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Research Paper

Pathways through the criminal justice system for prisoners with acute and serious mental illness

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ABSTRACT

Purpose: To evaluate pathways through the criminal justice system for 63 prisoners under the care of prison mental health services.
Results: A small number (3%) were acutely mentally ill at prison reception, which may reflect the successful operation of liaison and diversion services at earlier stages in the pathway. However, a third (33%) went onto display acute symptoms at later stages. Cases displaying suicide risk at arrest, with a history of in-patient care, were at increased risk of acute deterioration in the first weeks of imprisonment, with a general absence of health assessments for these cases prior to their imprisonment. Inconsistencies in the transfer of mental health information to health files may result in at-risk cases being overlooked, and a lack of standardisation at the court stage results in difficulties determining onward service provision and outcomes.
Conclusions: Greater consistency in access to pre-prison health services in the criminal justice system is needed, especially for those with preexisting vulnerabilities, and it may have a role in preventing subsequent deterioration. A single system for health information flow across the whole pathway would be beneficial.
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1. Introduction

Research has established that people in the criminal justice system exhibit higher levels of mental disorder than community samples, with increased levels of at-risk mental states amongst prisoners.[9,21,26,36,37] In England and Wales, there has been a dual service approach to the identification and management of these high morbidity levels, through national improvements in prison mental health services[12] and liaison and diversion services[3,25]; Where these liaison and diversion services are provided in courts and police stations, they generally offer fast access to mental health assessments for detainees.[19] Following this initial assessment, they then provide their key functions of *liaison* (e.g. with community, hospital or prison-based services depending on the clinical need) and *diversion* (e.g. by referring onto community based services, or diverting people into a hospital bed). Therefore, these services offer a key care navigation role at the earliest stages of the criminal justice system in order to ensure that alternatives to prison custody for people who are vulnerable, or suffer from mental disorders, are introduced when possible. Yet although there is some evidence that these services can be beneficial,[33] they have historically lacked consistency of funding and delivery[8,27,34] and their role in facilitating desistance remains unclear.[14]

Evaluations of these services have generally reported local improvements where they have been introduced, along with a number of limitations and difficulties within the criminal justice pathway. These barriers to service provision have included: variable service coverage; problems with information flow arising from incompatible systems and differing service demands; limited bed availability; differing organisational cultures; disputes regarding the outcome of assessments and the level of security required; disparity in the identification of medical needs and problems obtaining alternatives to custody.[4,28,29,34] The use of community alternatives for people with mental health problems

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has been particularly problematic, with Mental Health Treatment Requirements being systemically under-utilised.[32] In addition, there have been concerns regarding the identification of mental disorder within the criminal justice system, with a bias towards the use of historical information that can be unreliable or incomplete[1,6] and evidence of serious screening difficulties in police and prison settings.[24,35] Yet despite these limitations, there is good evidence that the use of health professionals can improve the identification of mental disorder during the early stages of the criminal justice system in police custody.[23] However, it is likely that cases are often missed,[24] raising questions about later arrival in prison with unidentified problems and risks, and the extent to which diversion at an earlier point in the criminal justice pathway would have been a preferred outcome for these individuals. Although imprisonment probably does not have a universally detrimental effect on mental health,[38] some groups are more vulnerable than others.[15] In particular, there is a group of prisoners who enter prison with non-acute mental illness, then deteriorate significantly during the early stages of imprisonment.[15] The use of services to better identify and optimally manage this group has yet to be fully explored.

In order to understand these pathways better, this evaluation reviews individual journeys for those on the caseload of a prison mental health service, with a focus on cases displaying acute and serious mental illness in prison. Such mapping exercises have been recommended as one way of understanding clinical pathways through the criminal justice system,[8] but have hardly been taken forward within the existing literature. In implementing this recommendation, this evaluation aims to examine information across a range of criminal justice stages (police, court, prison) for people who have been directly imprisoned from court in order to:

- Identify evidence of symptoms of mental illness across stages of the criminal justice system pathway
- Review access to healthcare services and referrals for diversion at each stage
- Review the accessibility of mental health information across the criminal justice pathway

2. Method

2.1. Design

This service evaluation took place in a Local prison in London, UK. The prison holds a maximum of 1877 prisoners and serves a number of courts in the London area. It has a population that includes a high proportion of remand (44%) and foreign national (37.3%) foreign national prisoners.[17] A cohort method was used to review pathways into the prison's mental health in-reach team, and this team used an open referral system[30] through which all referrals were reviewed by nurse-triage within a maximum of 3-working days.

The project was approved as an evaluation by the relevant body within the local National Health Service Trust.

2.2. Procedure

The evaluation used prison service and prison healthcare records that were already directly available to the mental health in-reach team (including: electronic healthcare records; prison system records such as the core record – also known as the F2050 - and the PNOMIS electronic record system). Demographic, court and offence information were also collected (including age, ethnic category, country of origin, current offence, dates of court and courts attended).

All records were reviewed for any record of mental health concerns or contact with a health professional, as outlined below.

Police station. All detained individuals are screened in police custody using a nationally agreed process during which initial mental health concerns can be identified.[24] A hard copy of the screen and answers is then meant to follow arrestees who are subsequently received into prison custody, with this information then entering the prison file at reception (known as the F2050 file). In addition to any current concerns, historical information is available to the desk sergeants from the Police National Computer (PNC), and this can be used to inform their screening process.

Each detainee in police custody is asked questions regarding their health and risk of harm at the start of their detention. Responses are then recorded on the PNC and may prompt a referral to a clinician (Association of Chief Police Officers, 2006). These questions are as below:

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

If concerns are raised, there is a statutory form in which clinicians should record their contact, including information regarding any concerns and outcomes. These police forms are transferred within the F2050 prison record, but in this evaluation they were not transferred into all health records (within the sample, only 42 cases had an F2050 available for analysis because some prisoners had been transferred or released before researchers could access them, and only 31 of those contained a copy of the original police screening document).

Court. There is no statutory document for recording the content of contacts, or their outcomes, with health professionals or court liaison and diversion services. It is, however, standard practice for liaison and diversion services to contact (or liaise with) relevant services, often providing a short report or letter (particularly when onward referral is required). However, the Prisoner Escort Record (PER) is a mandatory document that is used to communicate information about risks, and it is used at all stages of the criminal justice system when people are being transferred (Prison Service Order 1025, Ministry of Justice, 2009). It is always completed by escort staff, who record any concerns relating to health and safety and provide a log of any movements and contacts (including contacts with professionals such as solicitors and clinicians).

Prison reception. There are two stages to the health assessment provided on entry to prison. During the first night in custody, the mandatory screening tool (known as the F2169A or Grubin tool) is completed by a nurse (Prison Service Order 3050, Ministry of Justice, 2006). This 12-item health screening questionnaire involves a structured clinical interview with the prisoners, and the assessment includes five major sections, outlined below [36] (see Fig. 1):

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