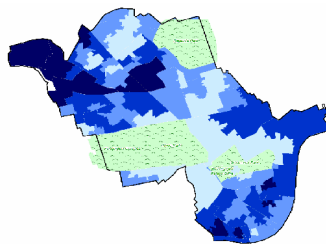


Westminster's
Joint Strategic Needs Assessment

Offender Mental Health

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November 2010



Westminster City Partnership

This document contributes to Westminster's JSNA

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Offender Mental Health and learning disabilities

Joint Strategic Needs Assessment 2010

1. Executive Summary

In April 2009, Lord Bradley reviewed the extent to which offenders with mental health problems or learning disabilities, could in appropriate cases, be diverted from prison to other services and the barriers to such diversion. 'The review highlighted that prison may not always be the most appropriate environment for 'those with severe mental health illness and that custody may exacerbate mental ill health, heighten vulnerability and increase the risk of suicide and self harm.

The population that this joint strategic needs assessment addresses, is the offending population brought into Westminster custody suites. The prevalence of mental health issues amongst offenders brought into three custody suites in Westminster was lower when compared to Psychiatric morbidity data (PMD) amongst prisoners in England and Wales. Low prevalence rates can largely be attributed to the complexities of identifying and diagnosing mental health and learning disabilities within custody suites.

Dual diagnosis and high levels of substance misuse amongst offenders contribute further to mental health issues not being identified appropriately.

The majority of offenders that were brought into the custody suites in Westminster were from other boroughs or out of London. Therefore referrals, treatment and care for offenders with mental health issues was often problematic.

Anecdotal evidence indicated that organisations within Westminster that supported offenders were often disjointed and different services within the pathway were unaware of the roles and responsibilities of each other. Therefore, in line with the Bradley report, identification of mental health and learning disabilities amongst offenders requires early assessment and services within the criminal justice system working in collaboration with each other, to ensure the continuity and care of the offender.

2. Introduction

Adults that are socially excluded and in contact with the criminal justice system experience greater health inequalities and are more likely to suffer from mental health issues, learning disabilities and issues relating to alcohol or substance misuse than the general population (DOH, 2009). Many offenders have significant mental health and physical health problems, some are diagnosed prior to serving a custodial sentence, however, others have serious conditions that remain undiagnosed. Such issues can be further exacerbated by imprisonment.

Studies have indicated that the physical health of prisoners is disproportionately worse than the general population. This is particularly apparent amongst female prisoners (Social exclusion, 2002). Therefore, the criminal justice system often provides the first point of contact for offenders to access healthcare in particular treatment and care for mental health issues.

Lord Bradley's report April 2009 reviewed the extent to which offenders with mental health issues or learning disabilities could be diverted from prison to other services and what the barriers to diversion were. The report highlights the diversity of individuals that offend and the high volume that are suffering from mental health issues or learning disabilities. As a result of the Bradley report, the issues highlighted above were looked at locally. The following joint strategic needs assessment considers mental health and learning disabilities amongst offenders, incorporating a two strand approach for the period January 2009 – June 2009. 1) Offenders arrested in Westminster and brought into the following custody suites, Belgravia, Paddington Green and Charing Cross. 2) Offenders providing a Westminster postcode upon discharge having served a custodial sentence or receiving a community order.

The needs assessment aims to describe current pathways of assessment, identification, treatment and care of offenders with mental health issues and learning disabilities at different points in the offender pathway, identify gaps and unmet needs and make recommendations accordingly.

Specifically this needs assessment will:

- Describe the offender pathway from the point of arrest, to prosecution, reception to prison and court diversion.

- Estimate the prevalence of mental health and learning disabilities amongst offenders arrested and brought into custody in Belgravia, Charing Cross and Paddington Green.
- Estimate the prevalence of mental health and learning disabilities amongst offenders providing a Westminster postcode upon discharge, having served a custodial sentence or receiving a community order.
- Identify at which points mental health issues are being identified within the offender pathway and possible areas where diagnosis is being missed.
- To gain a better understanding of service provision for offenders with mental health issues once released.

3. Westminster and its Population

Key messages:

- **An estimated 249,400 people live in Westminster, whilst approximately 244,700 are registered with Westminster GP practices.**
- **Westminster has a younger population structure than in most other parts of the country, with men and women aged 25-39 accounting for the largest proportion of the population.**
- **Westminster has an ethnically diverse population, an estimated 29% of the population are from Black Minority Ethnic (BME) groups.**
- **Westminster has a significant influx of both workers and visitors approximately 750,000 each day increasing the population.**

3.1 Overview of the population in Westminster

According to the mid year population estimates 249,400 people are thought to live in Westminster (Office of National Statistics, 2009).

The population of Westminster, has a higher proportion of men and women in the younger age groups, between the ages of 25-39.

Westminster is ethnically diverse, it is estimated that 29% of the population belong to Black and Minority groups (BME), it is estimated that 52% of the population is born outside of the UK, the highest percentage in the country; and only 65% have British nationality, the lowest proportion in London (NHS Westminster, 2009).

According to the Index of Multiple Deprivation (IMD) 2007, Westminster is ranked as the 72nd most deprived local authority out of 324 local authorities in England. Variations in the levels of deprivation in Westminster are complex, often areas of affluence are adjacent to areas of deprivation.

3.2 Offending in Westminster

In Westminster, the transient nature of the population, the demography, high levels of homelessness, increased mental health and substance misuse, are all contributing factors to a large proportion of people offending within the borough. In 2009/2010 there were 300,201 arrests made by the Metropolitan police in London, this ranged from 3,601 in Richmond upon Thames to 24, 794 in Westminster (Profile report on police detainees and Offenders in London, 2010).

Since April 2008, overall crime has reduced, however, robbery, vehicle crime and racially and religiously aggravated crimes have all risen. It is thought that the influx of visitors to Westminster per day has inflated the number of offenders within the borough (HMIC, inspection 2008).

In January- June 2009, 11, 324 offenders were brought into custody suites, situated in Westminster. Of this, the proportion of offenders that provided a Westminster postcode during assessment was 15%, 30% of offenders did not provide a postcode and the remaining 45% were non residents. The cost implications and the burden upon services within the borough are immense, particularly as the majority of people that offend in Westminster are non residents.

4. Policy Context

Prior to the Bradley Report 2009, a number of reviews and policy documents were published and recommendations made to try and reduce the high prevalence of mental health and learning disabilities amongst the prison population.

In 1990, Home office circular (66/90), was released highlighting the need for effective inter- agency work, to encourage the delivery of care and treatment for offenders with mental health problems by health and social services as opposed to being addressed by the criminal justice system.

Following on from this in 1992 the **Reed review of health and social services for mentally disordered offenders** was published. The review of health and social services for mentally disordered offenders recommended there should be local agreements between the police and health, social and probation services for the assessment of people who appear to be mentally disordered. The review recommended the implementation of the nationwide provision of properly resourced court assessment and diversion schemes to support this. As a result of the review expansion of court diversion and home office guidance were implemented.

In 1996 the Home Office produced Patient or Prisoner which highlighted the urgent need for the increased provision for mental health care amongst the prison population. The report concluded that the NHS should assume responsibility for the delivery of all healthcare in the hope that this would allow consistency of delivery to everyone in the community.

The future organisation of prison healthcare, 1999, produced by the Department of Health considered the recommendation from *Patient or Prisoner* that the responsibility for providing healthcare to prisoners should be moved from the Prison service to the NHS. The aim for prison healthcare was 'to give prisoners access to the same quality and range of healthcare services as the general public receives from the National Health service.' This document was the catalyst for the process of transferring budgeting and commissioning responsibility for health services from the prison service to the NHS, completed in 2006.

'Reducing re- offending by ex- prisoners' was considered in the **Social Exclusion Unit report 2002** established the link between offending, re-offending

and other wider determinants. The report identified nine key factors that influence offending and re-offending, namely; education, employment, drug and alcohol misuse, mental and physical health, attitudes and self-control, institutionalisation and life skills, housing, financial support and debt and family networks. Recommendations to address these issues included a cross government approach to implement a national rehabilitation strategy.

April 2006 Transfer of responsibility for health services.

2006 Five year strategy for protecting the public and reducing reoffending, this strategy set out the public protection agenda and emphasised that prison was not the only way to punish offenders and keep the public safe.

2007, Mental Health Act. The 2007 act amended the definitions of the term mental disorder from the 1983 Mental Health Act. The definition of mental disorder in the 1983 Act was revised from “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind” to “any disorder or disability of the mind” and is therefore more inclusive of all mental disorders. The act established personality disorder as a mental health condition requiring appropriate assessment and treatment.

Issues surrounding learning disabilities were also amended. Revisions of the 1983 Act indicate that ‘a person may not be considered to be suffering from a mental disorder simply as a result of having a learning disability, unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.’

In April 2009, the Bradley Report was published. This review examined the extent to which offenders with mental health issues or learning disabilities could be diverted from prison to other services. The report made a number of recommendations including the establishment of criminal justice mental health teams to promote assessment and early identification of mental health issues. It is hoped that more offenders be treated in the community, to ensure that individuals in prison receive targeted, effective care whilst serving a custodial.

December 2009, New Horizons; a shared vision for mental health, aimed to improve the mental health and well being of the population and improve the accessibility of services for people with poor mental health by a cross government approach. Key themes that were addressed within the document consisted of prevention of mental ill health and promoting mental health, early intervention, tackling stigma, strengthening transitions, personalised care and innovation.

5. What is the issue and why is it important?

5.1 Mental Health

The World Health Organisation defines mental health as 'a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.' (WHO, 2009). As such, mental health is greater than just the absence of mental illness, but includes the notions of positive self esteem, coping mechanisms and the importance of empowerment and control.

1 in 6 adults will have a mental health issue at any one time; over half of all adults will have developed a mental health issue by the age of 14, for many if left undiagnosed mental health issues can last for a number of years (New Horizons, 2009). Mental health encompasses a broad spectrum of conditions that range in severity from common mental health issues e.g. depressive episode, mixed anxiety and depressive episode, phobias, panic disorder, generalised anxiety disorder and obsessive compulsive disorders, to more severe mental health issues e.g. psychotic disorders such as schizophrenia or personality disorder. The diagnostic categories of mental health are described in the International classification of disease version 10 (WHO, 2007), see appendix.

5.2 Learning Disabilities

Limited data is available about the number of offenders with learning disabilities, largely due to the complexities of screening and diagnosis within the criminal justice system. It is estimated that 0.46% of the adult population are known users of learning disabilities services, in England (Healthcare commission, 2007). It is thought that amongst the offending population between 20- 30% of offenders have learning disabilities that affect their ability to cope with the criminal justice system (Prison reform trust 2007)

5.3 Definitions

Offenders with mental health needs are often referred to as 'mentally disordered offenders', however, definitions surrounding this remain inconclusive and clarity is still required as to whether this encompasses a direct link between the offending behaviour and the mental disorder (Nacro, 2007). Therefore the following definitions

are used throughout this document in line with the Bradley report 2009 and Nacro 2007.

Mental Health need; includes offenders without a formal mental health diagnosis and covers a wide range of conditions, from those that do not meet the criteria for admission under the mental health act 1983 (now 2007) to a disorder serious enough to warrant detention under the act.

Offender; includes all offenders who commit either minor or serious offences regardless of whether offending is related to their mental health need.

Offenders with mental health problems defined as; 'Those that come into contact with the criminal justice system because they have committed, or are suspected of committing a criminal offence, and who may be acutely or chronically mentally ill. It also includes those in whom a degree of mental disturbance is recognised, even though it may not be severe enough to bring it within the criteria laid down by the Mental Health Act, 1983 (now, 2007).

Learning Disabilities; In line with the Bradley report when referring to learning disabilities, learning difficulties (which in this instance include dyslexia and autistic spectrum disorders) are also incorporated. Learning disabilities are defined within the report as' a significantly reduced ability to understand new or complex information, to learn new skills with; a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development.

6. Mental Health, offending and re offending

Whilst discussing interventions the Bradley report highlighted safeguarding the public as a key priority. Offering offenders the opportunity to address not only their behaviour but also to look at the contributing factors to re-offending. The following contributing factors have been linked to offending and reoffending; education, employment, alcohol and substance misuse, mental and physical health, attitudes and self control, institutional and life skills, housing, financial support and debt and family networks (Social Exclusion, 2002). Compared with the general population prisoners are thirteen times more likely to have been in care, thirteen times more likely to be unemployed, 10 times more likely to have been a regular truant and two and a half times more likely to have had a family member convicted of a criminal offence.

As mentioned, mental health issues are a significant risk factor to offending. Psychiatric morbidity data presented in Table 1 amongst prisoners in England and Wales, (Singleton *et al*, 1998) indicates those that offend have higher rates of mental health issues than the general population.

Table 1: Prevalence of mental health issues amongst remand and sentenced offenders and the general population.

Mental Health issue	General population		Remand population		Sentenced population	
	Male	Female	Male	Female	Male	Female
Personality disorder	Borderline 0.3%	Borderline 0.6%	Overall 78%	Overall 64%	Overall 50%	
	Antisocial 0.6%	Antisocial 0.1%	Antisocial 28%		Antisocial 30%	
Psychotic and affective disorders	0.3%	0.5%	10%	7%	14%	
Neurotic disorders	12.5%	19.7%	59%	76%	40%	63%

Source: Office for National statistics, Psychiatric Morbidity Data among prisoners in England and Wales, 1998.

Common mental health problems and severe mental health problems in Table 1 are higher amongst remand and sentenced, male and female offenders in comparison to the general population. The prevalence of antisocial personality disorder in male remand offenders is significantly higher in comparison to the prevalence of antisocial personality disorder amongst the general male population. This is expected as antisocial personality disorder requires the presence of antisocial behaviour before the age of 15 years, which persists into adulthood (PMD, 1998).

The prevalence of neurotic disorders amongst female offenders in both remand and sentenced populations was significantly higher in comparison to females in the general population. Prevalence was also higher in comparison to male counterparts, generally women were more likely to report neurotic symptoms.

In Westminster, data regarding mental health and learning disabilities for remand and sentenced offenders providing a Westminster postcode was unavailable. Therefore, the findings are based upon data from risk assessment completed by the custody officer once offenders have been brought into the three custody suite situated in Westminster.

The prevalence of mental ill health amongst offenders that stated during self assessment that they were suffering from mental health issues and the custody officer agreed was 5.4%. There were no recorded diagnoses of personality disorder, neurotic disorders or psychotic disorders. Although affective disorders were recorded, recording was sporadic. Determining a true picture of the prevalence of personality disorder, neurotic, psychotic and affective disorders remains challenging within this population.

7. Overview of the Criminal Justice system in Westminster

The criminal justice system often referred to as the offender pathway, is complex for a number of reasons. Offenders may enter the pathway at various points, services are often provided by different organisations and the role of the differing organisations remains unclear. This results in confusion over responsibility and duplication of services. Offenders may also offend in one geographical area, however, serve a custodial sentence in another. As a result of this it is challenging to map out a clear pathway for the offender, for the purpose of this needs assessment and in line with the Bradley report the pathway has been divided into the following stages:

- Early intervention, arrest and prosecution
- The Court Process
- Prison, community sentences and resettlement

Figure 1: Overview of the offender pathway

7.1 Description of the Offender Pathway

Once an individual is arrested and taken into police custody an initial risk assessment is completed. This consists of two parts; a self assessment and an assessment completed by the custody officer. This provides information regarding previous suicide attempts, suicidal ideation, substance misuse issues and whether the individual requires help with reading or writing. Also recorded at this point is whether the offender requires an appropriate adult. Data collated provided information regarding characteristics of the offending population e.g. gender, ethnic appearance and age range. The prevalence of mental health amongst offenders that reported that they had mental health issues and had received treatment was determined from data correlating to this risk assessment.

Once the initial risk assessment is completed a custody healthcare assessment plan is completed by a custody nurse. In the absence of a custody nurse this is done by a forensic medical examiner (FME). This risk assessment provides details regarding physical health, mental health, whether the offender has taken any drugs in the past month, history of self harm or suicidal ideation, at this point the offender can request to see a doctor. The offender can then follow one of two pathways depending upon the outcome of the risk assessment, 1) if a mental health issue is suspected, referral

to the police liaison nurse for an assessment, in the absence of a police liaison nurse, the police sergeant can contact the local community mental health team for an assessment.

The possible outcomes following on from the police liaison assessment are; no further action, referral to local services for follow up, admission to hospital, which can entail the offender consenting to admission or being admitted under a civil section. The other outcome is remand to custody, if the police liaison nurse highlights a mental health issue they can refer to the court diversion team.

If charged the offender is seen by the crown prosecution service and prosecuted. If the offender is not prosecuted the following can occur; no further action, released on bail, or given a formal warning and released. A brief risk assessment is provided on release, signposting to other services.

7.2 Prosecution onwards

Prosecution leads to the first hearing at the magistrates court the outcomes from this hearing include remand to bail, remand to hospital or remand to custody. If remanded on bail, options include conditional or unconditional bail. The offender then appears at either the Magistrates or Crown court at a later date. As mentioned, an offender can then be remanded to hospital under section 35 or remanded to custody, if a mental issue has been identified the offender can be referred to the court diversion team.

If an offender is remanded to custody and no mental health issue is identified the following can occur; appears before the magistrates' court or the crown court and found guilty or not guilty. If found guilty, the pathway involves other sentence or fine, custody or a community order.

If the offender is found guilty, they either serve a custodial or a community order is issued.

If serving a custodial, the pathway for the offender is reception to prison. Screening and assessment is completed at this point; depending upon the health needs of the offender the following services exist; primary care mental health services, mental

health in reach services, substance misuse services and if the offender is suffering from a mental illness they could potentially be transferred to hospital.

If the offender serves a custodial of more than 12 months, probation are responsible for managing the case upon release into the community, in most cases the offender is on licence. If an offender serves a custodial of less than 12 months, they are discharged into the community with no supervision under probation or any other agency.

7.3 The role of the Crown Prosecution service

The crown prosecution service plays a pivotal role in diverting offenders with mental health issues or learning disabilities from prosecution (Bradley, 2009). The code for crown prosecutors emphasises a prosecution for an offender with significant mental health issues may not always be appropriate, unless it is in the public interest. In this instance, information regarding the offender's condition and the availability of suitable alternatives to prosecution require consideration (CPS, 2010).

7.4 Information for the court

(i) Pre sentence court reports and Psychiatric reports.

Pre sentence reports (PSR) are prepared by probation and are requested before reaching a decision on the best way to deal with the defendant. In a large number of cases the offender will arrive at court with no further information regarding their mental health issues or learning disabilities. If no diversion or liaison services are available it can fall to probation staff to recognise potential signs of a mental health issue.

Requests for psychiatric reports as part of the PSR are usually made by the Court or the Probation officer. The report entails an assessment of the individual to decide their level of fitness to plead and their fitness to take responsibility for their actions, until reports are produced generally offenders are remanded to prison.

In Westminster, lack of information exists surrounding the amount that is currently being spent on psychiatric court reports.

7.5 Police responsibilities under the Mental Health Act

If an individual is suspected of having a mental health issue the police have a number of operational policies that can be used if immediate care or control of a situation is required. Under the mental health act, the police can use Section 135 or Section 136 (Sainsbury, 2008)

Section 135

Section 135 of the Mental Health Act 2007, allows for a warrant to be issued in order to assess a person known to have a mental health disorder on private premises.

Section 136

Section 136 of the Mental Health Act 1983, allows the police to remove an individual suffering from a mental disorder from a public place to a place of safety. The Bradley Report recommended that partner organisations involved in the use of Section 136 of the mental health act should work together to develop an agreed protocol on its use. In Westminster a joint policy document exists between CNWL, Westminster City Council social and community services department and the Metropolitan police service based at north, south and central. The document states clearly the assessment process under Section 136, and an acceptable timeframe for the doctor to examine the person.

7.6 Provision of healthcare in Custody

Police and Criminal Evidence Act (PACE) 1984, sets out codes of practice regarding the physical health and mental health needs of offenders whilst detained in police custody. Offenders can often present with a multitude of complex needs therefore appropriate risk assessment and access to medical treatment is fundamental to risk management and the prevention of deaths whilst in custody (Bradley, 2009).

Health services in Westminster custody suites commissioned by the metropolitan police include the following services;

- Forensic Medical examiners (FME)
- Custody nurses
- Borough mental health liaison officers
- Police Liaison nurses, provided by Central and North West London NHS foundation trust.

Although each custody suite serves specific geographical areas, other factors such as available space are taken into consideration when determining which custody suite an offender is taken to.

7.7 Police Custody

Seven police stations exist within the borough of Westminster. These include Paddington Green, West End Central, Marylebone, Charing Cross, Harrow Road and St Johns Wood. Custody suites that are in operation all the time are Paddington Green, Charing Cross and Belgravia. Marylebone and Harrow Road are both used for particular operations.

Figure 2: Highlights the geographical areas covered by each custody suite within Westminster.



Table 2: Overview of the custody suites in Westminster

Custody Suite	Description	Staff
Charing Cross	<p>Consists of forty five cells.</p> <p>Geographical areas covered include: Oxford Street, Leicester Square, Piccadilly and Regent Street.</p>	<p>Four custody police sergeants.</p> <p>Five designated detention officers.</p> <p>Four nurses and One custody nurse manager.</p> <p>Three police liaison officers cover this custody suite.</p>
Belgravia	<p>Consists of sixteen cells.</p> <p>Geographical areas covered include: Buckingham palace, Victoria coach and train stations, Parliament, Hyde Park and Trafalgar square.</p>	<p>Two custody police sergeants.</p> <p>Three designated detention officers.</p> <p>Six nurses</p> <p>One custody nurse manager</p> <p>Three police liaison officers cover this custody suite.</p>
Paddington Green	<p>Consists of sixteen cells.</p> <p>Paddington Green, serves as the most important high security police station in the UK largely because prisoners suspected of terrorism are questioned there.</p> <p>Geographical areas covered by Paddington Green custody suite include, the Paddington area, North Westminster and Regents Park area.</p>	<p>Two police custody sergeants. Three police liaison nurses cover this custody suite.</p>

8. Screening and risk assessment

The following section describes the roles and responsibilities of staff once an offender has been taken into custody.

8.1 Roles and responsibilities of staff

(i) Custody officer

Upon initial entry to the custody suite the custody officer listens to evidence from the arresting sergeant and authorises the detention of the offender and ensures they are cared for in line with the Police and Evidence Act (PACE) 1984. Custody officers give the offender their rights and entitlements and are also required to complete a risk assessment around the detained individual, this is a structured assessment consisting of self assessment and a custody officer assessment. Once this risk assessment is completed a further assessment is completed by the custody nurse.

(ii) Designated Detention officers (DDO)

Initially employed as gaolers (in charge of prisoners) however, recently this has been adapted to incorporate a number of roles, including inputting data into the custody system. With the introduction of virtual courts the DDO's facilitate, assisting prisoners to fill out forms, sit in at court and complete any relevant paperwork.

(iii) Custody Nurse Practitioners

A further risk assessment is then completed by custody nurses, which consists of a healthcare assessment. This involves assessing physical health, substance misuse issues, and a brief section on mental health, incorporating questions on whether the offender has received treatment for a mental health issue, and whether they have spent any time in a mental health hospital, or ever been placed on a section. Currently, offenders within custody are not being screened for learning disabilities. The role of the custody nurse involves treating any physical health issues that the offender may present with.

(iv) Police liaison Nurses

Currently three police liaison nurses cover Belgravia, Charing Cross and Paddington. If a mental health issue has been highlighted by the custody nurse, the offender can be referred to and assessed by police liaison mental health nurses. Therefore close links between the two are essential. Police liaison nurses are then able to advise on appropriate diversion.

If a mental health issue is highlighted through the custody health care assessment, the custody officer contacts a forensic medical examiner (FME) or an appropriate adult from the local community mental health team. If no appropriate adult is available the offender may be detained.

(v) Appropriate adult

The role of the appropriate adult remains important with regards to offenders that are deemed vulnerable, if levels of distress are high or communication issues are evident. The role is generally fulfilled by any one of the following; a mental health professional, family member or a social worker, Westminster also has a volunteer scheme provided by Westminster City Council. If the offender is identified as being vulnerable and is to be interviewed access to an appropriate adult is crucial.

(vi) Forensic Medical Examiner (FME)

FMEs provide medical expertise, prescribe medication to offenders within police custody suites and determine whether the offender is fit to be detained and interviewed.

FMEs currently have no specialist mental health training and no formal risk assessment is used to identify mental health issues. Laing (1996) examined the role of the FME in identifying and assessing mentally disordered suspects in police custody, the study suggested that the quality of assessments and examinations provided to offenders with mental health issues could be improved considerably. Although this view is reiterated in the Bradley report, the role of the FME is diminishing with the introduction of the custody nurse.

9. Early Intervention: Arrest and Police custody

Key Facts

- **Total number of offenders brought into Paddington, Belgravia and Charing Cross from January- June 2009 was 11 324.**
- **Of this, 21% appeared drunk or under the influence.**
- **8.2% tested positive for cocaine/ opiates/ both.**
- **Prevalence of mental health amongst offenders that stated during self assessment that they were suffering from mental health issues and the custody officer agreed during their assessment was 5.4%.**
- **Prevalence of dual diagnosis was 0.96%.**
- **11% of offenders required an interpreter.**
- **16% provided a Westminster postcode during assessment.**
- **5.6% of offender stated during self assessment that they needed help with reading or writing.**
- **1.07% of offenders that were examined by an FME for a mental health issue.**

As mentioned previously, if an offender is suspected of having a mental health issue that warrants a section the police officer can issue a Section 136. If the offender is arrested, and no physical injuries are present, they are then taken into the police custody suite. The custody officer completes a risk assessment, following on from this a further assessment is completed by the custody nurse.

Figure 3: The offender pathway from post arrest to assessment within the custody suites.

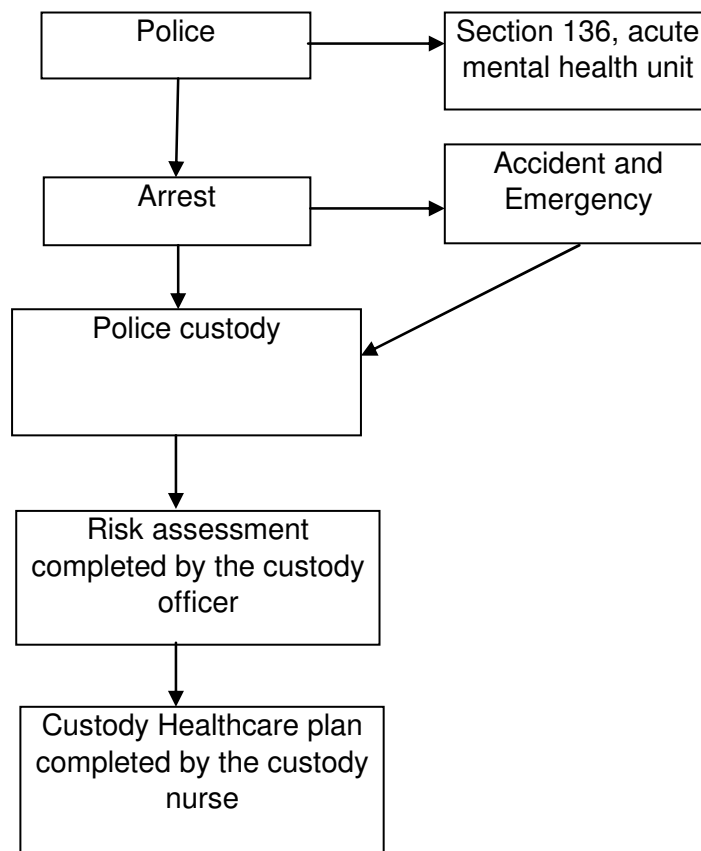


Table 3; Number of offenders brought into custody suites from January-June 2009.

Custody suite	Total custody numbers for January-June 2009
Belgravia	2832
Charing Cross	5747
Paddington	2745
Total	11324

10. Characteristics of offenders brought into custody suites

The characteristics of the offending population focuses on data obtained from the risk assessment completed by custody officers within Charing Cross, Belgravia and Paddington. Although Section 136¹, has been included on the offender pathway, limited available data meant that it was challenging to determine an accurate number of people being sectioned under 136 and therefore the number of offenders that were suffering from a mental health issue.

Psychiatric Morbidity data (PMD) among prisoners in England and Wales 1998, completed by the office of national statistics (ONS) collated baseline information on mental health amongst male and female remand and sentenced prisoners. Collating data for these populations in Westminster was problematic largely due to a number of factors; the range and availability of data sources, the varying methods of categorising and recording mental health and learning disabilities and offenders serving custodial sentences outside of the borough that they offend in, therefore PMD was used as a baseline for comparison.

¹ Section 136 defined under Police responsibilities, Mental Health Act (section 7.5)

(i) Gender

The proportion of male offenders arrested and brought into Charing Cross, Belgravia and Paddington between January 2009- June 2009 was 84%, the proportion of female offenders was 16%. The Ministry of Justice figures for England and Wales 2008, indicated that 77% of all sentenced offenders were male. Although a large proportion of offenders brought into Westminster custody suite will not be sentenced, statistics indicate that men account for the majority of the prison population.

Across all three custody suites the proportion of male offenders was generally consistent. However, the proportion of female offenders brought into Charing Cross custody suite was slightly higher, (17%) in comparison to Belgravia (13%) and Paddington (15%). It is difficult to ascertain why this might be without further information regarding offences.

(ii) Ethnic appearance

Ethnicity with the Metropolitan Police is recorded in two ways; ethnic appearance and self defined ethnicity². The available ethnicity data for the needs assessment was derived from IC codes, terms used by the police to describe the ethnic appearance of an offender. The codes are based upon the arresting police officers perception of the offenders ethnicity as opposed to self defined ethnicity.

Figure 2. Represents the proportion of offenders according to ethnic appearance. The highest proportion of offenders in the three custody suites described themselves as North European- White, (40%), followed by 24% described as Black. The lowest proportion of offenders (3%) were described as Chinese, Japanese or South East Asian and 2% described as other.

² Self defined ethnicity (where the individual defines their own ethnicity is based upon 16 descriptions) is now used alongside the IC codes, following recommendation 16 from the Stephen Lawrence enquiry. The gradual role out of this within London commenced in October 2004. (Ministry of Justice, 2009. London Borough Profile Report, National Offender Management Service).

Figure 4: Proportion of offenders according to ethnicity in Belgravia, Paddington and Charing Cross, January 2009- June 2009.

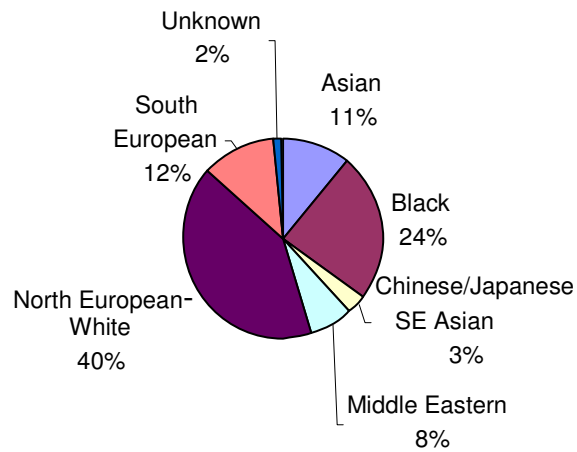
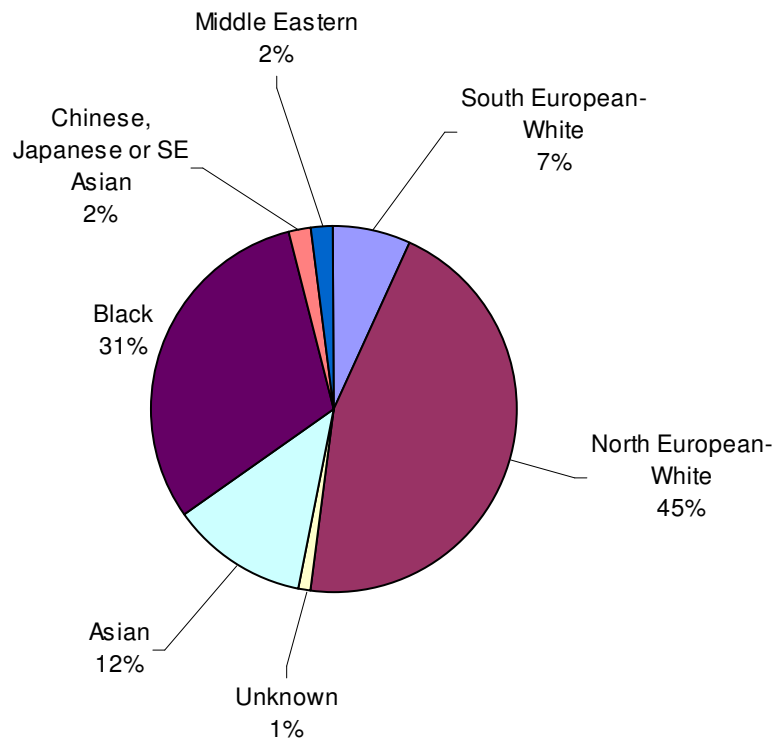


Figure 5: All arrests in London 2009/2010 by ethnic appearance

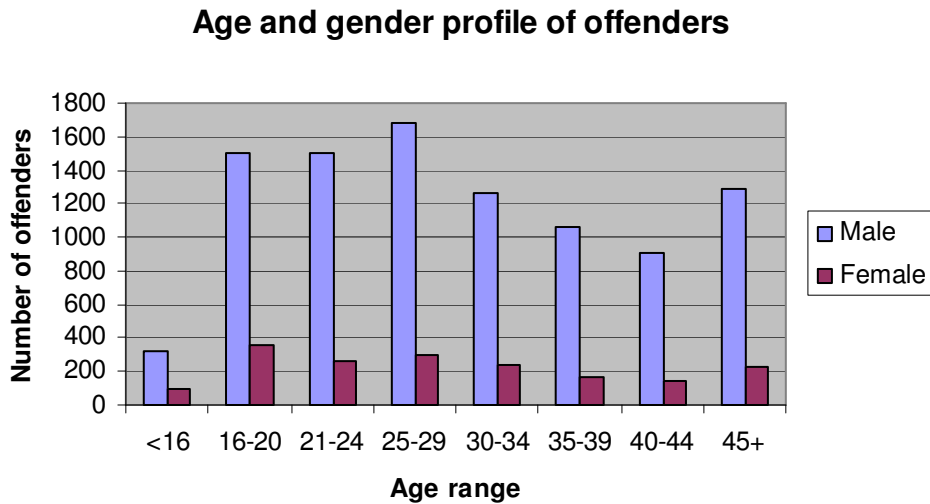


Psychiatric morbidity data (PMD) estimated that 80% of male remand prisoners were White and 13% classified as Black. PMD estimated that 77% of female remand prisoners described themselves as White and 23% described themselves as Black. In comparison, 42% of female offenders in the three custody suites were classified as North European White and 27% were described as Black.

The ethnicity of the offending population in Westminster custody suites (Figure 4) is reflective of the ethnicity of all arrests in London (Figure 5). However, increases are noted amongst the Middle Eastern offending population in Westminster in comparison to the London offending population, this could be attributed to larger numbers of Middle Eastern

(iii) Age and gender profile

Figure 6. Number of offenders according to age and gender arrested and brought into Charing Cross, Belgravia and Paddington,



PMD amongst prisoners indicated that 25% of male remand prisoners were aged 16-20 and approximately 66% were under the age of 30 years. The age distribution was similar in male sentenced prisoners, however, a smaller proportion of 16-20 year olds (16%) were sentenced. The age gender distribution for offenders in Charing Cross, Belgravia and Paddington, indicated that 15.7% of male offenders were aged 16-20 and 49% were under the age of 30. When looking at postcodes provided by offenders the majority are not Westminster residents, indicating that younger people, particularly younger men are travelling into the borough to offend.

PMD amongst prisoners indicated that the age distribution for female remand prisoners was similar to that of male sentenced prisoners, however a higher proportion of sentenced women (50%) were under the age of 30. The age gender distribution for Charing Cross, Belgravia and Paddington indicated that 21% of female offenders were aged between 16-20 and 54% were under the age of 30.

Comparing the age gender profiles, it is evident that a greater number of male offenders were aged between 25-29, peaks were also noted in the younger age ranges. Comparatively, the number of female offenders within each age bracket appear to be generally consistent, with a slight increase noted within the 16-20 age range.

(iv) Borough Profile

Across all three custody suites, the proportion of offenders providing a Westminster postcode was 15%, 85% of those that offended were from out of the borough, out of London, had no fixed abode or postcode was unknown. This is consistent with the transient nature of the population of Westminster and the significant homeless population.

Table 4: Number and proportion of offenders by borough brought into Belgravia Custody suite according to postcode.

Postcode	Number	Proportion
Westminster	417	15%
Southwark	127	4%
Lambeth	148	5%
Other London boroughs	583	21%
Out of London	648	23%
No fixed abode/unknown	909	32%

Table 2 indicates that the greatest proportion of offenders either had no fixed address or a postcode was not recorded, this accounts for 32% of the total population of offenders brought into Belgravia custody suite. This could be due to a higher number of homeless people in the South of the borough.

Table 5: Number and proportion of offenders by borough, brought into Paddington Custody suite.

Borough	Number	Proportion
Westminster	950	35%
Southwark	44	2%
Lambeth	45	2%
Other London boroughs	563	21%
Out of London	391	14%
No fixed abode/unknown	752	26%

The greatest proportion of offenders, (Table 3) brought into Paddington custody suite provided a Westminster postcode. A lower proportion of offenders provided no postcode, consistent with the smaller numbers of street sleepers in the North of the borough.

Table 6: Number and proportion of offenders by postcode, brought into Charing Cross custody suite.

Borough	Number	Proportion
Westminster	443	8%
Southwark	244	4%
Lambeth	267	5%
Other London boroughs	2043	36%
Out of London	986	17%
No fixed abode/unknown	1764	30%

Table 4 indicates only 8% of offenders arrested and brought into the Charing Cross custody suite provided a Westminster postcode, the majority of people brought into Charing Cross were from other London boroughs. This could largely be attributed, to people travelling into the central location and Charing Cross at the centre of London night life.

11. Identified health needs

Key Messages:

- **Prevalence of self harm in all three custody suites was greater in comparison to rates for attempted suicide and suicidal feelings**
- **Prevalence rates of self harm were greater amongst female offenders than male offenders.**

Health needs of the offending population were identified from the self assessment completed by the custody officer, once the offender had been brought into the custody suite. Information was collected surrounding self harm, attempted suicide and suicidal feelings.

Self harm data from Psychiatric morbidity data (PMD) incorporates suicidal ideation, suicide attempts and parasuicide. Prevalence amongst male and female remand and sentenced prisoners was based upon suicidal thoughts and attempts within the past week, past year and lifetime. For the purpose of this needs assessment, data was compared with lifetime prevalence data, as self assessment within Charing Cross, Belgravia and Paddington Green custody suites does not differentiate between time periods.

The prevalence rates were determined by data obtained from the offender responding yes/no to the following questions.

Have you ever tried to harm yourself?

Have you ever attempted to commit suicide?

Do you have any such feelings now?

Table 7: Overall prevalence of attempted suicide, self harm and suicidal feelings in all three custody suites.

Mental health issue	Prevalence rates in all three custody suites
Attempted suicide	5.8%
Self Harm	7.3%
Suicidal feelings	1.5%

Prevalence of self harm were higher, when compared to prevalence rates for attempted suicide and suicidal feelings considerable links have been made between personality disorder and self harm. This will be discussed further in section 13.

Table 8. Prevalence of mental health amongst offenders in all three custody suites in comparison to PMD amongst remand and sentenced offenders and the general population

Mental Health issue	General Population ¹		Custody Suites		Remand Population		Sentenced Population	
	Male	Female	Male	Female	Male	Female	Male	Female
Attempted suicide	3.7%	5.8%	5.0%	10.2%	27%	44%	20%	37%
Self harm	3.4%	3.5%	6.3%	11.6%	5%	7%	10%	9%
Suicidal feelings/thoughts	12%	15.4%	1.3%	2.4%	46%	59%	37%	52%

¹ Adult Psychiatric morbidity in England, 2007. Household survey.

As indicated in table 8 the prevalence of attempted suicide and self harm, amongst female offenders in custody suites, on remand and sentenced, was greater than the prevalence amongst females in the general population. Prevalence rates for suicidal feelings/ thoughts in both the general population and the remand and sentenced population were based upon whether the individual had ever experienced feelings over their lifetime, however, when the question was posed in the custody suite it related to the present moment. This may account for the seemingly lower rates in custody suites.

Prevalence rates for attempted suicide, suicide feelings and self harm were also higher amongst the general female population and amongst female remand and sentenced offenders in comparison to their male counterparts. Higher rates amongst female offenders could be attributed to the following; women entering the criminal justice system often suffer separation from children, resulting in higher levels of distress and disruption to families, female offenders are also more likely than men to be victims of domestic and sexual violence and experience high levels of substance misuse.

12. Limitations

The Bradley report highlighted possible areas of inaccuracy regarding the risk assessment completed in police custody to identify mental health issues and learning disabilities. These included, lack of training for police surrounding mental health, the lack of recourse to advice or guidance and the high number of detainees coming into custody under the influence of alcohol or substances.

In Westminster, the following were raised during two focus groups which included custody officers and designated detention officers covering Charing Cross, Belgravia and Paddington custody suites, participants stated; that they generally felt supported when trying to source guidance regarding mental health.

It was felt that the risk assessment relied on how much information the offender was willing to provide. This was often not that useful if the offender was under the influence of alcohol or drugs as it was difficult to identify if they were suffering from a mental health issue.

The purpose of healthcare assessment completed by the custody nurse is to identify physical health issues and to determine whether the offender is fit to be detained, the assessment incorporates a brief section on mental health which relies upon self reporting. However, the healthcare assessment, provides an opportunity for a wider health function, further screening questions could also be incorporated within to identify mental health and learning disabilities.

Mental health issues commonly seen were schizophrenia, depression and anxiety, however, it was felt just being in custody would contribute significantly to anxiety levels.

Training, surrounding mental health issues and learning disabilities was highlighted in the focus groups as being sporadic and inconsistent and remained unclear on terms such as dual diagnosis and personality disorder. Recent updates (October 2010) indicate that the Metropolitan police no longer receive mental health training

A possible route for identification of mental health issues is through court diversion, however, the court diversion team only see offenders that are remanded. Therefore opportunities to identify mental health or learning disabilities amongst offenders that are on bail are limited.

To surmise, diagnosis within police custody remains challenging, for a number of reasons;

- Information regarding mental health issues or learning disabilities relies on self reporting. If the offender does not disclose information or is not aware that they have a mental health issue or learning disability it may go unnoticed at the risk assessment stages, particularly if the offender is under the influence of drugs or alcohol;
- Offenders are often aware of the criminal justice system and therefore do not disclose mental health issues as they may have to spend longer in custody or an appropriate adult may be needed to be contacted, again resulting in the offender being detained for longer periods.
- Often mental health issues amongst offenders are recognised however, rarely reach the threshold that warrant the recommendation for a section. Depending upon the offence, if the offender is released without being charged and is signposted to services, no follow up exists, the circumstances of the offender may also not warrant this;
- The initial priority once an offender has been brought into police custody is to ensure that the offender is not a risk to themselves. If no obvious signs and symptoms of mental health are apparent, the police national computer does not indicate that the offender has any record of mental health issues and the

offender is not known to services then it is unlikely that a mental health issue would be identified.

Recommendation

- Improved screening surrounding the identification of individuals with learning disabilities. The feasibility of screening for learning disabilities within custody suites remains questionable, due to the length of assessment and the lack of appropriate professionals within custody to use specific tools.
- Evaluation of the risk assessment used in police custody in order to improve the identification of mental health issues.
- The role of the custody nurse to be broadened, the healthcare assessment currently being used to incorporate further screening questions to identify mental health and learning disabilities.
- Continued training regarding mental health awareness and learning disabilities for all police staff.
- Screening for mental health issues and learning disabilities of offenders on bail, through Westminster magistrates court.

Case study 1 highlights some of the complexities of offenders with mental health issues.

Case study 1

Subject is a black male of 45 years of age with a police national computer record warning signal for mental health (a diagnosis of Paranoid Schizophrenia.)

Arrested in September 2009 for theft of a pedal bike, brought to Belgravia custody suite.

During "Self" risk assessment admitted to being a heroin / cocaine user and requested a drugs worker, denied drinking alcohol today. Stated he had no mental health issues when questioned. The custody officers risk assessment found no issues with the subjects' current presentation therefore did not require an appropriate adult. The subject tested positive for Cocaine.

Whilst in custody the Gordon Hospital rang and stated that he was under their care and still under a mental health section. The Police Doctor (FME) spoke to the subject by phone, determined at this point that because the offender was under a section, he must have an appropriate adult.

He was interviewed by a Solicitor and a Mental Health appropriate adult. After interview on the advice of the crown prosecution service no further action was taken.

In this example despite having been known to Mental Health Services for some years and at the time being currently under section the subject appeared to display no signs of mental illness during his time in custody, the Police only became aware of his past mental health history because of his disclosure and some local knowledge.

Arrested again in January 2010 for possession of Cocaine following the execution of a drugs warrant at his address.

During the custody booking in self risk assessment he admitted to using cocaine and to be receiving treatment for mental health problems, the custody officer flagged him up for a medical examination regarding his mental health. The subject tested positive for cocaine.

The custody nurse found him to be both co-operative and well oriented. She noted that the subject was placed under section 3 of the Mental Health Act two years ago, is seen regularly at the Gordon hospital and had a depot injection last week. The subject was offered an appropriate adult but declined appearing to understand the implications of detention, therefore no appropriate adult was recommended on his medical form. He agreed to be visited by a drugs outreach worker.

The subject admitted the offence and expressed remorse during the interview which taken with a consideration of the public interest led to him being given a caution for possession of crack cocaine. The subject has two previous convictions (Common Assault 2007, Theft 1989) and several other offences which range from public order to robbery all of which were not proceeded with.

13. Mental Health

For the purpose of this needs assessment mental health data was obtained through self assessment completed by the custody officer within the custody suite. The offender answers yes/ no to the following question; 'Are you experiencing any mental health problems or depression?'

A total of 617 (5.4%) offenders stated during self assessment that they had a mental health issue and had had or were receiving treatment and the custody officer agreed during their assessment. The Bradley report estimated that the number of mentally disordered suspects passing through police stations vary between 2%- 20%. In comparison the number of offenders that stated they had a mental health issue, presenting at the three custody suites between January- June 2009 was 5.4%, this figure is likely to be an underestimate, as mentioned mental health data is reliant upon self reporting and various considerations may contribute to an offenders reticence in disclosing information.

Key facts

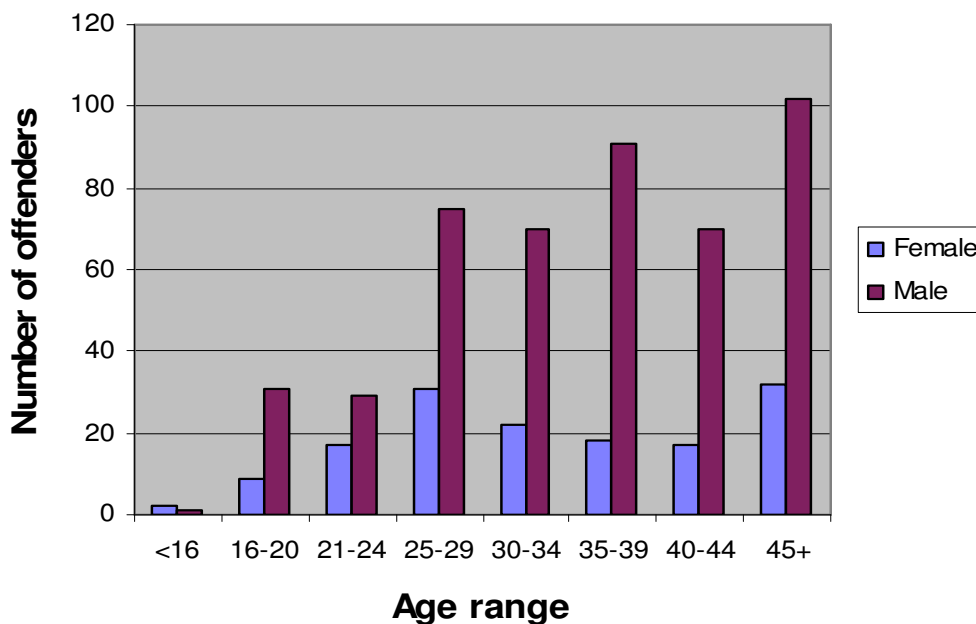
- **5.4% of offenders stated that they had a mental health issue and had had or were receiving treatment and the custody officer agreed during their assessment.**
- **Prevalence of mental health amongst female offenders was 8.3% and the prevalence of mental health amongst male offenders was 4.9%.**
- **Self reported mental health issues were greatest in men between the age ranges of 35- 39 and 45+ and greatest amongst women between the ages of 25-29 and 45+**
- **21% provided a Westminster postcode, 79% were from boroughs outside of Westminster, outside of London or did not provide a postcode.**

Table 9: Indicates the prevalence of mental health according to custody suite.

Custody suite	Number	Prevalence of mental health
Belgravia	167	5.9%
Charing Cross	299	5.2%
Paddington	151	5.5%

Prevalence of mental health in Belgravia is slightly higher in comparison to Charing Cross and Paddington, this could be attributed to a large homeless population residing in the south of the borough.

Figure 7: Number of offenders according to age and gender stating that they had a mental health issue, January- June 2009.



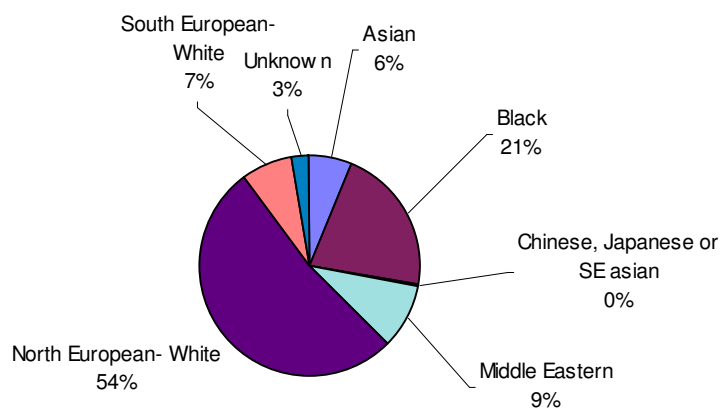
The number of men stating that they had a mental health issue was greatest between the age range of 35-39 and 45+ in comparison to female offenders, where numbers were greatest amongst the ages of 25-29 and 45+. The 45+ age bracket also has the widest parameters, therefore may not reflect a true picture. The National Psychiatric Morbidity Survey (NPMS) 2007 found that 16.4% of the adult population had displayed neurotic symptoms the week before the survey. More women than men are expected to experience neuroses. The prevalence of neuroses in Westminster is

similar across all age groups up until the age of 50-54, in which prevalence peaks. After this age the prevalence of neuroses in women decreases. In men the prevalence of neuroses increases from the 16-19 age group, peaking at the 45-49 age group and then steadily declining (JSNA. Mental Health).

Data from NPMS suggests that that 0.5% of persons aged 15-74 years old have a psychotic disorder; More men than women are expected to have psychosis; In terms of age, the majority of men with psychosis are likely to be aged between 30 and 34 years old, whilst for women the majority are likely to be aged between 35 and 44 years old, with lower numbers of people in the younger and older age groups.

(i) Ethnicity

Figure 8: Indicates the proportion of offenders that stated they had had a mental health issue and the custody officer agreed by ethnicity.



The greatest proportion (54%) were recorded as North European- White, followed by 21% Black and 9% Middle Eastern. As mentioned previously ethnicity is based upon the arresting officers perception, therefore this does not necessarily represent a true picture of mental health according to ethnicity.

(ii) Nationality

In terms of nationality, of offenders that stated that they had a mental health issue, the greatest proportion (78%) identified that they were from the United Kingdom. 2% of offenders stated that they were from Algeria and 1% from Iraq. All other recorded nationalities did not contain a significant number of offenders.

Table 10: The number and proportion of offenders by borough

Borough	Number	Proportion
Westminster	130	21%
Southwark	15	2.4%
Lambeth	26	4.2%
Camden	18	3%
Other London boroughs	43	7%
Out of London	175	28.4%
No fixed abode/unknown	210	34%

The table presents the number of offenders that stated during self assessment that they had a mental health issue and the custody officer agreed, according to borough. The proportion of offenders providing a Westminster postcode was 21%, 45% are from boroughs outside of Westminster, 34% did not provide a postcode.

Table 11: Mental Health diagnosis recorded on custody records

Recorded diagnosis	Number of offenders
Depression	83
MH issues, no specific diagnosis	20
Schizophrenia	<5
Self harm/ suicide	16

The forensic medical doctor would be contacted to examine the offender if the custody officer or custody nurse felt that medical expertise was required. The data indicated that the reason for the doctor being requested was recorded in 49% of custody records, in 19% of cases the reason for the Doctor's request was a mental health issue, often self reported. The largest proportion of offenders reported

suffering from depression, often mental health issues were recorded with no specific diagnosis. The number of offenders with a recorded diagnosis of Schizophrenia were relatively low. No formal assessment exists for FME's therefore the recorded data was inconsistent and dependant on the FME's knowledge and awareness of mental health. As mentioned previously only a small proportion of FMEs have mental health training, possibly contributing further to an underestimate in mental health issues being identified and recorded correctly amongst offenders.

The only recorded learning disability was Aspergers, which was recorded in >5 offenders, how this was diagnosed remains unclear.

In comparison Psychiatric morbidity data, 1998 (PMD) indicated that the prevalence of personality disorder was 78% amongst male remand prisoners, 64% amongst male sentenced prisoners and 50% for female prisoners. Antisocial personality disorder had the highest prevalence of any category of personality disorder. One of the diagnostic criteria for antisocial personality disorder is criminal behaviour, although often there is an over reliance on this as a basis for diagnosis and could account for the high prevalence rates (Moran, 2002). There is significant disparity between PMD and the medical diagnosis recorded on custody records (Table 8) which indicates no recording of personality disorders.

The overall prevalence of mental health amongst offenders brought into the three custody suites was 5.4%, which is relatively low in comparison to the prevalence of self harm, attempted suicide and suicide feelings amongst this population which was 36%, 34% and 9.4% respectively. Personality disorders are associated with suicidal behaviour, some studies have also indicated an association between personality disorders and deliberate self harm. Although, the magnitude of risk varies between categories of the disorder, people with personality disorders are more likely to suffer from depression, anxiety disorders and substance misuse issue, from this we can infer that personality disorder is not being identified during risk assessment.

PMD data for the prevalence of functional psychosis was divided into further sub sections to include; schizophrenia or delusional disorder and any affective psychosis which included bipolar affective disorder severe and recurrent depression and manic episode; Prevalence rates for any schizophrenic and delusional disorder were 9% amongst male remand prisoners, 6% amongst male sentenced prisoners and 13% amongst female prisoners. Less than five offenders had a recorded diagnosis of

schizophrenia, no recordings of delusional disorder, or any affective psychosis, indicating that these mental health issues are also not being identified.

Prevalence of any affective psychosis amongst male remand prisoners was 2%, 1% amongst male sentenced and 2% amongst female. As discussed previously, no recordings of affective psychosis existed on the custody records for the study period.

14. Summary

It is challenging to determine the number of offenders with mental health issues and learning disabilities coming through Westminster custody suites. As discussed previously in section 8, identification is based upon self reporting, the complexities of which, within the context of the custody suite are vast.

Evidence from the psychiatric morbidity data (1997) highlighted mental health issues amongst offenders were significant, particularly the prevalence of personality disorder. As is evident from the data, the prevalence of mental health amongst offenders brought into Westminster custody suites was significantly lower in comparison. The recording of mental health issues and learning disabilities onto custody records was inconsistent. Personality disorder was not recorded on any of the custody records, concluding that mental health issues and learning disabilities are not being identified effectively.

The findings from the focus groups indicate that the majority of custody officers and detention officers were not able to identify or distinguish between different mental health issues and knowledge of learning disabilities was limited.

The core function of the custody officer is primarily in line with PACE, therefore this may conflict with wider health needs of offenders.

Recommendations

- Further mental health and learning disability training for custody officers with emphasis on personality disorder.
- Diagnosis of mental health issues and learning disabilities are often reliant on self reporting, therefore more appropriate screening tools need to be

established within custody suites to identify mental health issues and learning disabilities more effectively.

15. Substance misuse, alcohol and Dual diagnosis

15.1 Substance misuse

The drug intervention programme (DIP), is a pivotal part of the governments strategy aiming to tackle drug related crime. The programme involves identifying Class A drug misusing offenders that have been arrested for acquisitive crimes.

The number of positive drug tests completed in custody between Jan- June 2009 was 932. Prevalence of offenders testing positive for cocaine and opiates was 3.4%, cocaine only was 3.4% and opiates only was 1.4%.

Table 12: Number of positive drug tests in each of the three custody suites, January- June 2009.

Custody suite	Cocaine and opiates	Cocaine only	Opiates only	Total
Belgravia	81	77	35	193
Charing Cross	238	238	98	574
Paddington	70	71	24	165
Total	389	386	157	932

Westminster's DIP programme manages a large number of people that are from outside the borough.

15.2 Dual Diagnosis

Key facts:

- **Number of offenders stating that they had a Mental health issue and tested positive for one or more substances were greatest amongst male offenders between the ages of 35- 39.**
- **The majority of offenders were not Westminster residents.**
- **Recording and diagnosis of Mental Health issues were inconsistent and incomplete.**

Dual diagnosis is summarised by the Department of Health, 2009 within four definitions:

- A primary mental health problem that provokes the use of substances.
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.
- A psychiatric problem that is worsened by substance misuse.
- Substance misuse and mental health problems that do not appear to be related to one another.

Bradley reiterates that dual diagnosis is a vital component in addressing the issue of mental health and criminal justice. Challenges exist surrounding identifying and treating offenders with dual diagnosis. However, services are not well organised to meet this need.

Dual diagnosis data was determined from the risk assessment by the number of offenders that stated that they had a mental health issue and the custody officer agreed, and also tested positive for cocaine or opiates or both. The prevalence of mental health and substance misuse (cocaine and opiates) amongst the offending population was 0.96%.

Psychiatric morbidity data (PMD) determined the prevalence of drug use through a series of questions that referred to the twelve months prior to prison entry. Custody data, relates information from offenders that tested positive having been brought into the custody suite, no information is provided on substance misuse prior to arrest, therefore the data is not comparable.

Evidence exists which associates cannabis use and schizophrenia, particularly amongst the younger population between the ages of 17-24. In police custody, cannabis use is only recorded if an offender tests positive for opiates or cocaine. Further screening and interventions are required surrounding offenders that only use cannabis and have mental health issues.

Figure 9: Number of offenders that tested positive for one or more substances and stated that they had a mental health issue by age and gender, January- June 2009.

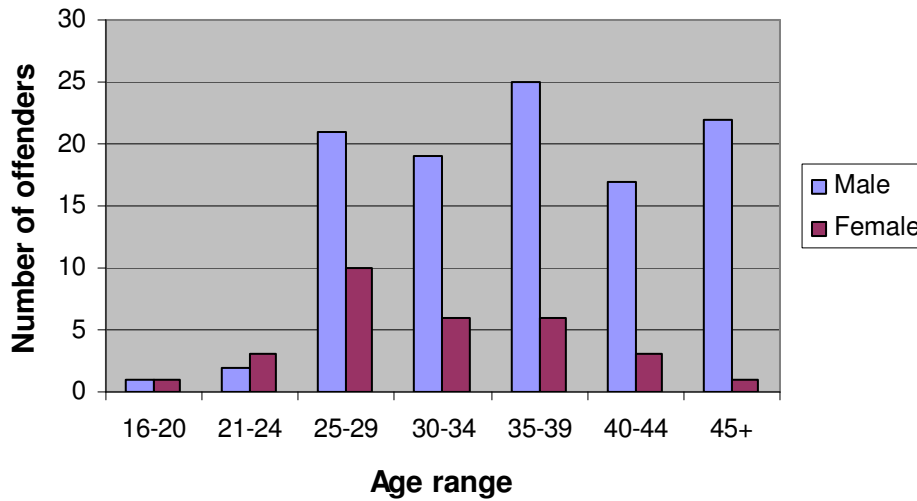
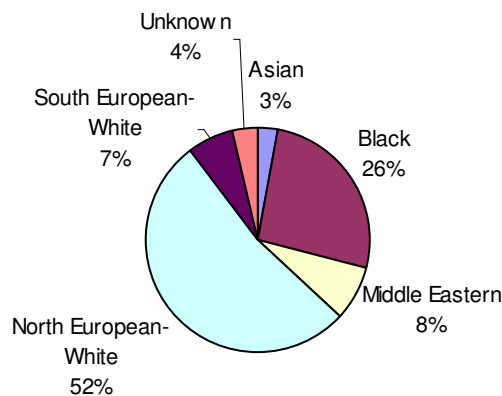


Figure 10: Proportion of offenders by ethnic appearance that state that they have or have had a mental health issue and tested positive for one or more substances, January- June 2009.



(i) Age and Gender

The data indicates that amongst male offenders, numbers were lowest within the younger age ranges and highest amongst male offenders aged between 35-39 and 45+. Amongst female offenders numbers were highest in the younger age ranges, particularly between 25-29 and 30-34, numbers become progressively lower in the 40-44 and 45+ age ranges.

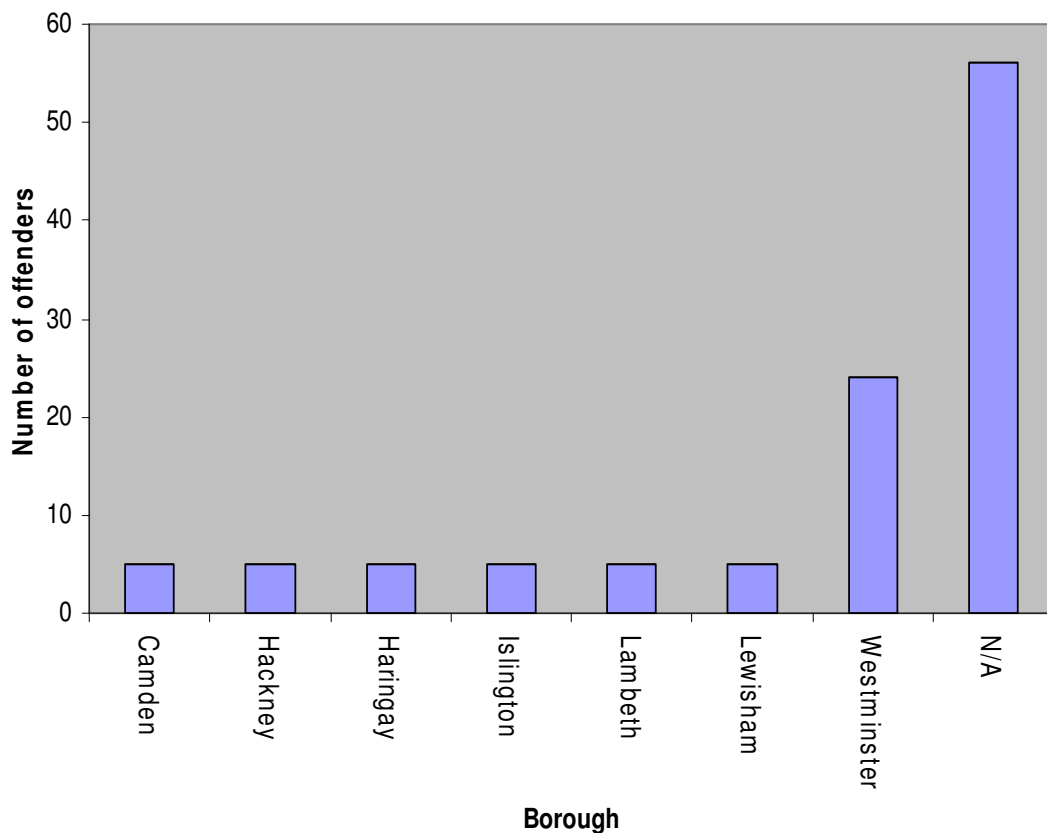
ii) Ethnic appearance

Ethnicity data indicates that the majority of offenders that stated that they had a mental health issue and tested positive for cocaine or opiates were North European White, the second largest ethnic group was classified as Black.

iii) Borough Profile

Borough profile data for offenders that stated that they had a mental health issue during the custody officers risk assessment and tested positive for cocaine, opiates or both (figure 11) indicates that the largest number of offenders either provided a Westminster postcode or had no fixed address or the postcode was not recorded.

Figure 11: Number of offenders with dual diagnosis, January – June 2009.



(iv) Nationality

The proportion of offenders amongst this population that stated that they were UK nationals was 77%. No other significant nationalities were identified.

(v) Diagnosis

The following information (Table 13) was collated by the Palbase case management system used by the Drug Intervention programme. 81 records were found for offenders that were seen by an arrest referral worker between January 2009- June 2009 and of this only 34 records were found to have a scanned risk assessment form, this was due to incomplete data recording. The risk assessment documents the following; whether the offender feels suicidal, learning disability, mental health diagnosis and whether the offender is on any medication for mental health issues. Table 10 highlights recorded mental health diagnoses.

Table 13: Mental Health diagnosis of offenders completed by arrest referral, January- June 2009.

Diagnosis	Total
Depression (severe)	>5
Depression	3
Diagnosis not stated	3
Personality disorder	>5
Schizophrenia	3
N/A	23

Table 13 indicates that mental health diagnosis amongst the majority of offenders was recorded as N/A, with relatively few recordings for personality disorder, schizophrenia and severe depression.

15.3 Alcohol

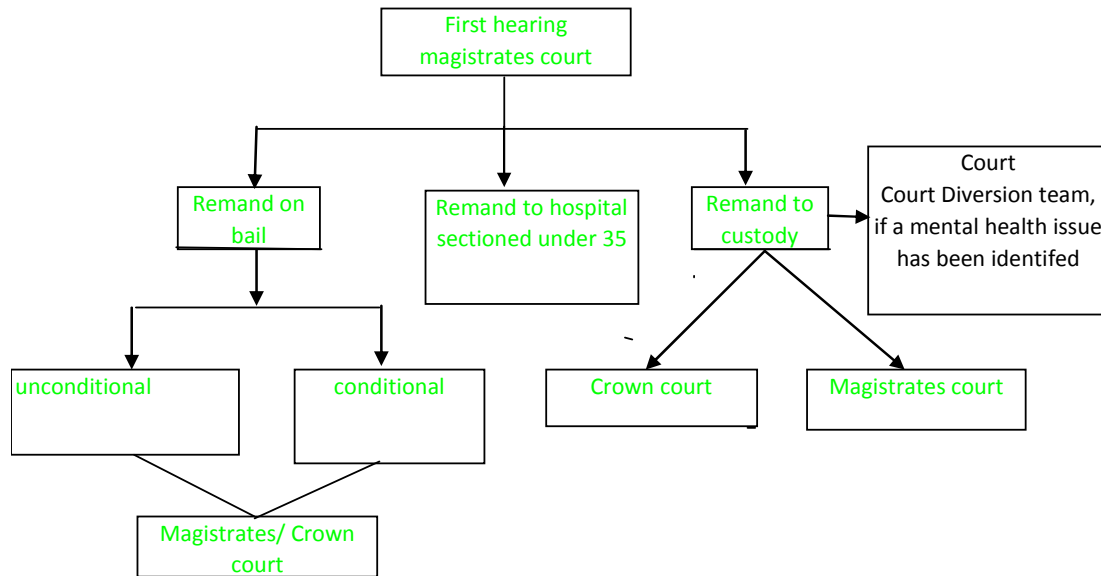
Information regarding alcohol was taken from the DIR assessments recorded on the Drug Intervention Programme (DIP) case management system. Alcohol information was collated on any offender that initially tested positive for one or more substances. Information was available on 71 individuals. The data indicates that 14% of offenders stated that they drank alcohol daily in the last month or in the month prior to entering prison, 37% stated that they never drank. Alcohol screening pilots in Charing Cross, Belgravia and Paddington have been in place since September 2009, however, priority is given to DIP clients that test positive for one or more substances therefore little is known about offenders that only drink alcohol. It is hope that screening will continue however, financial constraints mean that this seems unlikely.

Recommendations

- Further training for custody staff surrounding dual diagnosis
- Alcohol screening to be carried out on all offenders entering custody suites that appear under the influence regardless of testing positive for illicit drugs.
- Review of the risk assessment used by arrest referral workers to determine gaps in the recording of mental health information.

16. Remand decisions

Figure 12: Remand decisions relate to the following part of the offender pathway.



As mentioned previously remand decisions can result in the offender being remanded on bail or custody. Unfortunately it was not possible to source the data relating to this area of the offender pathway.

16.1 Remand on bail

If remanded on bail the offender can be remanded unconditionally or conditionally, both resulting in the offender presenting at crown or magistrates court at a later date. No follow up exists at this point for mental health or learning disabilities.

16.2 Remand to Custody

The majority of people that offend in Westminster are remanded to Wandsworth or Holloway prison. This needs assessment focuses on information relating to Wandsworth prison. If remanded to custody and a mental health issue has been identified the offender can be assessed by the court diversion team and be diverted if deemed appropriate. If no mental health issue has been identified at this stage the offender appears at either crown or magistrates court.

16.3 Remand to Hospital

The defendant could also be remanded to hospital, under section 35 of the mental health act. The two hospitals that offenders are remanded too within Westminster are St Charles and the Gordon Hospital, depending upon which custody suite the offender is seen in.

Recommendation

- Further work to determine the prevalence of mental health issues and learning disabilities of offenders that provide Westminster postcodes that are remanded on bail or to hospital.
- Further research to determine reoffending rates of offenders remanded on bail with an identified mental health issue.

Case study 2 highlights some of the issues that arise if an offender is remanded.

Case Study 2

**Subject; White male, 24, with a police national computer record.
Warning signals for violence and drug use.**

Arrested on 21/08/2009 wanted for common assault, after racially abusing a female and throwing a glass of water over her. Police attended his address with a mental health team, found not to be sectionable at that time.

During "self" risk assessment he claimed to suffer from panic attacks, anxiety and claustrophobia and stated he had been given Prozac for depression although he was afraid to take it.

A mental health assessment had been completed earlier, as a result an FME was requested. The FME stated that a diagnosis of a personality disorder, had been recorded in the assessment, the offender was taking stimulants and had presented under the influence of drugs. Having spoken to the mental health team an appropriate adult was not deemed necessary since the subject was thought to be able to understand everything that was going on.

The subject was later interviewed for common assault and bailed to return to the police station on 01/10/2009 whilst enquiries continued. He received bail conditions not to visit his mothers' address - who he had been arguing with recently.

The subject failed to return on bail and was therefore circulated as 'wanted.' Subject was subsequently arrested and put before the City of Westminster magistrates court in Horseferry Road, he received a fine of £50 and had to pay £65 compensation for the charge of racially aggravated common assault.

Arrested again on 06/03/2010 for criminal damage, had attempted to take his own life by cutting his wrists with a razor blade shortly before his arrest.

During the custody booking in self risk assessment he stated he had numerous mental health issues, paranoia, stress and anxiety for which he was currently taking

Prozac. He claimed not to use drugs and not to have drunk any alcohol or any other substance in the last 24 hours, although police believed otherwise. He stated he no longer felt suicidal. The custody officer felt the subject was in need of a Doctor to ensure his fitness to detain / interview.

On request, a mental health (CRISIS) team attended and assessed the subject. He was found not to be sectionable since he had no mental illness other than a personality disorder, but he had given informed consent to attend hospital and had attended the Gordon Hospital as an out patient, the previous month. Since he had committed offences on bail and still represented a real risk to his mother and others it was decided that he would be interviewed with an appropriate adult for the offence of Criminal Damage. He was charged and kept in custody until the next morning, when the court could put a mental health assessment in place (the court diversion team were specifically requested to assess him before he appeared at court).

The FME reports during custody identified that the subject certainly needed a mental health assessment and suffered from skunk (cannabis) abuse and psychomotor retardation. He was deemed at low risk of suicide and his prevailing mood was noted as being one of anger - he began banging his head on the cell wall and picking at the treated cuts on his wrist in an effort to avoid court and instead be taken to hospital.

The subject was charged and his bail refused, this led to numerous attempts to self harm which eventually required that he be placed in both handcuffs and leg restraints for his own safety. He was taken to the City of Westminster magistrates court the next morning where he was subsequently assessed by the courts diversion team before being allowed to appear in court the following day. He has been found guilty but the sentence was postponed (for further pre sentence reports) until 30/03/2010.

17. The Court Process:

17.1 What is court diversion?

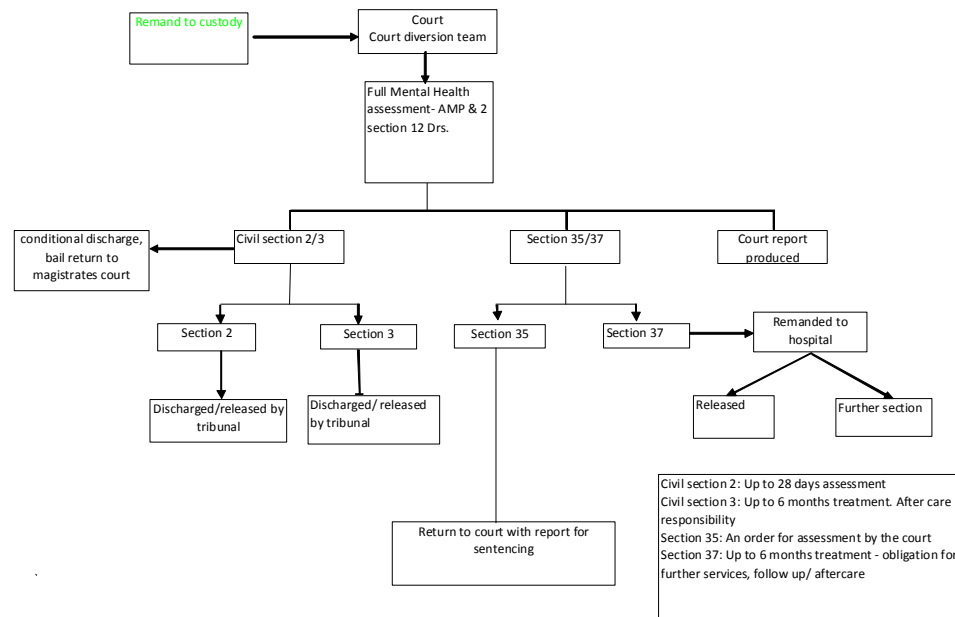
Throughout the eighties and early nineties it became increasingly clear that greater improvements were required to the system of liaison between the criminal justice system and the management of offenders with mental health issues.

The Reed report first highlighted the need for diverting offenders with serious mental health issues away from prisons and into appropriate services.

The definition for diversion remains debatable and can vary in its meaning within the criminal justice system. For the purpose of this report and in line with Bradley, diversion is defined as 'Diversion is a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including early prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence.

Although this section focuses on court diversion, diversion may occur at any stage of the criminal justice process: before arrest, after proceedings have been initiated, in place of prosecution, or when a case is being considered by the courts.' (All stages of the diversion model adapted from Sainsbury Centre 2008, see appendix C).

Figure 13: Offender pathway in relation to court diversion in Westminster.



If an offender has been remanded to custody and thought to have a serious mental health issue police liaison nurses can refer the offender to the court diversion team. Once referred to the court diversion team, a full mental health assessment is completed by the approved mental health practitioner. Depending upon the needs of the offender there are four possible outcomes.

- Civil section 2/3, both result in being discharged or released by tribunal. A civil section 2, can also result in conditional discharge and the offender returning to magistrate's court.
- Sectioned under section 35 or 37. Section 35 involves an order for assessment by the court. Section 37 involved being remanded to hospital, following on from there being released or a further section.

Further information regarding the sections mentioned is available in appendix B.

18. Court diversion in Westminster

The scheme has been in operation in Westminster since the 1980s and was one of the first to be set up in the United Kingdom. The service operates from City of Westminster magistrates court, formerly known as Horseferry Road magistrates court and is funded by Kensington and Chelsea and Westminster PCT, the role of the Approved Mental Health Practitioner is funded by Westminster City Council. Offenders suitable for the scheme are referred to Westminster from City of Westminster magistrates' court and City of London magistrates' court. Recent closures at Marylebone and Bow have also resulted in offenders being assessed at Westminster.

The court diversion team at Westminster is a multidisciplinary mental health team, comprising of two consultant psychiatrists, a court liaison nurse and an approved social worker. Assessments are conducted on Tuesdays and Thursdays, up to four offenders are seen per day, if an offender requires an interpreter this accounts for two sessions. Assessment focuses on two issues; the fitness of the prisoner to plead and stand trial and secondly, determining whether the offender is suffering from a mental health issue, which requires them to be diverted to hospital.

Offenders are generally detained under Section 2 or Section 3 of the mental health act 2007. If an offender is suffering from a mental health issue that requires diversion, the team are involved in identifying beds. This is subject to negotiation, beds are not automatically available. If there is no bed availability on the day of diversion an offender is remanded back into custody and brought back to court on the next diversion day.

18.1 Westminster Criminal Justice liaison services

Diversion and liaison differ in their definitions, however, often complement each other, liaison links offenders into appropriate community agencies and services, generally working with offenders that do not require an admission to hospital.

Two borough mental health liaison officers are employed within Westminster and work in conjunction with the following community organisations; Community mental health team in Paddington, Victoria assessment services, West end team, Joint homelessness team and the Abbey road community mental health team.

In 2010, The London offender health partnership board in conjunction with HMCS London, the London Criminal Justice board, London Probation service commissioned the mapping of current provision of Criminal Justice liaison and diversion schemes across London (Appendix). The survey highlighted themes and gaps, which will be discussed in further detail in the context of Westminster.

As mentioned in Chapter 8 police liaison nurses cover Charing Cross, Belgravia and Paddington custody suites. The majority of referrals to the police liaison nurses are through custody nurses. The assessment process completed by the police liaison nurses involves an initial screening and mental state assessment, including a records check and relevant services. The service does not assess for learning disabilities, however, they can refer to the Westminster learning disabilities service if necessary. Police liaison nurses generally see offenders that have severe mental health issues or appear to be very unwell, therefore it is possible that offenders with less severe mental health issues may go unnoticed.

During January- June 2009, 365, people were referred for a full mental health assessment with an Approved Mental health Practitioner (AMPH) to determine whether they were sectionable or not. Referrals for a full mental health assessment by an approved mental health practitioner within the court diversion team can be made through various agencies, these include the Crown Prosecution service, defence solicitors, probation officers, court clerks, custody staff, prison staff and magistrates. During January- June 2009, 95 offenders (26%) were recorded as being referred by the police or the courts for a full mental health assessment by the approved mental health practitioner within the court diversion team.

18.2 Court Diversion

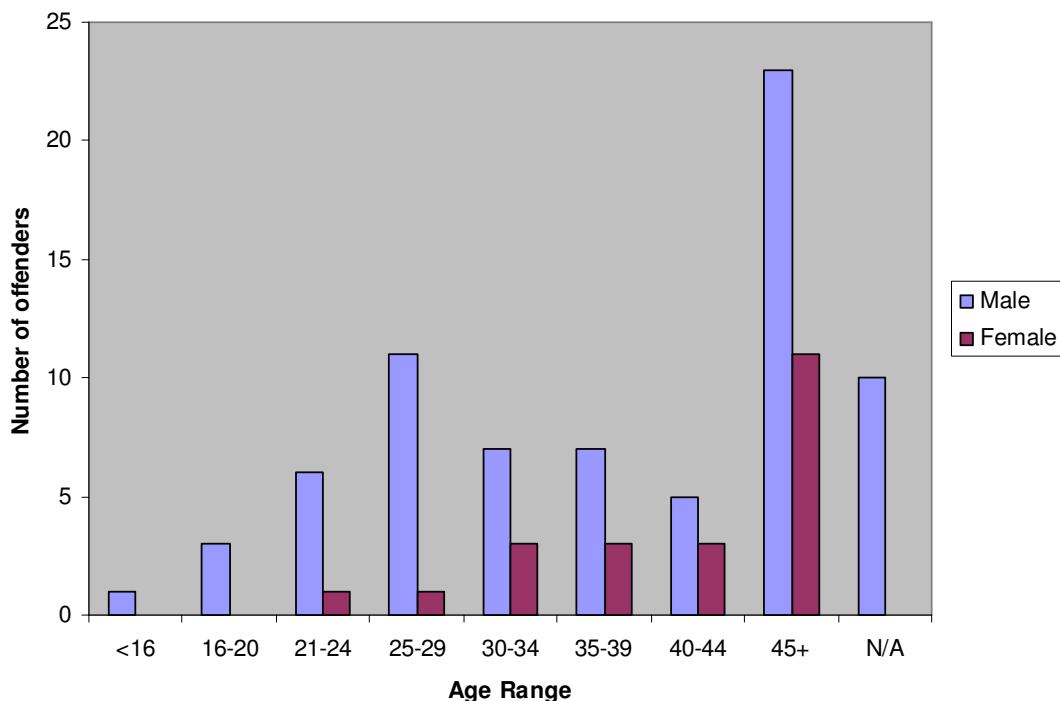
Key Messages:

- Male, offenders aged 45+ account for the largest number identified and assessed for a full mental health assessment.
- Largest proportion of offenders assessed identified themselves as White British, followed by Black African and Black Caribbean.
- Larger number of offenders were diagnosed with Schizophrenia
- The majority of offenders stated that they did not live in Westminster.

(i) Age and Gender

The proportion of men assessed by the approved mental health practitioner was 76% in comparison to 24% of women.

Figure 14: Number of offenders assessed by the court diversion team according to age and gender, January- June 2009.



Comparing age and gender profiles it is apparent that a greater number of male and female offenders aged 45+ were identified and assessed for a full mental health assessment. However, 45+ was also the largest age category, therefore it is difficult

to ascertain any conclusive evidence from this. No female offenders were identified to be eligible in the younger age groups. N/A refers to no recorded birth date.

(i) Ethnicity

Assessments completed by the court diversion team contained standard ethnic group categorisation, the majority of offenders were White British. A large proportion of offenders were from Black African and Black Caribbean ethnic groups. However, neither of these groups were over represented, therefore no conclusions can be drawn from this. Proportions were low amongst ethnic groups that were categorised as Arab and Chinese.

(ii) Mental Health Diagnosis

A large number of offenders were diagnosed with Schizophrenia. Numbers were also relatively high amongst offenders diagnosed with affective psychosis and no recorded diagnosis. In comparison figures were low for learning disability and personality disorder. Evidence from Psychiatric morbidity data (1997) indicated that the prevalence of personality disorder amongst sentenced prisoners was 66%. Although, within this context comparisons are being made amongst offenders being assessed on their eligibility for court diversion as opposed to sentenced prisoners. It would be expected that the number of offenders with personality disorder would be greater. As shown in figure 15 numbers are relatively low, indicating that personality disorder is not being identified. This could be attributed to the mental health assessment completed by the AMPH being orientated towards offenders that display severe mental health issues, therefore mental health issues that only display low levels of distress or symptoms that may not be as easily recognisable remain unnoticed.

As we can see from figure 16 the majority of offenders being diverted do not live in Westminster, therefore if an offender has a serious mental issue and is only displaying mild levels of distress and no prior knowledge of the offender is known referrals into services may not be feasible.

Associations between ethnicity and mental health diagnosis indicated that the majority of White British offenders were diagnosed with affective psychosis. No other significant associations were noted between mental health diagnosis and ethnicity.

Figure 15: Proportion of offenders assessed by the court diversion team by ethnicity, January- June 2009.

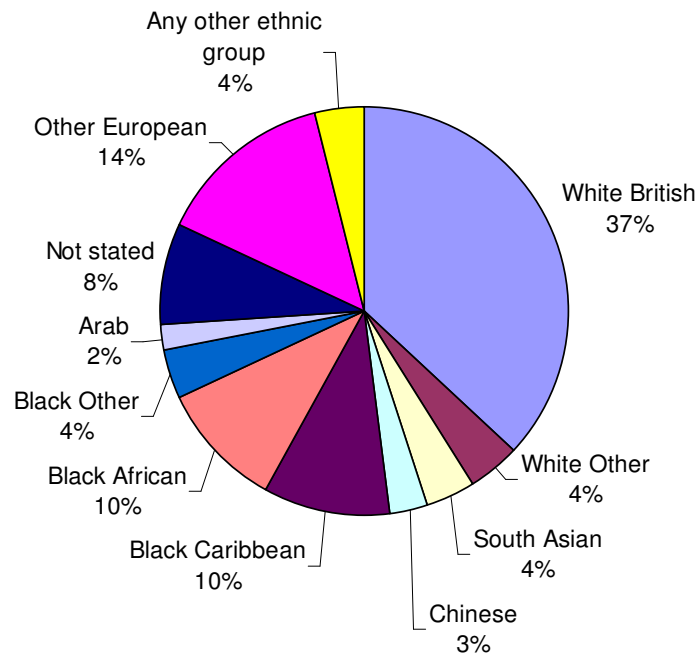


Figure 16: Mental health diagnosis of offenders referred for a full mental health assessment, January- June 2009.

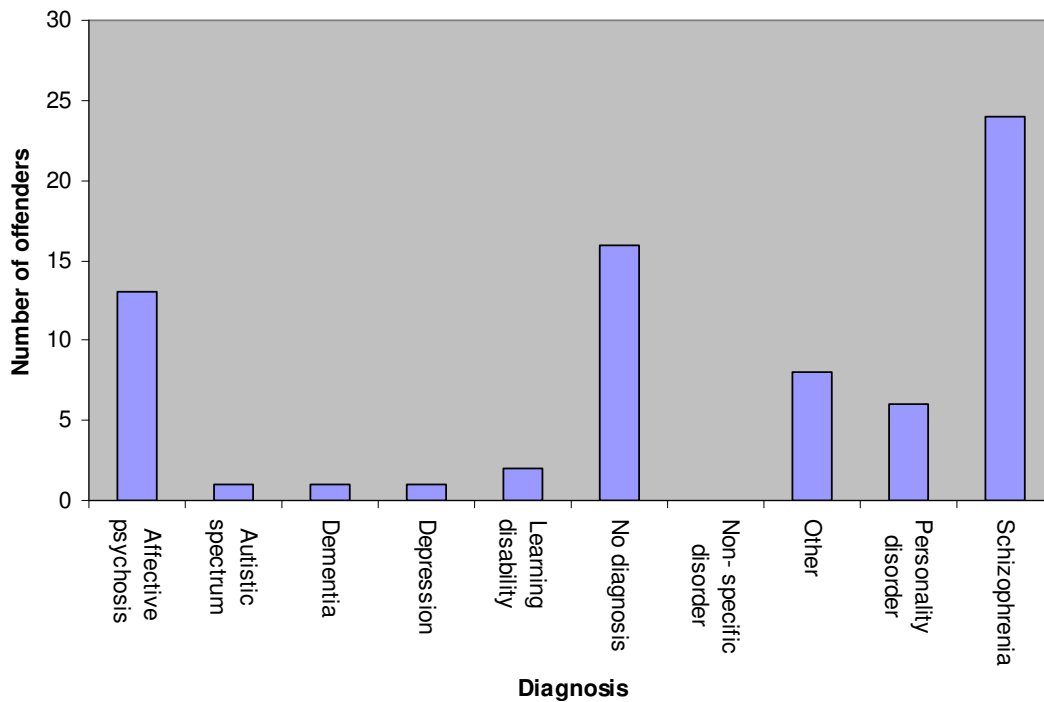
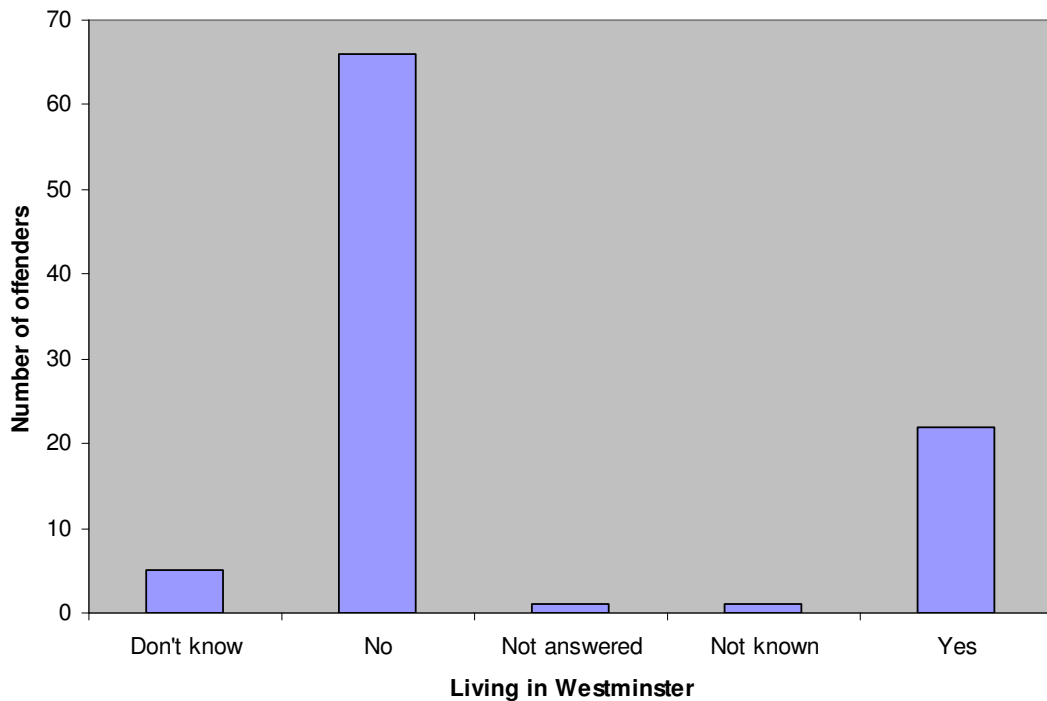
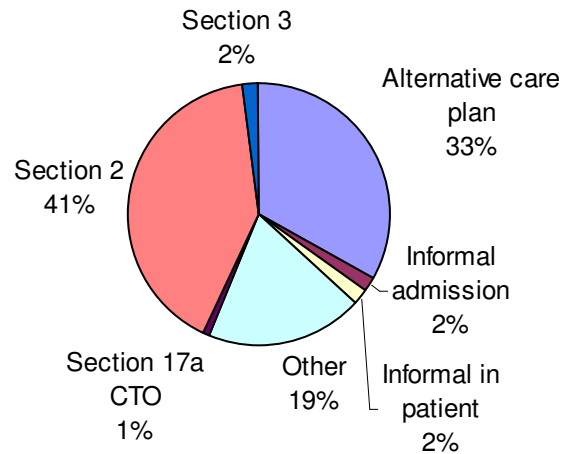


Figure 17: Number of offenders living in Westminster, January- June 2009.



The majority of offenders (69%) stated that they did not live in Westminster. Housing data indicated that 31% stated that they had no fixed abode, 18% resided in council or housing association properties and 23% of offenders housing was recorded as not known. Therefore, a significant number of offenders using the court diversion scheme at City of magistrates are non Westminster residents with no fixed abode. The cost implications and burden on Westminster services are significant. It is also difficult to determine which court diversion schemes Westminster residents are accessing and which services they are being referred to for treatment or support as no further data was available from neighbouring court diversion schemes in London.

Figure 18: Outcome of full mental health assessments



3

As figure 17 indicates the greatest numbers of offenders, assessed were sectioned under section 2 of the mental health act, consisting of compulsory admission and assessment for 28 days. A large percentage were also provided with an alternative care plan, however, no further information was available regarding what this comprises of. Accessing beds when referring offenders can also be problematic. In 2010, a service mapping report was completed of criminal justice liaison and diversion services, highlighting that although the majority of services had processes in place to access psychiatric beds, availability was limited. If a bed wasn't available, an offender was generally remanded back to custody or bailed to undertake treatment, as mentioned previously being remanded back to custody could exacerbate pre-existing mental health issues further.

Recommendations

- Currently police liaison nurses cover Charing Cross and Belgravia custody suites, recently this service has been extended to Paddington Green custody suite.

³ CTO refers to Community Treatment Order

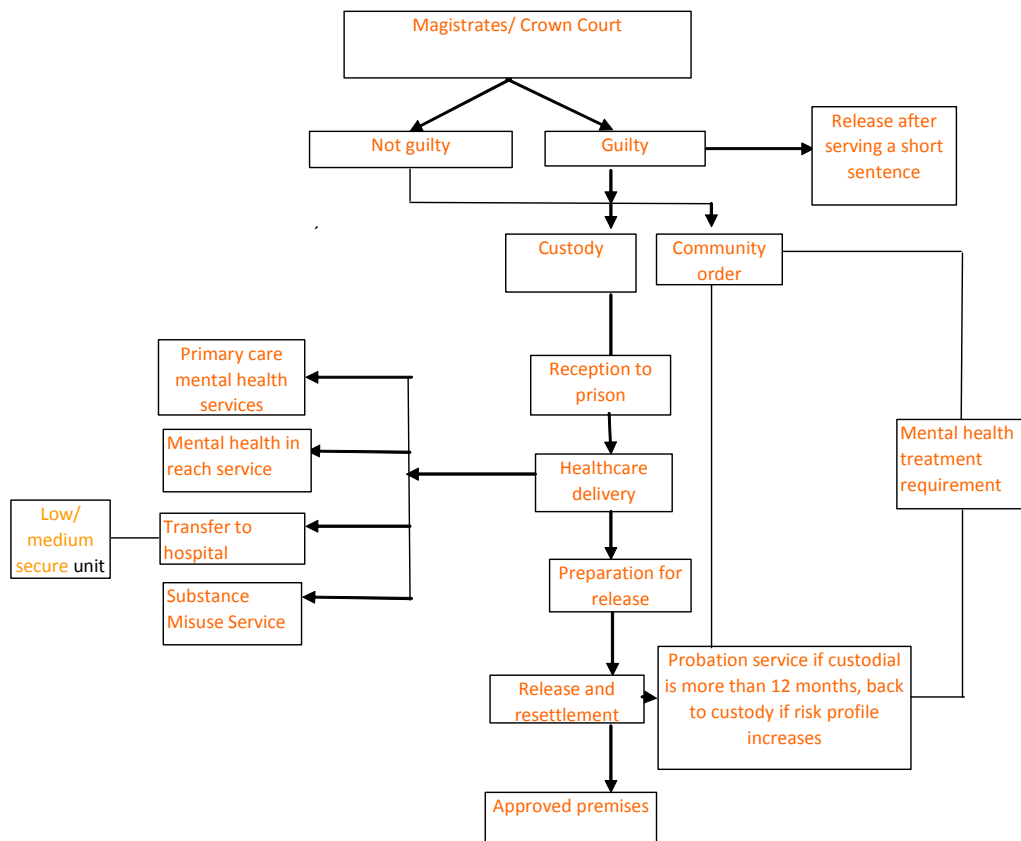
- Further data collection and analysis to determine which court diversion schemes Westminster residents are accessing and which services, if any they are being referred to.
- Further training surrounding the identification of learning disabilities for all agencies involved in referring to court diversion team.
- Implementation of screening tools to assess and identify learning disabilities within court diversion.

19. Prison and community sentences

Once an offender appears at court, alternatives to custodial sentences are available when sentencing offenders that are guilty of a crime. These consist of community orders.

This considers the following aspect of offender pathway. Data was obtained from the probation service for the six month period. Probation incorporates data on offenders that provided a Westminster postcode upon discharge having served a custodial for more than 12 months and offenders that received community orders.

Figure 19:



19.1 Community orders and the probation service

Key Messages:

- **30% of offenders providing a Westminster postcode received either a community order or were released from custody having served a custodial, with a mental health issue having been raised.**
- **Greatest number of offenders on probation White British, males.**

The criminal justice act 2003 introduced a new style of community sentence, known as a community order. Community orders give 12 different requirements that an offender can be ordered to be completed as part of a community sentence. Courts are able to choose different elements to make up the community order which relates to a particular offender and the crime committed (Bradley 2009).

The national probation service supervises all offenders subject to a community order and those that are released from prison on licence or released from prison having served a custodial of more than 12 months.

One of the twelve requirements of a community order is mental health treatment. With the offenders consent, the court may undergo treatment or under the direction of a medical practitioner and/or chartered psychologist, with the view to improve their mental health. Treatment maybe as a resident patient of a care home or hospital, as a non resident patient of such an institute or under the direction of a medical practitioner or a chartered psychologist. If residential treatment is proposed consent of the offender is required.

The number of offenders on probation providing a Westminster postcode for January-June 2009 was 1179. Of this, 46% (549) received either a community order or were released from custody having served a custodial, with a mental health issue having been raised. Mental health issues were highlighted using OASys, (Offender assessment system) the risk assessment tool completed by probation or at prison reception. If an offender scores 1 or 2 in a series of questions (please see appendix) they are identified as having a potential mental health issue. The scoring method does not indicate that the offender has a mental health issue, however suggests that this may be the case. Offender managers are then advised to make a referral to a

medical officer, GP, psychiatrist or a psychologist if the offender is not already engaged with a service.

In relation to the data received from probation regarding offenders that provided a Westminster postcode, no further information was available regarding diagnosis, treatment or care.

19.2 Issues relating to Community Orders

An audit in 2008 completed by the national audit office examined the management of community orders by the national probation service. 302 files were reviewed, seventy four of these were in London, of these, eight included a mental health treatment requirement (10.8%). In all instances the findings showed that the offender was already receiving treatment prior to the order commencing, treatment was therefore incorporated into the order. In all cases, mental health treatment was not initiated as part of the community order, possibly due to the cost implications that mental health treatment within this context poses.

As mentioned previously probation data indicated that 549 offenders received either a community order or were released from custody having served a custodial, with a mental health issue having been raised, of this 173 (31%) of offenders had mental health treatment as a requirement of their community order. No further information was available as to whether the offender was receiving treatment prior to the order commencing.

The proportion of male offenders was 84% and the proportion of female offenders was 16%. In terms of ethnicity and gender, the greatest number of male and female offenders identified themselves as White increases were also noted from offenders that identified themselves as Black. Increases were also noted amongst male offenders identifying themselves from any other ethnic group.

Figure 20; Number of Offenders on Probation according to ethnic group, January- June 2009.

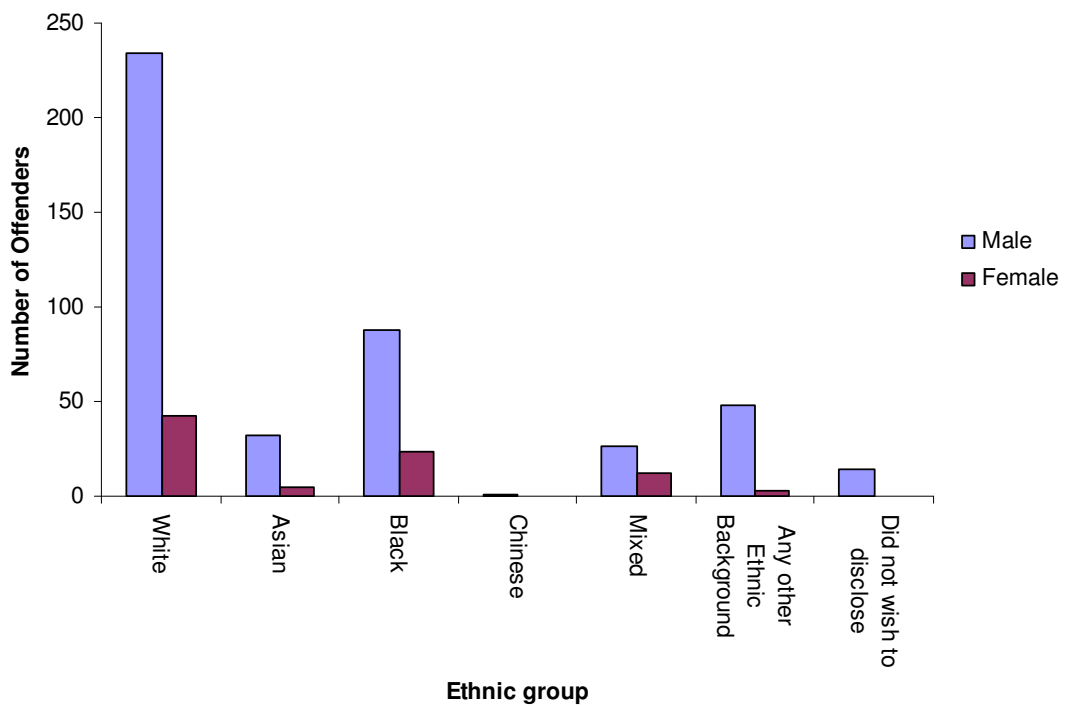
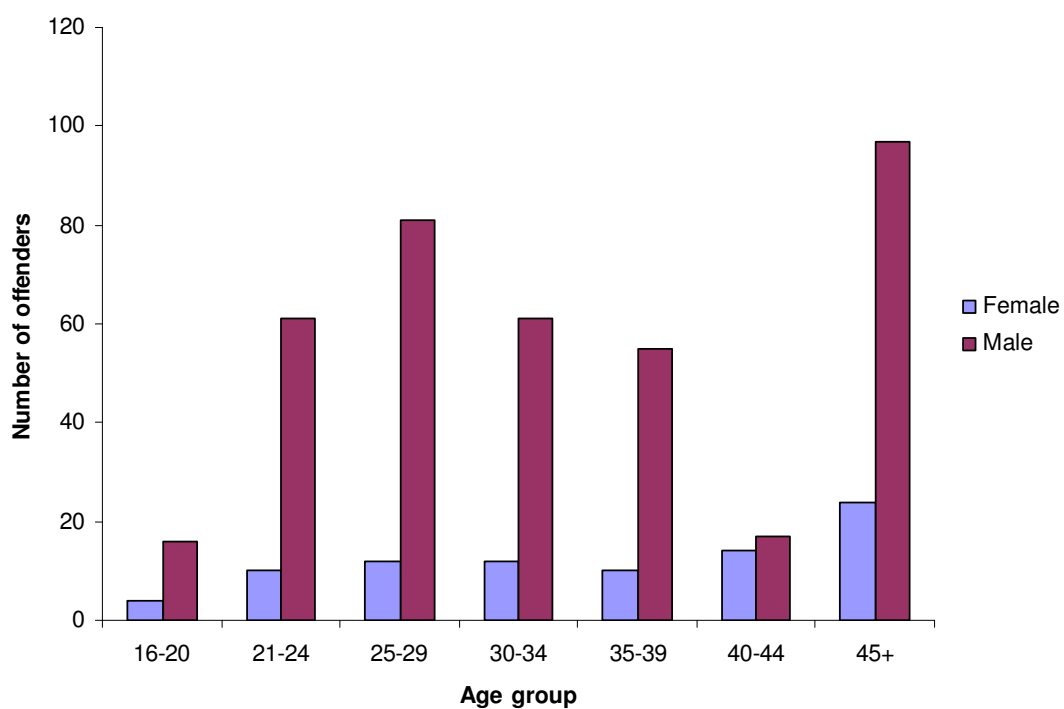


Figure 20 indicates that the number of offenders on probation was greater amongst male offenders that fall into the 45+ age range. Increases amongst male offenders was also noted amongst 25-29. This is consistent with the general profile of offenders coming through Westminster.

Figure 21; Number of Offenders on probation according to age and gender, January- June 2009.



20. Custodial sentences

There are no prisons in Westminster, however, the majority of individuals that offend in Westminster are transferred to Wandsworth prison. Wandsworth prison will therefore be the focus of this section. The services that exist within the prison are: primary care, mental health in reach service and the substance misuse service. No demographic data or information regarding mental health or learning disabilities was available for offenders providing Westminster postcodes transferred to Wandsworth. Therefore it is difficult to ascertain prevalence, treatment or continuity of care for offenders with mental health or learning disabilities.

20.1 Primary Care

Primary care in prisons is the responsibility of General Practitioners; however, many have no specialist mental health training to be able to treat the complex needs of prisoners effectively.

20.2 Mental Health in reach

Mental health in reach services were originally established to treat people with severe and enduring mental illness although this has now broadened to include a range of mental health problems (Bradley, 2009).

In 2007, £20.8 million was spent on mental health care in prisons through in reach teams, a total of 11% of prison health care. Although in reach teams aim to provide specialist mental health services limited resourcing, constraints imposed by the prison environment, disparities in continuity of care and variations in local practice often result in this being hindered (Sainsbury, 2008).

Wandsworth prison consists of two mental health teams, an in reach team and a twelve bedded unit. As mentioned previously no data was available to determine prevalence of mental health issues, and continuity of treatment and care, upon release. Anecdotal evidence suggested that of the number of offenders seen by the mental health in reach team, 80% had a personality disorder. however, a difference between a personality disorder and a treatable personality disorder was reiterated.

20.3 Transfer to hospital

Transferring prisoners to hospital for treatment of an acute mental illness has generally been challenging and often prisoners have had to wait long periods of time to receive treatment. In line with the Bradley report, a fourteen day target was recommended for transfer. A pilot project has been commissioned at Wandsworth to identify current transfer rate on section from prison to hospital, in order to try and achieve this target. Joint assessments are also occurring between Wandsworth and high secure units to increase the referral rate and to avoid duplication.

20.4 Release and resettlement

If an offender serves a custodial of less than twelve months and has accommodation issues they are referred to an approved premise. No continuity of care is present at this point. If the custodial sentence is for longer than twelve months continuity of care continues with the probation service.

20.5 Approved Premises

Thirteen approved premises are currently in operation in London. Only one of the approved premises is female only and one, funded by the Inner London probation service and cited in the Bradley review as a practice example is the Bracton centre specifically for mentally disordered offenders that have been diagnosed as high risk due to personality disorders. There are currently no approved premises in Westminster, the nearest is Camden, if there is no room availability offenders could be transferred to any of the other approved premises.

In 2008, a joint inspection of probation approved premises was completed, indicating that a high number of residents were experiencing physical and mental health issues. Results indicated that over 70% of residents in five hostels were assessed as high or very high risk of harm, in three 90% and in one hostel the proportion was 96%. A possible place for intervention amongst offenders with mental health issues are approved premises.

Recommendation

- Existing structures, within the criminal justice system mean that currently no continuity of care exists for offenders serving custodial sentences of less than 12 months. Further research is required to determine prevalence of mental health amongst offenders that serve custodial sentences of less than 12 months with the view to implementing appropriate interventions to address unmet need.
- In line with the Bradley report; London wide audit to be undertaken of the mental health needs of individuals in the thirteen approved premises.

21. Information Gaps

This needs assessment has estimated the prevalence of mental health amongst offenders in the three custody suites in Westminster. However, little is known about the prevalence of mental health amongst remanded or sentenced prisoners that provide Westminster postcodes. Therefore further work is required within these areas.

This needs assessment highlighted that personality disorder and learning disabilities were being missed within custody suites, however, further work needs to be completed surrounding the feasibility of introducing appropriate screening tools within these settings.

Although some data was available from Probation, further information is required to gain a greater understanding of their role within the offender pathway and in the identification and assessment of mental health and learning disabilities amongst offenders.

Information on Court diversion highlighted that the majority of offenders being referred to the court diversion team are not Westminster residents. A more detailed piece of work needs to be completed to find out which court diversion schemes Westminster residents are accessing and if once assessed they are being directed back to Westminster services or are accessing services outside the borough.

Further research needs to be completed surrounding mental health, offending and re-offending within Westminster.

22. Conclusions

Westminster has a high number of offenders requiring health and other services. It is disproportionately affected by non residents travelling into the borough to offend. The transient nature of the population, the high levels of homelessness, substance misuse are all contributing factors. As a result the burden on service provision, such as liaison and diversion services are immense.

Identification and diagnosis of mental health and learning disabilities within the offender pathway remain complex, particularly if offenders do not present with high levels of distress, are under the influence of alcohol or drugs or are unknown to services. Evidence indicates that prevalence rates of personality disorder amongst offenders are high however, prevalence rates in Westminster in the three custody suites, court diversion and probation, were low indicating that diagnosis is being missed. An evaluation of the current risk assessment tools within each setting are required with emphasis on identifying personality disorder to improve identification.

Two focus groups highlighted that clear gaps were evident in the knowledge of mental health and learning disabilities; therefore continued, consistent training covering both these areas is required for all staff involved in the criminal justice process.

Continuity of care for the offender within the criminal justice system remains fragmented, therefore closer links between services is required to ensure that adequate information regarding offenders is available.

This needs assessment has attempted to provide an overview of the mental health and learning disabilities amongst offenders in Westminster custody suites. However, the complexities of the pathway and gaps within the pathway have meant that not all of the issues have been addressed in this needs assessment. Further work is required to gain a comprehensive view of the offender pathway in the context of Westminster in order to implement interventions appropriately. Particular areas that should be considered for further work include:

- Mental health needs of offenders remanded on bail.
- Further work surrounding court diversion, which schemes Westminster residents are accessing and which services they are being referred to.

- The role of Westminster probation within the offender pathway and the mental health and learning disabilities needs of offenders on probation.
- Further knowledge regarding pre sentence court reports and the current commissioning of psychiatric courts reports in Westminster.
- The mental health and learning disability needs of prisoners within Wandsworth prison that provide a Westminster postcode.

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Appendix A; For the purpose of this needs assessment the following diagnostic categories for mental health are included from the International statistical classification of diseases, 10th version (WHO, 2007).

ICD 10 Code	Category	Disorders covered in this needs assessment
F00- F09	Organic, including symptomatic, mental disorders	Dementia in Alzheimers
F10- F19	Mental and behavioural disorders due to psychoactive substances	Alcohol use, opioids and cocaine.
F20- F29	Schizophrenia, schizotypal and delusional disorders	Paranoid schizophrenia, delusional disorders, acute and transient disorders.
F30- F39	Mood (affective) disorders	Manic episode, bipolar affective disorder, depressive episode and affective mood disorders
F40- F48	Neurotic, stress- related and somatoform disorders	Phobic anxiety disorders, generalised anxiety disorders, obsessive compulsive disorders
F50- F59	Behavioural syndromes associated with physiological and physical factors	
F60- F69	Disorders of adult personality	Specific personality disorders.
F70- F79	Mental retardation	Mild mental retardation
F80- F89	Disorders of psychological development	
F90- F98	Behavioural and emotional disorders onset usually occurring in childhood and adolescence.	

Appendix B

Civil section 2

'Section 2 of the mental health act allows compulsory admission for assessment followed by medical treatment up to 28 days. An application under this section can be made by a relative or an approved mental health professional (AMHP) and must be supported by two medical recommendations one of which must be from an approved doctor under Section 12 of the. The medical recommendations must agree that the detention is in the interests of the patient's own safety, or the safety of others, or the patient is suffering from mental disorder of a nature or degree which warrants detention for assessment, or assessment followed by treatment, at least for a limited period'.

Civil section 3

Section 3; Detention for treatment as opposed to assessment, up to 6 months, this can be extended. A responsibility of aftercare comes with this section.

Section 35

Section 35; Remand to hospital by the court for assessment up to 28 days, the court can renew this, but only up to 28 days at a time.

Section 37

Section 37; A hospital order from the court, treatment up to 6 months. Under this section there is an obligation for further services-

Appendix C All stages diversion model (adapted from Sainsbury's centre, 2008)

Early intervention

Prevention	Early identification of risk factors for vulnerability, mental health problems and offending and of supporting protective factors.
Pre- arrest	Identification of vulnerable people before they experience a crisis. Links to local mental health and other support services. Prevention of vulnerable people coming into contact with the criminal justice system. Support for families and carers.
Point of Arrest	Common sense policing. Options for police officers other than arrest. Increased partnership working between the police, mental health and other support services. Appropriate referral to local mental health and other support services.

Criminal Justice decision making

Arrest/ Pre- court	Identification and assessment of mental health problems at police stations. Appropriate use of cautions. Early liaison with bail support services. Liaison with police/ crown prosecution on charging decisions. Appropriate referral to local mental health and other support services.
Bail, remand and sentence	Identification and assessment of mental health problems at the courts. Improved understanding and use of diversion options. Avoidance of remand and imprisonment where appropriate Co- ordinated packages of care Assertive interventions to ensure engagement of services

Through- care and recovery

Custody/Detention	Identification and assessment of mental health problems in prisons Appropriate referral to prison mental health in reach teams Appropriate transfer to hospital. Plan for resettlement.
Community	Resettlement and continuity of care Assertive interventions to ensure continuing engagement with services. Support to promote stabilisation, aspirations and lifestyle change Support for families and carers.

Appendix D; Criminal Justice Liaison and diversion service provision in London

Service	Service Provision	Local authority
South London and Maudsley NHS foundation trust	HM Prison Brixton and Camberwell Green Magistrates court	Lambeth
Central and North London West London NHS foundation trust	Magistrates court	Kensington and Chelsea and Hammersmith and Fulham
North London forensic service	Police station	London Borough of Camden. London Borough of Haringay.
Together (Kingston and Richmond)	Richmond and Kingston magistrates court	Kingston and Richmond
Together (Camden and Islington)	Highbury Corner magistrates court	Camden and Islington
Together Hackney	Women's court liaison and outreach project	Hackney
Harrow mentally disordered offenders team	Police stations/ magistrates court/ Crown court	London borough of Harrow
South West London and St Georges Mental Health NHS trust	Wimbledon Magistrates court.	
CNWL Police liaison nurses	Charing Cross and Belgravia police station	.Westminster
Court diversion scheme, Wandsworth- South west London and St Georges Mental Health Trust.	South Western Magistrates Court	London borough of Westminster.

Service	Service Provision	Local authority
CNWL Mental Health foundation trust	Brent magistrates court	Brent
South London and Maudsley NHS foundation trust.	Croydon Magistrates court	London borough of Croydon
Together (Enfield)	Enfield magistrates court	Enfield
Together (Southwark)	Camberwell Green Magistrates court	Southwark.
Together (Hackney and Tower Hamlets)	Thames Magistrates court	Hackney PCT/ Tower Hamlets
Together (Hounslow)	Hounslow magistrates court	Hounslow
Together (Ealing)	Ealing magistrates court	Ealing PCT
East London NHS Foundation Trust	Magistrates court	
Central and North West London NHS foundation trust	Uxbridge Magistrates court and Heathrow, West Drayton and Uxbridge police stations	London Borough of Hillingdon
Central and Northwest London NHS foundation	Central criminal court	
Together	Stratford Magistrates court	Newham
Westminster City Council	Horseferry Road, magistrates court	City of Westminster
Oxleas NHS Trust, The Bracton Centre	Magistrates court	Southwark, Bexley, Bromley, Greenwich.

Appendix E; The recommendations' included from the Bradley Report from arrest onwards in the context of Westminster.

Recommendation from Bradleys report.	Recommendation in the context of Westminster.
A review of the role of appropriate adults in police stations should be undertaken and should aim to improve the consistency, availability and expertise of this role.	Review of the role of the appropriate adult in Charing Cross, Belgravia and Paddington Green custody suites.
Appropriate adults should receive training to ensure the most effective support for individuals	Mental health and learning disability training for appropriate adults.
All agencies involved in the use of Section 135 of the Mental Health Act 2007 must agree a joint protocol on its use.	Mental health standard operating procedure provides information regarding section 135. However, no joint local document exists.
All partner organisations involved in the use of Section 136 of the Mental Health Act 2007 should work together to develop an agreed protocol.	Joint policy document exists between CNWL, Westminster City Council social and community services department and the Metropolitan police service based at north, south and central. (page)
Discussion should immediately commence to identify suitable local mental health facilities as the place of safety, ensuring the police station is no longer used for this purpose.	
The NHS and the police should explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS at the earliest opportunity.	

Recommendation from Bradley's report.	Recommendation in the context of Westminster.
<p>All police custody suites should have access to liaison and diversion services. These services would include improved screening and identification of individuals with mental problems or learning disabilities, providing information to police and prosecutors to facilitate the earliest possible diversion of offenders with mental disorders from the criminal justice system and signposting to local and social care services as appropriate.</p>	<p>Two police liaison mental health nurses currently provide cover for Charing Cross and Belgravia police custody suites. Provision to be made for Paddington Green. Two Mental Health liaison officers are employed within Westminster. (Page)</p>
<p>Liaison and diversion services should also provide information and advice services to all relevant staff including solicitors and appropriate adults.</p>	
<p>Mental health awareness and learning disabilities training should be a key component in the police training programme.</p>	<p>Current training provision surrounding mental health issues and learning disabilities is limited and sporadic. Training to be reviewed and implemented as a consistent and integral part of police training. (page</p>
<p>An audit should be undertaken of the mental health needs of individuals in approved premises and the capacity of local services to deal with the identified need.</p>	<p>Thirteen approved premises exist in London. The nearest approved premise is in Camden, however, if no beds are available the offender could be sent anywhere. Therefore an audit of all approved premises in collaboration with other PCTs, would provide an evidence base for the mental health needs of individuals in approved premises.</p>

Recommendation from Bradleys report.	Recommendation in the context of Westminster.
A full evaluation of the three approved premises with enhanced mental health provision should be undertaken. The evaluation should look at the effectiveness of the current service provision and whether it offers value for money.	London wide: An evaluation of the mental health needs of offenders within the thirteen approved premises in London.
All probation staff should receive mental health and learning disabilities awareness training.	
Courts, health services, the probation service and the crown prosecution service should work together to agree a local service level agreement for the provision of psychiatric reports and advice to the courts.	
Improved services for prisoners who have dual diagnosis of mental health and drug/ alcohol problems should be urgently developed.	Dual diagnosis services within Wandsworth prison are delivered by: Three dual diagnosis trained CPNs employed within the mental health in reach service and a Consultant trained in addictions.
An evaluation of the dangerous and severe personality disorder programme should be conducted, including current therapeutic communities in the prison estate.	Therapeutic community at Grendon.
Prison mental health teams to link in with liaison and diversion services to ensure that planning for continuity of care is in place prior to a prisoners release, under the care programme approach.	

Recommendation from Bradley's report.	Recommendation in the context of Westminster.
Awareness training on mental health and learning disabilities must be made available for all prison officers.	Mental Health awareness training is delivered in Wandsworth in conjunction with the Prison. No current training exists for learning disabilities. Both mental health teams have also completed training on Personality disorder.
Where appropriate, training should be undertaken jointly with other services to encourage shared understanding	
And partnership working. Development of training should take place in conjunction with local liaison and diversion services.	
Key role of developed liaison and diversion schemes to liaise with prison mental health in reach teams to ensure that planning for continuity of care for prisoners on release is in place. Once a prisoner has been released, the liaison and diversion services will continue to act as a point of information and support for probation and third sector staff and other organisations involved in resettlement.	
Further work should be undertaken to ensure better implementation of the care programme approach for people with mental health problems in prisons, to ensure continuity of treatment through the prison gate	Links between Wandsworth and CMHT's exist, however continuity of care is sporadic and complex. Often based upon the following: If the offender provides/ has a postcode if so, service provision within the offenders' catchment area. If not, service provision and capacity within the area that the offence was committed. Continuity of care is also largely dependant on whether the offender is known to services prior to serving a custodial.

A comprehensive mentoring programme for people leaving custody with mental health problems or learning disabilities and returning to the community.	
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Appendix F; Focus groups

Two focus groups were completed, consisting of custody officers and designated detention officers. Groups were divided according to role. The aim was to determine how aware and knowledgeable both groups felt about mental health issues, the range of mental health issues, ability to differentiate between mental health issues and learning disabilities and how effective the risk assessment tool is in determining this.

The first focus group took place on February 9th 2010, 22 participants, 11 custody officers and 11 designated detention officers. The second focus group took place on February 16th 2010 and consisted of 16 participants, 8 custody officers and 8 designated officers. A series of 13 questions were asked and the answers collated, please see Appendix.

The main themes raised by the custody officers were as follows;

- The risk assessment was used daily and was fairly easy to use however, often became repetitive in places and some of the questions could be pooled together. It was found to be useful for and was used as an aide memoir, but often what mattered was their own experience. Some questions were vague e.g. medical history, how far back do you go?
- The majority felt knowledgeable regarding mental health issues.
- Common mental health issues seen within the custody suites included schizophrenia, depression and anxiety.
- It was also raised that it was very common to see people coming into the custody suites under the influence of illicit substances or alcohol.
- The most common learning disabilities highlighted were dyslexia and literacy issues, however often people would state that they had dyslexia when in fact they could not read or write as this was seen to be more acceptable and less embarrassing.
- Differentiation between mental health and learning disabilities was not necessarily important for custody officers as people with either or both would be treated as vulnerable.

- Basic training (need to determine what this is?) was received surrounding mental health issues; however, no specific training was received around learning disabilities.
- Finding an appropriate adult was fairly straight forward as long as it was a family member, however, contacting social services was very challenging particularly if it was after 6pm. Social services would generally not want to attend if a solicitor wasn't present.

The main themes raised by the detention officers were as follows:

- It was felt that the risk assessment was useful, however only as useful as the information provided by the detainee and not particularly useful if the person was under the influence of drugs or alcohol.
- A large number relied on instinct and relationships with other officers regarding suspicions surrounding mental health and learning disabilities of offenders.
- Common mental health issues seen were depression, anxiety, personality disorder and paranoia. However, it was felt that being in police custody heightened feelings of anxiety, stress and fear.
- The role of the appropriate adult was felt to be difficult and needed to be defined, what is considered to be appropriate as some adults that were contacted clearly weren't.
- Training experiences were mixed within the group, with some receiving more than others. In general it was felt that more information or training surrounding mental health and learning disabilities would be useful, particularly when assessing whether there was any risk to themselves e.g. likelihood of violence. In terms of training it was suggested that it would be useful if it was delivered by a mental health team using role play.

The groups were also asked to define personality disorder and dual diagnosis:

Dual diagnosis: The majority of the group were unable to define the term.

When asked to define personality disorder comments included the following; unpredictable behaviour, a form of mental illness, someone who thinks or believes she or he is someone else, suicidal, self harmer, attention seeker.

Appendix G

Probation

An offender is identified as potential having a mental health issue in OAsys if they score 1 or 2 in one or more of the following questions:

2.10 – Non-Compliance with medication (No = 0, Yes = 1)

2.10 – Psychiatric Problems (No = 0, Yes = 1)

10.1 – Difficulties Coping (Evidence of emotional instability or emotional stress, does s/he become easily upset, feel low or anxious, or have worries which interfere with everyday functioning?) Score 0, 1, 2)

10.2 – Current psychological problems/depression (Psychological dysfunction or symptoms diagnosed by a GP, psychiatrist or clinical psychologist, including any history or treatment of phobias or hypochondria) Score 0, 1, 2

10.5 – Self harm, attempted suicide, suicidal thoughts or feelings - No = 0 Yes = 2

10.6 – Current psychiatric problems (Psychiatric illness or symptoms diagnosed by a GP or psychiatrist including anxiety, obsessive compulsive behaviours, anorexia, sexual dysfunction, schizophrenia, bipolar disorder) Score 0, 1, 2

10.7 – Current psychiatric treatment or treatment pending – (No = 0 Yes = 1)

