and Girls (VAWG) strategies and gender-specific women's community support services can offer. It is vital that the Mayor of London and the London Assembly works in partnership with the NHS and local third sector providers to come up with realistic plans for service provision. Actors from several fields need to be involved in this discussion, including criminal justice actors, homelessness charities, women-specialist providers, mental health support providers and substance misuse support agencies.

### **Suggestions for further reading and inquiry**

- The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system
- The Corston report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system
- Professor Seena Fazel, Department of Psychiatry at University of Oxford
- Faculty of Forensic Psychiatric at the Royal College of Psychiatrists

### **Further Information**

This consultation response was prepared by Sofia Gullberg, Policy and Information Coordinator at Women in Prison with expert input from frontline staff at Women in Prison: Georgette Desira, Falak Naz, Ioanna Palioura and Sarah Smart.

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<sup>1</sup> Ministry of Justice (2013) Gender differences in substance misuse and mental health amongst prisoners, London: Ministry of Justice

<sup>2</sup> Ministry of Justice (2013) Gender differences in substance misuse and mental health amongst prisoners, London: Ministry of Justice

<sup>3</sup> <http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth>

<sup>4</sup> ibid

<sup>5</sup> Ministry of Justice (2017) Safety in custody statistics bulletin, p.4

<sup>6</sup> Ministry of Justice (2017) Safety in Custody statistics: Self-harm annual tables, 2004-2016, England and Wales, table 2.1

<sup>7</sup> Ministry of Justice (2017) Safety in Custody Statistics: Deaths annual tables, 1978 – 2016, Table 1.2: Deaths in

prison custody<sup>1</sup> by apparent cause<sup>2</sup> and gender since 1978, England and Wales

<sup>8</sup> <http://www.prisonreformtrust.org.uk/projectsresearch/mentalhealth>

<sup>9</sup> Lord Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system

<sup>10</sup> Prison Reform Trust, Directors of Adass, Centre for Mental Health Education Policy Institute (2016) Leading change: the role of local authorities in supporting women with multiple needs, p.24

<sup>11</sup> Lord Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, p. 45

<sup>12</sup> Criminal Justice System Statistics publication: CJS Outcomes by Offence 2006 to 2016: Pivot Table Analytical Tool for England and Wales (18 May 2017)

<sup>13</sup> Table A2.1i, Ministry of Justice (2016) Offender management statistics annual tables 2015, London: Ministry of Justice

<sup>14</sup> Commission on Women Offenders (2012) Commission on Women Offenders Final Report: Edinburgh, The Scottish Government

<sup>15</sup> <http://www.re-unite.org.uk/>

<sup>16</sup> Home Office (2007) The Corston report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system

<sup>17</sup> Baroness Corston (2007) A Review of Women with Particular Vulnerabilities in the Criminal Justice System, London: Home Office