

Not a Marginal Issue

Mental Health and the criminal justice system in Northern Ireland

March 2010

Criminal Justice Inspection
Northern Ireland
a better justice system for all





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List of abbreviations

ACE	Assessment, Case Management and Evaluation used by the PBNI
ACPO	Association of Chief Police Officers
ASD	Anti-social personality disorder
ASIST	Applied Suicide Intervention Skills Training
CAMHS	Child and adolescent mental health services
CBT	Cognitive behavioural therapy
CJI	Criminal Justice Inspection Northern Ireland
CJS	Criminal Justice System
CPN	Community psychiatric nurse
DHSSPS	Department of Health and Social Services & Public Safety
FMO	Forensic Medical Officer
GB	Great Britain
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
IQ	Intelligence quotient
JJC	Juvenile Justice Centre
MDO	Mentally Disordered Offender
MHLOs	Mental Health Liaison Officers
NACRO	National Association for the Care and Resettlement of Offenders
NIACRO	Northern Ireland Association for the Care and Resettlement of Offenders
NI	Northern Ireland
NiCHE RMS	Records Management System provide by Niche Technology (in PSNI)
NICtS	Northern Ireland Court Service
NIPS	Northern Ireland Prison Service
PBNI	Probation Board for Northern Ireland
PD	Personality disorder
PDP	Potentially Dangerous Person
PPANI	Public Protection Arrangements for Northern Ireland
PPS	Public Prosecution Service for Northern Ireland
PSNI	Police Service of Northern Ireland
PSR	Pre-Sentence Report (by the Probation Board)
REACH	Reaching out to prisoners through Engagement, Assessment, Collaborative working and Holistic approach
RMN	Registered mental health nurse
SpR	Specialist Registrar
YCS	Youth Conference Service
YJA	Youth Justice Agency
YOC	Young Offenders Centre



Chief Inspector's Foreword

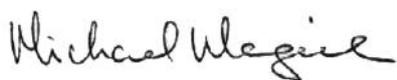
Evidence suggests that around 16% of those individuals who are placed into custody meet one or more of the assessment criteria for mental disorder. In addition, it is estimated that 78% of male prisoners on remand and approximately 50% of female prisoners are personality disordered – a figure seven times that of the general population. Personality disorder is often combined with and aggravated by the abuse of alcohol and drugs. Mental health within the criminal justice system is not a marginal issue.

This report follows the treatment of people with mental health problems through the criminal justice system starting with the police, moving through prosecution and the courts and ending up with prisons and probation. During this thematic inspection Inspectors saw some excellent practice across the system as professional staff try to deal with some very vulnerable, difficult and in some cases, dangerous people. Our report highlights a range of deficiencies in provision across the system. Agencies struggle with the demands of dealing with people with mental health issues and find it difficult to access the expert services they need.

The amount the justice system spends on mentally disordered persons who are repeat offenders is substantial; to the detriment of the rest of the criminal justice system. There are also important questions of how society can be sure that justice is being done, the rights of individuals are being respected and, the safety of staff assured when dealing with vulnerable and sometimes very dangerous people. The consequences of the release from prison of people with mental health problems without having received adequate treatment, are seen in some of the most appalling offences ever to hit the news headlines.

The treatment of people with mental disorders presents enormous challenges to the criminal justice system. Earlier screening and assessment is critical. The strategic objective should then be to divert, whenever appropriate, more offenders away from custodial care. Prisons are not therapeutic environments and generally make mental health matters worse. For those who are imprisoned, the quality of care within the system needs to be improved. In addition, more effort should be made to successfully re-integrate people into the community when they emerge from the justice system. Greater collaboration between justice agencies is required to provide a more connected service that deals with the needs of individuals at each critical stage of their interaction with the criminal justice system. We also recognise that this cannot be the sole responsibility of the justice system. A stronger relationship between justice and health is an important foundation for moving forward.

The inspection was carried out by John Shanks, Brendan McGuigan and Danielle Reaney. I would like to express my thanks to them and to all those who participated in the inspection.



Dr Michael Maguire
Chief Inspector of Criminal Justice in Northern Ireland
March 2010

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Executive Summary

Northern Ireland's prisons hold a number of people with mental health problems who arguably should not be there. Imprisoning them is not always the best response to their offending; it frequently does them no good and risks further harming their mental health, making them more likely to re-offend. Mentally disordered offenders are adding to the prison population and will increasingly do so with the introduction of extended and indeterminate sentences for offences of 'dangerousness'. The cost implications are worrying. Moreover, the prisons are not staffed to deal with these people. There has been a deficit of professional psychological and psychiatric input not just for the Northern Ireland Prison Service (NIPS) but for the Criminal Justice System as a whole.

The Police Service of Northern Ireland (PSNI) likewise is struggling to deal with mentally disordered persons, with often inadequate support from the Health Service. On occasion it finds hospitals unco-operative and having to return people into the community with every expectation that they will be back into the criminal justice system within a short time.

In Northern Ireland there has been a historic lack of resourcing for mental health services. There is an estimated 25% higher level of need than in England and Wales, and in this context, a wide-ranging review of mental health services (The Bamford Review) was undertaken. This review, among other things, looked specifically at mental health in relation to the justice system. There are some commendable initiatives being taken in response to Bamford, but its recommendations were ambitious and there is understandable difficulty in implementing many of them in the face of current resource constraints.

Mental health provision is deficient across Northern Ireland and we cannot expect a top class service for offenders. Nevertheless, there is a particular concentration of mental health problems in the offending population and it is in the wider public interest - for financial reasons no less than for reasons of public protection - that they should receive special attention. This may well mean a criminal justice 'premium' in terms of budget for the provision of mental health provision. There needs to be greater clarity about who is responsible for what in relation to mentally disordered offenders, and a real commitment on the part of the Health Service to accord the necessary priority and resources to their treatment.

Even if more mentally disordered offenders are diverted into the Health Service, it may be that, at the end of the day, society is forced to conclude that there is no alternative to imprisonment for an increasing number of people. But if so, that has radical implications for the future character of the NIPS. It will need to be seen as a secure care service, no less than as a penal service. In addition it will need to be resourced with the right mix of professionals to provide mental healthcare as a core function. It will also be required to plan its estate and design its next generation of buildings with mental health, not just security, in mind. Above all, it will need to run 'healthy prisons' as defined in previous inspection reports by Criminal Justice Inspection Northern Ireland (CJI) and Her Majesty's Inspectorate of Prisons (HMIP).



There are messages in this report for all the agencies of the criminal justice system. They all struggle with the issues of mental health, and find it difficult to access the expert services they need. The Inspectorate has been cautious in its recommendations, recognising that these are difficult times and additional resources are unlikely to be forthcoming. Nevertheless, we believe that a clearer understanding of the issues can lead to better co-operation between the justice agencies and health and social care services, resulting in better outcomes, both in terms of fairness and appropriate clinical treatment for the individual, and of safety and cost for the citizen and taxpayer.

Developing effective partnership arrangements between the criminal justice system and the Health Service is the right way forward in the next few years. This cannot be taken for granted, and it is necessary to ensure that appropriate services are being delivered that provide a meaningful impact on the care regime for prisoners. We accept that the Health Service should have responsibility for the delivery of healthcare in prisons. This is in line with practice in England and Wales. We recommend, however, that the quality of service delivery should be subject to formal review to ensure that appropriate developments are taking place.

This report identifies the following as the six main areas in which changes need to be made:

- Establish clear rules about where mentally disordered people are to be taken when they are arrested or detained by the police. The rules should distinguish between different sorts of cases and should be specific about the relevant place of safety for each category in each police district.
- Make sure that mentally disordered people are properly assessed when they arrive at the place of safety. In police stations, this means extending the Mentally Disordered Offender (MDO) scheme to cover all the custody suites in Northern Ireland.
- Make sure that the assessment (and any other available information) is properly recorded on the PSNI's information system (NiCHE) and is passed on as part of any file which goes to the Public Prosecution Service for Northern Ireland (PPS).
- Make sure that the PPS brings any mental health issues to the attention of the Court at the earliest opportunity, so that the judge can consider it (and call for further expert advice, if necessary) before the case is heard.
- Make sure the care of prisoners is based around the 'healthy prison' agenda which provides real and significant outcomes for prisoners. There is a need for on-going review of the quality of care provided by the Health Service and corrective action taken where necessary. In addition, there is a need for a local high secure hospital to which the most dangerous mentally disordered prisoners can be transferred for treatment.
- Focus on the need for suitable accommodation to help mentally disordered offenders to make the transition back into the community with adequate supervision and aftercare.



Recommendations

- The PSNI should introduce a training module on mental health based on an e-learning package currently being developed by The National Centre for Applied Learning Technologies, the National Police Improvement Agency and Association of Chief Police Officers (ACPO) (*paragraph 2.4*).
- The PSNI should finalise a protocol with the Health Service making clear the precise respective responsibilities of the two services, so that there is clarity about how mentally disordered persons are to be handled (*paragraph 2.12*).
- The PSNI should ensure that Custody Officers complete a mental disorder warning on NiCHE RMS for those detainees presenting with a mental health condition (*paragraph 2.23*).
- The Mentally Disordered Offender (MDO) scheme should be extended to all custody suites in Northern Ireland (*paragraph 2.32*).
- The Northern Ireland Court Service (NICtS) should arrange for judges to have access to expert advice in interpreting psychiatric reports and handling cases which involve mental health issues (*paragraph 3.3*).
- Where material issues of mental health are raised by the Public Prosecution Service for Northern Ireland (PPS) or other advisers, judges should hold preliminary hearings to establish the mental state of the defendant (*paragraph 3.4*).
- The Public Prosecution Service *Code for Prosecutors* should devote more space to questions of fitness to plead and possible non-responsibility by virtue of mental incapacity or mental disorder (*paragraph 3.15*).
- The PSNI should bring mental health issues that might affect the conduct of a case to the attention of the PPS at the earliest opportunity (*paragraph 3.17*).
- The PPS should be pro-active in flagging up for the Courts, mental health issues that might affect the conduct of a case (*paragraph 3.17*).
- The Probation Board for Northern Ireland (PBNI) should be granted more time to prepare Pre-Sentence Reports (PSRs) in cases which involve difficult mental health issues (*paragraph 3.29*).
- Assess the need for a local high secure hospital to which the most dangerous mentally disordered remand prisoners can be transferred for medical treatment (*paragraph 3.36*).

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- The needs of mentally disordered offenders should be factored into the strategic review of hostel (Approved Premises) accommodation (*paragraph 3.44*).
 - A specialist child and adolescent psychiatrist should be appointed, based in Northern Ireland, to advise the criminal justice agencies (*paragraph 5.23*).
 - All the criminal justice agencies in Northern Ireland should collect statistics on the incidence of mental health issues in the cases they handle and these should be shared with the Health Service (*paragraph 5.32*).
 - The Health Service should be held accountable for the delivery of the programme of improvements to mental healthcare in prisons which is planned (*paragraph 6.2*).
 - The Northern Ireland Personality Disorder Strategy should be pursued as quickly as possible, and to the degree that, resources allow (*paragraph 6.7*).
 - A formal review of the service provided by the Health Service to the NIPS should be undertaken in 2014. The review would consider the impact on prisoner outcomes of the services provided by the South Eastern Health and Social Care Trust against NIPS requirements and Her Majesty's Inspectorate of Prisons' 'healthy prison' test (*paragraph 7.9*).
 - A joint Health and Criminal Justice Programme Board should be created to bring together all relevant organisations to develop a clear approach to the needs of mentally disordered offenders (*paragraph 7.15*).



Section



Inspection Report



CHAPTER 1:

The issues to be addressed

1.1 The treatment of people with mental disorders presents enormous challenges to the criminal justice system. Mentally disordered persons¹ are not merely troublesome to deal with, but are also costly to the system. There are important questions to ask about how one can make sure that justice is being done to them, that their rights are being respected, and that the safety of staff and of the public is being assured.

Mental illness and personality disorder

1.2 The subject is complicated by the problem of definitions and by the frequent difficulty of diagnosis. The term 'mental disorder' embraces both mental illnesses such as paranoia and schizophrenia and personality disorders such as borderline personality disorder and anti-social personality disorder. We are talking primarily about people whose behaviour is seriously disturbed and perhaps aggressive and unpredictable, such that they pose a danger to others or to themselves. Lord Bradley, in his review of people with mental health problems and learning difficulties within the criminal justice system,² provides what seems

an acceptable option: *“Those who 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 ill. It also includes those in whom a degree of disturbance is recognised even though it may not be severe enough to bring it within the criteria laid down by the Mental Health Order Northern Ireland 1986.”*

1.3 It is estimated that 78% of male prisoners on remand and 64% of sentenced prisoners are personality disordered. For females the figure is said to be 50%. Anti-social disorder (ASD) is the most common in all categories, particularly among men. Paranoid personality disorder (PD) is the second most common among men, while borderline PD is second among women. The Probation Board for Northern Ireland (PBNI) told us they believed there was a great deal of confusion and mis-diagnosis, and that many people were on medication for mental illness who were actually personality disordered. Inspectors understand that medication is indicated and commonly prescribed, in the management of co-morbid

1 The NI Human Rights Commission prefers the term 'people with mental health problems'. The reasons for that are acknowledged, but 'mentally disordered persons' is more convenient and is in standard use in discussions of this subject.

2 *Review of people with mental health problems or learning disabilities in the criminal justice system*; The Rt. Hon Lord Bradley, 30 April 2009; [www.dh.gov.uk/en/Publications and statistics/Publications/PublicationsPolicyandGuidance/DH_098694](http://www.dh.gov.uk/en/Publications%20and%20statistics/Publications/PublicationsPolicyandGuidance/DH_098694)



symptoms in people with a personality disorder.

1.4 These high figures for the incidence of personality disorder, however, cover a wide range of *degrees* of disorder and have to be treated with caution. The incidence of PD in the offender population is significantly higher than in the population at large, but the majority of them have to be seen as offenders who have a degree of PD, rather than as innocent sufferers from PD. There is a tendency sometimes to interpret the high figures for PD in the prisoner population as a sign that the justice system is flawed. Inspectors do not share that view. The boundary between responsibility and incapacity is necessarily fuzzy, and it may not be set exactly right – we look at the issues of fitness to plead and or the capacity to form a criminal intent (*doli capax*) in Chapter 3 – but there are no grounds for thinking that the great majority of those convicted should not have been tried for their offences.

1.5 There is a separate question of how mentally disordered offenders should be sentenced once they have been convicted. To what extent should mental disorder count as a mitigating factor? Even if mental disorder is not directly causative of offences, it is at least stochastically causative³, with the incidence of PD in the prisoner population three or four times that in the general population. The reality is,

however, that for a wide range of offences of ‘dangerousness,’ current sentencing policy means that mentally disordered offenders are liable to be sentenced more severely than others⁴ for similar offences. There is an acknowledged policy dilemma there.⁵

Personality disorder

‘Psychopathic disorder’ is the term used in the Mental Health Act (England and Wales), referring to people who have: “*a persistent disorder or disability of mind ... which results in abnormally aggressive or seriously irresponsible conduct.*”

The Act distinguishes between ‘psychopathic disorder’ and ‘mental illness,’ but puts both under an umbrella term of ‘mental disorder’. Anti-social disorder is the diagnosis most commonly, though not exclusively, associated with psychopathy. People all have a mixture of personality traits, and where a tendency to one or other trait shades into personality disorder is necessarily a matter of judgment. Someone with a personality disorder will engage in a certain behaviour pattern that causes more problems than it solves - if not for them, then for the people around them. This behaviour tends to be the result of a deeply held belief related to the way they view the world. Their belief in this world view is so strong that any evidence to the contrary is discounted. They may be aware of the problems experienced by the people around them, but are unable to make a connection between these problems and their behaviour. When they are

3 In the way that smoking can be said to cause cancer: it does not happen in every case, and plenty of personality disordered persons manage their lives successfully, but there is a strong positive correlation between PD and offending.

4 Under the Criminal Justice Order (NI) 2008 extended and indeterminate sentences have been introduced for a range of offences indicative of ‘dangerousness’.

5 There are currently proposals in England and Wales for sentencing guidelines which would reduce the ability of judges to exercise discretion in cases of diminished responsibility. Inspectors believe that, if anything, more not less room for judicial discretion is required, and would be concerned if such guidelines were to be introduced in Northern Ireland.

affected by negative consequences they will often try to find ways of coping that, because they are based on the same world view, only create more negative outcomes.

Given the uncertainty about diagnosing personality disorder, it is not surprising that there are disagreements about which patterns of belief and behaviour make up antisocial personality disorder. Four features recur, though, all of which are linked to offending behaviour.

They are:

- failure to make intimate relationships;
- impulsiveness;
- lack of guilt; and
- not learning from adverse experience.

the more moderate end of learning disability. Of those, roughly half would have severe or profound learning disability, which in a quarter to a third of cases is accompanied by very challenging behaviour, not dissimilar to the behaviour encountered in some personality disordered patients. A large number of people coming into custody would have a low IQ, but those with serious learning disability are usually identified by the police and diverted into care without ever coming before the courts. It is particularly difficult to treat personality disordered patients with learning disabilities because many of the therapies (such as Cognitive Behavioural Therapy - CBT) rely on a degree of verbal ability.

Addiction and mental disability

1.6 Mental disorder is often combined with, aggravated by and sometimes masked by the abuse of alcohol and other drugs. The combination is known as a 'dual diagnosis'. Separating out the effects of the mental disorder can often be problematic. But we do not include people with a drug addiction alone in the category of the mentally disordered. If we did so the proportion of offenders and suspects covered by the definition would be impossibly large.

1.7 Another 'dual diagnosis' is the combination of mental disorder and learning difficulty (or learning disability). People with learning disability amount to about seven per 1,000 of the population, or about 10,000 people in Northern Ireland. The figure is imprecise, especially at

1.8 Even without the addicted and the learning disabled, the proportion of people coming into the criminal justice system who suffer from some significant mental disorder is substantial. The PSNI Musgrave Street scheme for mentally disordered offenders ('the MDO Scheme') found that 16% of custody records met one or more assessment criteria for mental disorder. Studies in England and Wales found a range from 7 – 15%. Central Belfast is not typical of Northern Ireland as a whole, but on a conservative estimate, at least one person in eight coming into contact with the criminal justice system in Northern Ireland is likely to be suffering from some mental disorder.

1.9 Mental health is therefore **not a marginal issue** for the criminal justice agencies, especially since many of those with mental disorders are



liable to be persistent offenders. The Social Exclusion Unit of the Cabinet Office calculated in 2002 that the cost to the system of each recidivist was around £65,000. Good quality mental healthcare is not cheap, as we shall see, and not all conditions are treatable, but if even a proportion of mentally disordered offenders could be restored to a stable mental condition, there would be significant financial savings.⁶

Children and young people

1.10 Within the category of mentally disordered offenders, special attention needs to be given to children and young people, for whom separate arrangements are in place in Northern Ireland under the aegis of the Youth Justice Agency. We devote a separate chapter (Chapter 5) to that subject.

Human rights

1.11 The concept of responsibility is central to consideration of the human rights of people with mental health problems. It is a general principle of law that a person liable to be punished should, at the time of his/her offence have had the capacity to understand what was required by the law and to control his/her conduct accordingly. Normally, functioning adults are generally assumed to have these capacities, and therefore to be responsible for their

actions. In principle, if someone is not responsible for their actions they should not be punished but should be diverted to the appropriate health or social care services.

1.12 The courts, however, also have to take into account the safety of the public, the public demand for retribution for the offence, the general deterrent effect of the sentence on the offender and on others, and the long-term interests of the offender. In theory, there is a presumption against prosecuting someone who was mentally disordered at the time of the offence unless that is overridden by the public interest, as in the more serious cases. In practice, in the great majority of cases there is a bias in favour of prosecution.

1.13 The Association of Chief Police Officers (ACPO) guidance⁷ reflects a restrictive stance on diversion away from criminal proceedings. It says: “*The mental health of an individual should only be taken into account in deciding not to charge or to take other action through the criminal justice system if **all** of the following criteria apply:*

- *The offence is not serious and relates to a minor infringement of the law;*
- *the offence is not part of a series of offences or a pattern of offending behaviour;*
- *the mental health issue has affected*

⁶ If, very roughly, an eighth of those arrested each year are mentally disordered there are at least 3,000 regularly active mentally disordered offenders in Northern Ireland (almost certainly more). If a quarter of them could be caused to desist as a result of improved treatment that would produce savings of about £5 million a year to the justice system. £5 million a year could also be saved if the prison population could be reduced by 60, or if 80 of those currently in prison could be moved out to supervised hostel accommodation.

⁷ *Guidance/Practice Advice on Police Responses to People with Mental Health Issues*, issued on behalf of the Association of Chief Police Officers by the National Police Improvement Agency, 2008.

- the individual's criminal responsibility for their actions;
- the decision has been made in consultation with the CPS [PPS in Northern Ireland] through pre-charge advice and health and social care professionals who agree that it is in the public interest, and the interests of the offender, that a criminal justice system (CJS) response should not be pursued; and
- the individual's needs will be addressed by an appropriate health and/or social care response."

1.14 There is often a tension between the rights of the mentally disordered offender and the rights of others; and the fact that the overwhelming majority of mentally disordered offenders are prosecuted, rather than diverted out of the justice system prior to prosecution (as we shall see in Chapter 3), is not necessarily wrong in terms of human rights. It may be in the interests of some mentally disordered offenders to be prosecuted for their offences as a way of helping them to measure their own perceptions of their behaviour against those of society at large. Sometimes encouraging aggressive patients to accept responsibility for their behaviour in this way can be clinically beneficial.

The Bamford Review

1.15 The background to this thematic inspection is the review of *Forensic Services* conducted as part of the Bamford Review of Mental Health and Learning Disability in Northern Ireland, published in October 2006. That review was extremely thorough, and a great many of those with

expertise in the field contributed to it. There can be no question of this inspection attempting to improve upon the analysis contained in it.

1.16 The review produced 169 recommendations, all of which have much to be said for them. But it is often the problem when a report makes so many recommendations that it is seen as something of a counsel of perfection and the system fails to respond to it. The Northern Ireland Assembly Executive published a draft response for consultation in June 2008, but it was sketchy in relation to Forensic Services. Admittedly some of Bamford's recommendations would have been expensive, and in the current economic climate we have to be realistic about what can be achieved, but there is clearly more to be done. Bamford can be regarded as an agenda for the next 20 years.

1.17 Bamford's perspective was essentially a therapeutic one: the perspective of mental health practitioners rather than that of the justice system. In looking at the subject from the criminal justice perspective, as we do in this report, it is important not to lose that focus. Mentally disordered offenders are in the first place patients, without prejudice to the extent of their criminal liability. The principles of the Code attached to the Mental Health (NI) Order 1986 must be regarded:

- "People with mental health problems should:*
- *be treated or cared for in such a way as to maintain their dignity;*
 - *receive respect for, and consideration of, their individual qualities and*



background: social, cultural and religious;

- *have their needs taken fully into account notwithstanding the fact that within available resources, it may not be possible to meet them;*
- *receive any necessary treatment or care with the least degree of control and segregation consistent with their safety and the safety of others;*
- *be discharged from any form of constraint or control to which they are subject under the Order immediately this is no longer necessary; and*
- *be treated or cared for in such a way as to promote their self-determination and encourage personal responsibility to the greatest possible degree consistent with their needs, wishes and abilities.”*

1.18 Apart from Bamford, a great deal has been written about this subject by other authorities in recent years. In 1996 HM Inspectorate of Prisons published a report entitled *Patient or prisoner?*, which drew attention to the deficiencies in mental health provision in the Prison Service and led, some 10 years later in England and Wales and 12 years later in Northern Ireland, to the transfer of primary responsibility for prisoner health to the Health Service. They produced a further report in October 2007, which made two main findings: “*The first is that there are still too many gaps in provision and too much unmet and sometimes unrecognised need in prisons. The second is that the need will always remain greater than the capacity, unless mental health and community services outside prison are improved and people are appropriately directed to them*

before, instead of after, custody.”

Those findings would be equally relevant to this report.

- 1.19 Some of the specific needs they identified were:
- the need for the organisation and provision of specialised primary mental healthcare;
 - the need for joint working between mental health and substance misuse teams;
 - the need for care and support for those with mental and emotional needs not to be seen as the exclusive province of mental health professionals;
 - the needs of learning disability prisoners to be properly identified and adequately met; and
 - the special needs of women, who had the highest levels of emotional and psychological distress, often related to past abuse and exacerbated by distance from home and children.

1.20 In 2002 the NI Human Rights Commission published a report on *Mental Health and Human Rights*, from which we have already quoted. The National Association for the Care and Resettlement of Offenders (NACRO) published an important report in 2005 on mental health liaison schemes for mentally disordered offenders in England and Wales, together with proposed standards for the treatment of mentally disordered offenders; and in 2009 a report has been issued by *Policy Exchange*⁸ bringing together a valuable collection of national and

⁸ *Inside Out: the case for improving mental healthcare across the criminal justice system*, by Professor Charlie Brooker and Ben Ullman, Policy Exchange, 2009.



international evidence bearing on the issues. Lord Bradley's admirable report on people with mental health and learning difficulties in the justice system in Great Britain (GB) has provided further clarity on the issue. Inspectors acknowledge a debt to all these publications.

Early intervention

1.21 This report follows the usual order for thematic inspections of the criminal justice system, starting with the police, moving through prosecution and the courts and ending up with prisons and probation.

1.22 But there is an alternative way of looking at the subject. In a way it would be logical to start with the Youth Justice Agency, because of the importance of early interventions in determining the life chances of a mentally disordered offender. Experts hesitate to make diagnoses of personality disorder during childhood, because the personality may not yet be fully developed, and what is normal behaviour for adults is not necessarily normal for children. But teachers - as we note in Chapter 5 - as well as others who work with children, such as social workers, can often pick up signs of mental disorder at an early age, and it is important that they should do so and that such detection should be followed up with professional intervention.

1.23 Early interventions can be extremely valuable. As a mental health nurse at the Woodlands Juvenile Justice

Centre (JJC) told us: *“Better intervention at a younger age reduces the risk to the young person and to the community and keeps the young person out of the criminal justice system.”* If people do not receive treatment they can end up as habitual offenders and prison residents, their mental health being so poor that they feel safe only in prison and will re-offend immediately in order to be re-admitted. The cost of this, quite apart from the human tragedy, is immense. Not all interventions are going to be successful: sometimes there is a genetic element and sometimes there is early childhood trauma which is very hard to treat, but concentrating on early interventions in childhood is likely to yield disproportionate benefits.

1.24 NACRO⁹ has made the case for ‘early intervention’ in another sense, meaning ‘before the case goes to court’. NACRO believes that the focus of efforts to improve healthcare for offenders with mental health needs should be on the criminal justice process before sentencing. This shift in focus, it argues, would ensure that resources are not pre-empted by prison healthcare when they could more advantageously be directed towards treating offenders at an earlier stage of the process. Better systems need to be put in place to ensure that offenders with mental health problems are properly identified and treated as early on as possible.

1.25 Dr Shadd Maruna, Reader in

⁹ NACRO *Mental Health and Crime Policy Briefing*, 2007. See also *Liaison and diversion schemes for mentally disordered offenders*, NACRO, 2006.



Criminology at Queen's University, Belfast endorsed that view to us, arguing that the focus should be on improving community mental health provision, since mental health needs become compounded once someone is in prison. He argued forcefully for more diversion away from prison at the court stage. We shall look at the scope for that in Northern Ireland in Chapter 3.

Aims of this inspection

- 1.26 On the face of it, there are few votes to be won by championing better mental healthcare for offenders. But the amount the justice system spends on mentally disordered persons who are repeat offenders is substantial, to the detriment of the rest of the criminal justice system; and the consequences when mentally disordered people are released back into the community without having received adequate treatment are seen in some of the most appalling offences ever to hit the headlines. This is therefore a subject which merits the closest political attention.
- 1.27 It could be argued that, especially now that responsibility for prison healthcare has transferred to the Health Service, mental health is no longer an issue for the criminal justice system (or for CJI), and that this inspection should limit itself to the specific issues of:
- the management of dangerous offenders, particularly those mentally disordered offenders who pose the greatest threat to public safety; and
 - the question of whether justice is being done equitably to those who

are mentally disordered.

- 1.28 Those are indeed the priorities, but they do not narrow the scope of the inspection much. Every part of the criminal justice system (CJS) is concerned with the handling of persons with mental disorders and with the management of the threat they pose to themselves and others; while ensuring that they are treated fairly is a responsibility of all those who work in the justice system. In prisons, care of the mentally disordered is a matter for prison staff, not just for the health professionals. The case of Colin Bell (see Chapter 4) was not at the high end of the range of PD, but his death in custody was a matter of the utmost concern to the NIPS.
- 1.29 Better management of mental health issues in the justice system could result in:
- more just outcomes and fairer treatment generally for mentally disordered offenders;
 - improvements in the safety of staff working with such offenders and suspects;
 - more effective treatment of mentally disordered offenders, leading to wider societal benefits, including improved public safety, and
 - a reduction in the cost to the criminal justice system resulting from the 'revolving door' of mentally disordered offenders repeatedly presenting at police stations.

These are what we shall be looking for in the following chapters.

CHAPTER 2:

Arrest and detention



Police involvement

- 2.1 The police come into contact with mentally disordered persons in two main ways. Mentally disordered persons may be arrested on suspicion of having committed an offence, or they may be detained under the Mental Health Order (MHO) because their conduct has given cause for concern. Under the MHO, someone in a public place who is deemed to be *'in immediate need of care or control'* can be taken to a designated place of safety, where he may be detained for up to 72 hours.
- 2.2 The police may remove someone from private premises only with a warrant from a court. This is seen by some we spoke to as an unnecessary constraint, and many in the police told us they would like to see the law amended to obviate the need for a warrant. However, there are clear human rights implications and it is a policy matter on which CJI does not take a view¹⁰.
- 2.3 There is a lack of clarity among the police about their powers under the MHO, which reflects the fact that, for
- most officers, their training in mental health matters is very limited. In basic training at the PSNI Police College at Garnerville, PSNI officers receive only a few notes on the subject, and in subsequent training the main emphasis is on recognising situations of risk (such as excited delirium and positional asphyxia) and the physical actions to be taken in terms of restraint and control. Suicide prevention also features. A PSNI Procedure (*Operational Procedure and Guidance for dealing with persons with a mental disorder*) had recently been completed and circulated across the PSNI and the police have appointed a Mental Health Liaison Officer (MHLO) who is attached to Operational Support Department at Police HQ. This officer is currently attending the North West (England) Regional Forum where best practice is shared. In addition, the ACC Operational Support Department is the PSNI ACPO lead on mental health issues and represents the PSNI at a national level.
- 2.4 Inspectors would not want to impose extensive new training obligations on officers, which would be unrealistic,

10 Some police officers admitted that they occasionally circumvented the Order by arresting someone for breach of the peace in the first instance and then switching to the Order once in the police car, but that should not be necessary and can clearly not be condoned.



but there is a need for a little more attention to mental health issues. We were told that there was a manageable training package currently being developed which would be beneficial, and we recommend that the PSNI should consider adopting it. We recommend **the PSNI should introduce a training module on mental health based on an e-learning package currently being developed by The National Centre for Applied Learning Technologies, the National Police Improvement Agency and the Association of Chief Police Officers (ACPO).**

Policy on mental health

2.5 More generally, there is a need for mental health to be given a greater salience in police management. It is something of a poor relation at present. We were told it was “*not viewed as an issue to be championed*”. In policy terms it comes under Victims and Witnesses, and is regarded as a subset of policy on disability. Its handling is patchy in the different police Districts, and it is not managed consistently by Operational Support. This does not match the importance of the subject in terms of the number of offenders and other detainees who present with mental health problems. It is almost as though (as with the ACPO guidance mentioned at paragraph 1.14) the system plays down the significance of the mental health dimension, lest it should get in the way of the primary function of preventing crime and protecting the public.

2.6 Recently MHLOs have been appointed in each police District. But they range in rank, and none of them has that as their full-time responsibility. In one case, Inspectors were told it had simply been added on to existing full-time duties in a Public Protection Unit. No police officers on the ground that we spoke to had heard about their introduction or knew who they were. Inspectors are sure that MHLOs can perform a useful function, but the role needs to be taken seriously by management.

2.7 The MHLOs we spoke to showed enthusiasm for the role and were doing good work building contacts with local hospitals and social services, but they need to be given the time to do the job and they could do with a central mental health unit at headquarters to guide and co-ordinate their work. Some had to liaise with a number of health trusts. They told us that it would be helpful if their training could be localised, so that in the course of it they had opportunities to meet with their actual counterparts in health and social services.

Public protection

2.8 Public Protection Units have an important role in relation to mental health. They act as a central point for mental health issues in the police Districts. A range of mental health related issues come within their ambit. Potentially Dangerous Persons (PDPs) are now covered by the Public Protection Arrangements for Northern Ireland (PPANI) arrangements for offender



management. The great majority of PDPs would be personality disordered. Domestic violence also often involves perpetrators with mental disorder. Similarly most sex offenders are personality disordered in one way or another, though there is a wider variety of diagnoses and, as with all these offences, other than exceptions, PD is not to be regarded as an excuse.

- 2.9 There has been a marked improvement in the arrangements for the management of PDPs in recent years, but the end result has been that the majority of the most serious PDPs are now in prison. Offender A provides an example of how difficult it can be for the system to deal with such people:

Offender A

Offender A, who suffered from personality disorder, completed a seven year sentence for very serious sexual violence but was still deemed by the authorities to be highly dangerous when the time came for his release. He was three times re-arrested at the prison gates and re-committed for breaching the terms of his licence in that he had no suitable accommodation to go to. Judicial Review found against the Secretary of State for a breach of human rights. The new extended and indeterminate sentences will simplify the procedure for holding PDPs in custody, but there may still be human rights appeals if the prisoner can show that he has not been given a fair opportunity to demonstrate that he is now safe to be released.

- 2.10 It is also worth flagging up the extent to which the new arrangements will increase the PBNI's workload. Overall, Category Three (high risk) clients amount to about nine percent of those subject to PPANI. This means that the Category Three caseload should be approximately 37 cases. This figure will increase by approximately 15% annually, and will be further increased by the addition of domestic violence cases and hate crimes. Estimates would therefore suggest that by October 2011, the number of PBNI clients subject to PPANI will increase from 359 to approximately 640, with a possible 58 in Category Three.

A place of safety

- 2.11 The 'place of safety' will usually be a hospital or a police station. In practice hospitals are reluctant to admit mentally disordered persons, especially when they are still intoxicated, and police cells are more often used. Inspectors accept that people require to be managed according to clinical indications and it may not be appropriate or beneficial to admit them to hospital. But Custody Sergeants are likewise reluctant to accommodate mentally disordered persons unless they have to. Inspectors heard that police officers are often frustrated at having nowhere suitable to place such people: they feel a sense of responsibility for them, and find themselves sometimes having to release them back into the community against their better judgement.



2.12 There is an alternative view of this in the Health Service, however as a consultant told us that in his view the police could be more effective about this, and accused some of them of displaying ‘learned helplessness’. The Mater Hospital felt that it was unfairly used as a dumping ground by police from all over Belfast – particularly for off-loading people at the weekend. The police themselves were sensitive to a degree of anti-police feeling from the Health Service. There is clearly a need for building better understanding between the two services; even if some tension is unavoidable because of the competing pressures they are both under. **We recommend the PSNI should finalise a protocol with the Health Service making clear the precise respective responsibilities of the two services, so that there is clarity about how mentally disordered persons are to be handled.**

2.13 Hospitals do not see A&E Departments as a suitable place of safety. Police officers complained of having to stay with patients in hospital waiting rooms for long periods, especially if they needed to see a psychiatrist, who might work only normal office hours. Inspectors acknowledge that psychiatric sessions are available out of hours and provide 24/7 cover. The ideal solution, it was put to us, would be to create a 24-hour central mental health unit in hospital grounds, with a psychiatric ward close by; but that idea would need close examination and cost-benefit analysis before any such recommendation could be made.

Diversion out of the criminal justice system

2.14 Judges told us that they believe there should be a stronger diversionary policy in place to reduce the number of mentally disordered persons appearing before the courts. They felt the police should be diverting them to community health teams and giving them an informed warning. But the PSNI told us that they found it hard to divert such people effectively.

2.15 There is a widespread feeling among the police officers we spoke to that the level of care available in the community is inadequate, and this results in the same people coming back to the attention of the police repeatedly without having received any effective treatment. Police sometimes find themselves having to provide aftercare as long as 48 hours after an incident, which they say, is not a good use of their time. They felt they should be able to hand over responsibility for the care of a mentally disordered person to health and social services as soon as the person has been discharged from the police station.

2.16 Diversion into the health service does not necessarily mean that the person is lost sight of by the criminal justice system. On the contrary, in serious cases the police will watch closely the progress of the individual and will be ready to take appropriate action whenever they are ready to be released from healthcare.

Police cells

- 2.17 Police cells are not well suited to the purpose of a place of safety. The Joint Committee of the Lords and Commons on Human Rights in a 2005 report on *Deaths in Custody* said: *“People requiring detention under the Mental Health Act should not be held in police cells. Police custody suites, however well resourced and staffed they may be, will not be suitable or safe for this purpose. In our view, there should be statutory obligation on healthcare trusts to provide places of safety”*.
- 2.18 There is evidence to suggest that the police station environment can have a negative effect on the condition of a mentally disordered person. It has been noted that a significant proportion of deaths in custody and of serious complaints against the police in England and Wales have related to detention under the Mental Health Act.
- 2.19 Although Custody Sergeants recognised that custody should not be used as a place of safety for mental health detainees, in reality, most admitted that it was being used as such in the absence of alternatives. They saw a lack of formalised strategic partnership arrangements with healthcare providers, and officers spoke of their frustration at the way management did not seem to be able to resolve these difficulties.
- 2.20 There are therefore suggestions for a different sort of facility to be set up specifically for this purpose under the auspices of the Health Service: many of those we interviewed (including

the psychiatric nurses working in police custody facilities) argued for a central detox facility, which would provide for offenders and non-offenders alike, with the necessary secure facilities for the former. Once patients were detoxified they could be assessed and directed as appropriate into healthcare or into custody. Inspectors can see the desirability of this but, are not certain that it is a first priority in current circumstances. We believe it would be more cost-effective on the one hand to strengthen the healthcare support given to police stations and on the other hand to support the existing detox facilities for non-offenders provided by charities such as Extern.

Role of the police vis à vis the Health Service

- 2.21 At the root of many of the problems Inspectors encountered is a lack of clarity about who is responsible for dealing with mentally disordered persons who come in to the criminal justice system. The police and the Health Service are both under pressure to meet potentially limitless demands from the public. They are therefore almost bound to want to pass responsibility on to someone else if they can. The present situation of uncertainty leads to friction and bad feeling between the services. There needs to be an agreed protocol for the handling of mental health cases – which is indeed being worked upon. If that could be supplemented by some joint training of police and health service personnel, that would help to



improve mutual understanding and promote good working relations.

- 2.22 One solution which was suggested was that the Health Service should take full responsibility for health assessment and treatment in police stations, as it has (or is doing) in the prisons. In England and Wales there are discussions currently about that possibility. But the police told us that they would not find that acceptable, because they see their own forensic agenda as being in conflict, to some extent, with the clinical agenda. They regard offenders as first and foremost, criminals who need to be subject to sanctions, and they are distrustful of health professionals who, by regarding them as patients, might help them to escape justice (as the police would see it). It is not unknown for offenders to attempt to manipulate the system by feigning illness, and the police have reason to be sceptical. Inspectors agree with the police that they should retain control of health provision in police stations subject to the duty of health professionals to provide essential care.

Information systems

- 2.23 It would be helpful if the PSNI's NiCHE IT system could flag up if an offender has mental health problems. At present NiCHE records whether someone is vulnerable or intimidated and it records if they are violent towards others, but it does not record mental health issues as such. It would also be helpful if statistics could be kept of the numbers of mentally disordered person being processed through police stations. The nurses at Musgrave Street

recorded 450 cases last year, but that is only a small proportion of the total. Inspectors recommend **the PSNI should ensure that Custody Officers complete a mental disorder warning on NiCHE RMS for those detainees presenting with a mental health condition.**

The Appropriate Adult scheme

- 2.24 If a Custody Sergeant suspects that a person might be mentally disordered or otherwise mentally vulnerable he is obliged under PACE to seek the services of an 'appropriate adult' to represent the person's best interests (as with juveniles). Their role is to support, advise and assist the detainee, and in particular to ensure that the individual understands the processes and their rights during detention in police custody. The Appropriate Adult scheme in Northern Ireland has been in operation since 1 June 2009. The scheme is funded by the NIO and MindWise an independent mental health charity whose staff members are trained in mental health issues, and whose work is well regarded by those we spoke to. In the case of juveniles, the appropriate adult is normally a parent or guardian, but MindWise will provide a pool of specially trained adults able to stand in if required. MindWise staff have an advantage in terms of their familiarity with police procedures and they have demonstrated good response times.
- 2.25 The service is only available in police custody, but it has been suggested that it would be useful to roll it out across the criminal justice system.



Judges told us that they are doubtful about it. They wonder whether the scheme should rely on a charity in the first place. They think it may be just about adequate for low level cases, but believe it would struggle with more serious cases. There would be a danger, indeed, that mishandling of such a case might lead to its coming off the rails. Inspectors can see that an extension of the scheme might be desirable, but the stage at which quick assistance is most necessary and no other help is available is the point of initial detention by the police. Inspectors therefore make no recommendation for extension.

Forensic Medical Officers

- 2.26 In police custody, healthcare is conducted under the supervision of Forensic Medical Officers (FMOs) who are responsible for deciding whether a detainee is fit for questioning by the police. Where an FMO thinks admission to hospital may be appropriate he or she may advise the Custody Sergeant to arrange a MHO assessment, which can lead to compulsory admission under the Order or to voluntary admission. When an FMO decides a person is not ill enough to justify admission but is at the same time not fit for custody he will be released, and a file will be completed and passed to social services to follow-up.
- 2.27 In its recent report on *Police Custody* (published in June 2009) CJI commented on the work of the healthcare staff in Northern Ireland's police stations. There were positive

comments from detainees, and custody staff confirmed that the FMOs worked in a caring and sensitive manner. There were, however, deficiencies in the way in which the FMOs were managed, which the PSNI is already addressing. The Youth Justice Agency (YJA) expressed some doubts about whether many FMOs were adequately trained to deal with children with mental health issues: they said some had admitted to them that it was not their area of expertise. This would not be surprising, as FMOs are essentially General Practitioners (GPs) and would not be specialists in mental health.

- 2.28 In most custody suites there was no formal liaison or diversion scheme to enable detainees with mental health issues to be diverted into appropriate mental health services. Local arrangements existed between custody suites and local healthcare providers but these were *ad hoc* and not always sufficient. For example, one Custody Sergeant whose suite was close to a mental health hospital, commented that it was much harder than expected to divert detainees despite the proximity of the hospital, due to the reluctance of healthcare staff to admit them – particularly those who had a personality disorder, had consumed drugs or were considered violent. Healthcare staff are reluctant to admit people in this condition when there is an absence of any clinical indication.

The Mentally Disordered Offender (MDO) scheme

- 2.29 There are two psychiatric nurses



based in Musgrave Street who cover the four Belfast custody suites, undertake risk-based mental health assessments and when appropriate, make onward referral to mental health specialists. The scheme, which was introduced in 1998, is highly regarded by many within the PSNI and by observers abroad. The nurses are effective in placing people in healthcare, partly because of their personal contacts with their opposite numbers in the Belfast hospitals. Inspectors were told that when they accompanied a person to hospital they were never refused admission. They also had good links with the healthcare team at Hydebank Wood, and could advise them when young people with mental health issues were about to be remanded. Their recommendations as to how cases should be disposed were given great weight by District Judges.

2.30 The nurses said that it was often difficult to get a bed for someone of no fixed abode. They would sometimes liaise with the District Courts (formerly the magistrates' court) and agree that the person was best not released into the community, and the result was then that the person might end up in Maghaberry Prison for lack of an alternative. They said that they sometimes followed up people they knew to be at risk of suicide or self-harm after they returned to the community.

2.31 There were some criticisms of the MDO scheme, mainly on the grounds that the service was limited to daylight hours and alternate weekends, and there was a suggestion that there was occasionally friction between the nurses and the FMOs. But overall the assessment Inspectors received, which was confirmed by an independent academic review of the scheme¹¹, was highly positive: *“Our findings illustrate unambiguously that mental illness among many detainees was not detected by Custody Sergeants or by FMOs, but was identified accurately by the mental health nurses, who also achieved considerable success in linking MDOs to health and social services.”*

2.32 The service is confined to Belfast, and there is no counterpart in other police Districts. Inspectors were surprised to discover that there is some uncertainty about the future of the scheme, and it is possible that it may be absorbed into community psychiatric nursing. They believe it represents good practice, and recommend that the MDO scheme should be preserved and rolled out across Northern Ireland. **We recommend the Mentally Disordered Offender (MDO) scheme should be extended to all custody suites in Northern Ireland.**

11 *Mental illness in the Criminal Justice System: A police liaison scheme for Mentally Disordered Offenders in Belfast*, by Dr Sinead McGilloway and Michael Donnelly, published in the *Journal of Mental Health*, 2009.

CHAPTER 3:

The options available to the Court

3.1 Significant numbers of mentally disordered offenders are ending up in prison when they ought, it is argued, to be diverted into the Health Service. There is a particular problem in Northern Ireland at present due to the failure to recognise personality disorder on a par with mental illness. Inspectors understand that there are differences between mental illness and personality disorder, that are relevant to diverting offenders, and while both groups are particularly challenging to the criminal justice system, they require different solutions not least because of current mental health legislation. As a result the prisons see themselves having to cope with too many personality disordered offenders who pose a risk to themselves, to staff and to other prisoners. The Director of the Northern Ireland Prison Service (NIPS) told Inspectors he had made several approaches to the judiciary to attempt to persuade them to consider alternative disposals in more cases.

3.2 There are two questions that need to be addressed. Firstly, are the courts receiving the best possible advice as to the mental condition of those brought before them? And secondly, do they have a suitable range of

options open to them when considering what disposal to order?

The Judges' perspective

3.3 Judges told us that from their point of view there were three main problems:

- The large number of 'poor copers' who were offending repeatedly, generally receiving short sentences for petty offences, and not staying in prison long enough to receive any useful treatment. They described it as a 'revolving door';
- The difficulty they had in obtaining advice about mental health issues early enough. In the great majority of cases mental health issues were not addressed until after conviction, on the basis of the PBNI's pre-sentence report (PSR). Or the first the judge would know about the issues was when they were raised by the defence: it was most often the defence that recommended some form of examination, having picked up on the issues through its dealings with the client. Judges said they would often find it helpful if mental health issues could be identified earlier and could, if possible be established non-adversarially by



some form of pre-trial conference;

- Their isolation from sources of expert mental health advice. The PBNi told us that they thought judges sometimes needed help in interpreting psychiatric reports, and the judges we spoke to agreed. A particular problem was when, as sometimes happened, someone with a mental health issue dismissed his counsel half way through a trial. If they had mental health professionals close at hand, they felt they would be better placed to co-ordinate a more satisfactory solution. They also told us they did not know how to contact the psychiatrists who assisted the NIPS, and they would sometimes find it valuable to be able to talk to the mental health nurses who assisted the PSNI. They said that the most difficult cases were those involving personality disorder, which were currently outside the scope of the Mental Health Order.

Inspectors recommend **the Northern Ireland Court Service (NICtS) should arrange for judges to have access to expert advice in interpreting psychiatric reports and handling cases which involve mental health issues.**

- 3.4 As regards the second point above, a judge's options are more limited once a trial has commenced, and better outcomes might be possible if rather more cases could be disposed without ever coming to trial. The test

of 'fitness to plead' is not always a sufficient protection, because it does not address the question of mental capacity at the time of the offence. Someone like the psychotic Offender C (referred to in Chapter 7) may be fit to plead once he has taken his medication (because he would then be able to understand the proceedings in court), even if he was out of his mind at the time of the offence.¹² What is needed, as learned judges suggested, is a hearing in which questions of non-responsibility by virtue of mental incapacity or mental disorder, can be examined outside the context of a criminal trial. Inspectors **recommend** that there should be such hearings, which could with advantage be held by a judge specialising in mental health issues. Inspectors accept that in many instances the defendant's mental state or condition may only be within the knowledge of the defendant and his legal advisors. However, it should be a duty of the Public Prosecution Service for Northern Ireland (PPS) to identify such cases from the police files and to bring them to the attention of the court as soon as possible. We recommend that **where material issues of mental health are raised by the PPS or other advisers, judges should hold preliminary hearings to establish the mental state of the defendant.**

- 3.5 The PPS told us that it was, in principle, open to the defence to make representations to them pre-trial that the defendant was not

¹² Conversely, in the Bulger case the problem with Thompson and Venables was not that they were *doli incapaces* but that they were evidently unfit to plead. If the test of fitness to plead were applied more liberally it might reduce the pressure for raising the minimum age of criminal responsibility.



capable of having formed the intent to commit the crime, but it rarely happened. The defence usually left such issues to the trial. If they were to raise it, there was then the question of whether the defendant would consent to being examined by the PPS's expert or, whether the PPS would be restricted to the evidence supplied by the defence's psychiatrist. Unless the defendant consented, it was difficult for the PPS to judge what weight to give to the representations.

Fitness to plead

At the police station, a FMO examines the offender to assure their health and to check that they are fit for questioning. If the FMO suspects that s/he may be mentally disordered, s/he may ask a psychiatrist to examine him/her, and it is that psychiatrist's report which determines fitness to plead. If the psychiatrist decides that s/he is not fit to plead, the offender is diverted to the Health Service and that is the end of the matter so far as the Criminal Justice System (CJS) is concerned. The CJS cannot appeal the decision.

Conversely, if the psychiatrist finds that the offender is fit to plead, there is little further opportunity to stop the trial going ahead. The judges told us they had effectively no role in the matter at that stage. In principle, if a defendant appeared before them about whose mental capacity they had doubts, they could ask for a psychiatrist's report, but they would not usually know unless the defence raised the question, which the defence would be unlikely to do, until sentence had been passed for fear that

it might be prejudicial.

The criteria for unfitness to plead are extremely restrictive. Essentially they relate to whether the defendant has the mental capacity to understand the court proceedings. Even if the defendant was out of his/her mind at the time of the offence, s/he may still be deemed to be able to understand what is going on once s/he has been detoxified and/or given appropriate medication. The PPS confirmed that as things stood, very few cases were excluded on the grounds of unfitness to plead.

There is some concern in the legal profession¹³ that the test of fitness to plead in the criminal courts is out of line with the tests in the 2007 Mental Capacity Act, and that the Lords may at some time be asked to rule on whether that disparity might constitute a breach of the Human Rights Act. In the meantime, it is possible that some mentally disordered offenders are going through the criminal process and ending up in prison who should have been diverted at an earlier stage.

A Mental Health Court

- 3.6 It has been suggested that there should be a separate court in Northern Ireland to take cases involving mental health issues. There are examples of this quoted in the literature, notably one in Brooklyn, NY, which serves to divert mentally disordered offenders into community-based sentences and treatment programmes.

13 See, for example, Lucy Scott-Moncrieff and Guy Vassall-Adams in *Counsel* for October 2006.



Brooklyn Mental Health Court

Brooklyn Mental Health Court is a specialised court for mentally disordered offenders. It aims to address both the treatment needs of defendants and the public safety concerns of the community, by diverting mentally disordered offenders away from custody and into long-term treatment in hospital or in the community.

To achieve its goals it has adopted the following operating principles:

- detailed screening and assessment to create individualised treatment plans;
- frequent judicial monitoring to keep the judge engaged with the defendant and emphasise to the defendant the seriousness of the process;
- accountability of the defendant for his or her actions; and
- co-ordination of services with a broad network of government and voluntary providers to address the problems of substance abuse, homelessness, unemployment and physical and mental health.

3.7 Though there were some supporters, the judiciary in Northern Ireland were by and large sceptical of this proposal. They saw difficulty in defining the cases that would come to the court, pointing out that perhaps 60% of the cases coming before the District Court would involve some mental health issue, broadly defined. Who was to conduct the necessary assessment, and who was to decide? They feared that introducing such a court would lead to delay, and they were doubtful about the benefit: on the contrary, there was the possibility

that inequities could result.

Moreover, in a small jurisdiction like Northern Ireland, users of a mental health court could be unfairly stigmatised if they were known.

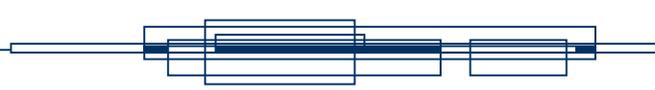
The answer was rather to ensure that every court had the capacity to deal with mental health issues when they arose.

3.8 Inspectors are not convinced that a dedicated Mental Health Court is what is needed in Northern Ireland. As we stated in the introduction to this report, mentally disordered offenders are not a marginal issue: a high proportion of those coming before any court are likely to suffer from some degree of mental disorder, and *all* courts therefore need to be mental health courts. However, pre-trial hearings of the kind mentioned in paragraph 3.4 could usefully be held by a judge specialising in the field of mental health, and in that sense a mental health court could be a useful development.

The Public Prosecution Service for Northern Ireland

3.9 The Public Prosecution Service for Northern Ireland (PPS) is involved both in the decision to prosecute, on what charge or charges a prosecution is taken forward, and in the treatment of victims and witnesses.

3.10 As regards the decision to prosecute, the PPS relies largely on the information presented by the police in the investigation file. If there are mental health issues in relation to the offender, the PPS told us they would expect to find them flagged up in the file in the form of a mental health



assessment. They may also pick up the fact from the presence of an Appropriate Adult in the police station. They would not, however, commonly see medical reports. The prosecutors we spoke to were not aware of the assessment forms prepared by the psychiatric nurses working out of PSNI Musgrave Street, but thought it would be extremely helpful to receive them.

- 3.11 Basically prosecutors take their decisions to prosecute on the basis of the twin tests in *The Public Prosecution Service Code for Public Prosecutors (The Code)*: The Test for Prosecution is met if (i) ‘the evidence which can be adduced in court is sufficient to provide a reasonable prospect of conviction’; and (ii) ‘prosecution is required in the public interest’. Among the considerations weighing against prosecution on public interest grounds is: ‘where the defendant was at the time of the offence or trial suffering from significant mental or physical ill-health.’
- 3.12 If a defendant was found to be suffering from significant mental or physical ill-health either at the time of the offence or at trial, the PPS having weighed the public interest consideration, could divert the offender to a police caution, but there would be no prescription regarding treatment for the mental disorder. It was not within the power of the PPS to divert an offender to a mental health hospital. Young offenders could be diverted into youth conferencing.
- 3.13 Fitness to plead is a separate issue to the decision to prosecute. If the Test for Prosecution is met, the PPS

will prosecute. It is for the court to determine whether or not the defendant is fit to plead and in doing so, will have regard to evidence which may be called by either party, and the submissions made by both the prosecution and defence. If the court rules that the defendant is fit, then the case will proceed to trial. If the court rules that the defendant is not fit, the trial will not proceed to trial.

- 3.14 For those cases that do proceed to trial and the accused is found to have committed the act with which s/he is charged, the court does have at its disposal a variety of orders. These can range from an order that the accused be admitted to hospital to an absolute discharge, depending on the circumstances of the individual case.
- 3.15 The *Code for Prosecutors* while mentioning that ‘significant mental ill health is a public interest factor against prosecution’, there is not a full treatment of the issue of responsibility for one’s actions, or anything about the alternative disposals (or diversions) that might be possible. Inspectors suggest that it would be worth giving the subject slightly fuller treatment in the *Code*. **We therefore recommend the Public Prosecution Service Code for Prosecutors should devote more space to questions of fitness to plead and possible non-responsibility by virtue of mental incapacity or mental disorder.**
- 3.16 As noted above, judges said that they would welcome it if the PPS were more pro-active and would flag up to them, at the earliest opportunity,



that there was a question about the defendant's mental state at the time of the offence. Evidence bearing on that might affect the course of the trial or even obviate the need for a trial at all.

- 3.17 Inspectors believe that the role of the PPS in relation to diversion on grounds of mental health could be further developed, and recommend that they should be more pro-active in advising the Court on mental health issues. For that to happen, the PPS needs to receive better and more prompt information from the police. They told us they were only receiving relevant information from the PSNI when it was needed for Court, rather than as soon as it was available. This put them under pressure and meant that the best use was not always made of the information. Providing that necessary professional/patient relationships and confidentiality issues are addressed, the assessment forms completed by the psychiatric nurses at Musgrave Street should be included in the file submitted by the PSNI to the PPS, and there is scope for more training within the PPS to alert prosecutors to watch out for mental health issues. Inspectors recommend **the PSNI should bring mental health issues that might affect the conduct of a case to the attention of the PPS at the earliest opportunity.** They also recommend that **the PPS should be pro-active in flagging up for the Courts, mental health issues that might affect the conduct of a case.**

Victims and witnesses

- 3.18 The PPS must consider what evidence can be presented at court and if the evidence is credible. Where issues of mental health arise in respect of a prosecution witness, great care must be taken to ensure that such evidence is properly assessed and all appropriate steps are taken to protect the vulnerable witness including 'Special Measures'. They need to make sure that the witness is reliable and then to ensure that the quality of the witness's evidence is maximised.
- 3.19 The PPS told us that they would generally assume that a witness would be satisfactory unless the police told them that there was a question about it. The police report might contain an assessment of the witness which would advise them if there was a potential problem. The prosecution will ask a witness to consent to examination by a psychiatrist if the circumstances so require. The outcome of such examination could be extremely important, if, for example, there was evidence that the witness was a habitual fantasist.
- 3.20 When a witness with mental health problems came to court¹⁴ they could receive the treatment accorded to other categories of vulnerable witnesses, such as:
- the possibility of giving evidence by pre-recorded video;
 - the use of screens to protect them from the view of the defendant;

¹⁴ There is an underlying problem, according to MENCAP, of a large proportion of victims with mental health and learning disabilities failing to report crime.

- the removal of wigs and gowns; and
- arranging their court appearance in short periods.

3.21 The usual caveats however applied to the giving of evidence by video. It is a general rule that evidence should be given orally at court. However, as each case and witness is different, the decision to give video evidence is still subject to the Court being satisfied that the witness was available and could be called live, if necessary, for the purpose of cross-examination.

3.22 Inspectors were told that staff in the PPS Northern Region had joined a Vulnerable Adults forum, where they could train with social workers on the treatment of clients with mental health issues. This had led to useful contacts being made with colleagues in the Health Service, Women's Aid and social services.

3.23 Prosecutors said that it was a common problem that witnesses claimed they could not attend court because of depression or other mental ailments (actual or alleged) and suggested that GPs too readily signed them off as unfit. When this had happened more than once, judges would often dismiss the case. It is important that GPs should exercise careful judgement and bear in mind the potential importance of the witness's evidence.

The legal framework for disposals

3.24 In Northern Ireland the Mental Health (NI) Order 1986 provides a range of powers for the courts to seek information about a person's

mental health and, if appropriate, divert or transfer them from prison to hospital. The most frequently (though still very sparingly) used power is a Hospital Order under Article 44 which enables the Court to detain a person who has been convicted of an offence in hospital or (rarely) place them under guardianship rather than sending them to prison. The number of Hospital Orders has been in single figures in most recent years, while total court disposals have been running at the level of around 25,000 a year.

3.25 The specific powers available to the Court are to:

- remand to hospital for a report on the accused's mental condition (Art. 42);
- remand to hospital for treatment (Art. 43);
- order hospital admission or guardianship for people who have been convicted (Art. 44);
- impose an interim Hospital Order (Art. 45); or
- restrict discharge from hospital (Art. 47).

3.26 People may also be treated by community mental health services as a condition of probation.

The Pre-Sentence Report (PSR)

3.27 The main source of advice to the Courts is the Probation Board for Northern Ireland (PBNI), by means of the pre-sentence report (PSR). The PSR will contain a risk assessment, which will highlight any mental health issues. The ACE (Assessment, Case Management and Evaluation) risk assessment form gives the Probation



Officer a good insight into the mental condition of the offender. It asks about any medication s/he is receiving and about any physical or mental difficulties s/he is experiencing. The PBNI's *Standards* specify that: "Where the main proposal envisages a Probation Order which includes a requirement for treatment of a psychiatric condition or drug/alcohol dependency, the report should reflect prior consultation with a relevant practitioner."

The PBNI is currently strengthening its complement of forensic psychologists to help with the preparation of risk assessments.

3.28 Nevertheless, Probation Officers told us that they experienced difficulty in obtaining all the information they required in order to advise the Court adequately. The judges themselves felt that the PBNI was not always able to identify the issues as well as it might. Other agencies did not share information readily, and the PBNI had to take the initiative in seeking it out. Community Psychiatric Nurses (CPNs) did not disclose information, and psychiatric reports were often not attached to depositions when they should be. There were cases where the Probation Officer suspected mental health issues, but where no report had ever been commissioned. The defence sometimes recommended programmes of treatment to the Court without consulting the PBNI, and the recommendations were often inappropriate in the Probation Officer's view but, there was no way of challenging them.

3.29 The PBNI said that the timescale for writing PSRs was extremely constraining and did not vary according to the nature and seriousness of the offence. If the offender had mental health problems, and PBNI required reports from health professionals, that could easily take longer than the time allowed. Inspectors have recommended that **the Probation Board for Northern Ireland (PBNI) should be granted more time to prepare Pre-Sentice Reports (PSRs) in cases which involve difficult mental health issues.**

3.30 The PBNI's *Standards* said that the duty of the Probation Officer was to support and divert offenders with mental health issues into appropriate services, but that was not always easy. Probation Officers experienced difficulties in obtaining appropriate community mental health support and a perceived reluctance of psychiatrists to commit resources to offenders.

3.31 Probation Officers emphasised the extent to which homelessness was related to addiction and mental health issues and said that it would be beneficial if in mental health cases there could be a multi-agency, pre-sentence conference which could include the Northern Ireland Housing Executive (NIHE). They drew attention particularly to the difficulty of finding suitable places for mentally disordered women in view of the lack of suitable hostel (Approved Premises) accommodation.

3.32 On the positive side, Probation Officers said that the regime for sex offenders was working well. Their

mental health needs were generally identified and Article 26 was used to good effect.

What are the alternative disposals?

3.33 If an offender suffering from a mental disorder (within the meaning of the 1986 Mental Health Order) is made subject to a Hospital Order with restrictions, the Secretary of State is responsible for:

- referring the case to the Mental Health Review Tribunal;
- reviewing Restriction Orders;
- exercising powers of discharge or variation;
- granting leave of absence; and
- exercising powers of recall.

3.34 A Hospital Order can be regarded as a criminal sanction¹⁵, even though it is carried out within the health service. However, once someone is a mental patient within the Health Service they can be released by the Mental Health Tribunal. Inspectors were told that the NIO represent the Secretary of State's interest and submit reports and representations at the hearings, however the focus of such hearings tends to be on the medical officer's advice.

Offender B

Offender B was committed to the State Hospital at Carstairs in Scotland under a Hospital Order and later transferred to the Shannon Clinic at Knockbracken outside Belfast. His psychiatric diagnosis was changed, and the Mental Health Tribunal then ordered his release. The criminal justice system had no way of challenging that decision, which was a purely clinical one.

3.35 At the time of writing there were 52 restricted patients in Northern Ireland, 48 of whom were men and four women. Of those, 42 were held in hospital and 10 had been conditionally discharged. A total of 18 were held in the Shannon Clinic at Knockbracken, eight in the State Hospital at Carstairs, Scotland, and 16 were in other Northern Ireland hospitals. Of the 38 patients subject to a Hospital Order, six were on life sentences, one is sentenced and seven were on remand.

High secure hospitals

3.36 The most dangerous mentally disordered offenders can be sent to the State Hospital at Carstairs, or occasionally to English hospitals such as Ashworth, Broadmoor and Rampton. Since there are no suitable secure facilities in Northern Ireland, it is often the case that some very dangerous mentally disordered offenders therefore sometimes remain in Maghaberry Prison for the whole of their sentences.

Inspectors recommend an assessment of the need for a local high secure hospital to which the most dangerous mentally disordered remand prisoners can be transferred for medical treatment.

The Shannon Clinic

3.37 The local Shannon Clinic is medium secure. It has 34 beds, not all of which are available for offenders. They are allocated on the basis of

¹⁵ It is the one aspect of the health service in Northern Ireland which formally comes within the remit of Criminal Justice Inspection Northern Ireland.



clinical need, but that does not necessarily work to the disadvantage of offenders, who often have high needs. However, the rules for admission are restrictive, and the referral process is lengthy. The clinic caters only for mentally ill people, and it will accept mentally disordered offenders as a step-down from state hospitals like Carstairs.

- 3.38 The clinic is owned by the Belfast Trust. Inspectors were told that there were good relations between the clinic and the mental healthcare professionals in the NIPS, and the work of the clinic was highly regarded. There can, however, be a tension between the health agenda and the requirements of the criminal justice system for public protection – between clinical and forensic priorities – as we discuss in Chapter 7.

Other medium and low secure facilities

- 3.39 Adult and adolescent offenders may be sent to privately run facilities in England, such as Cheswold Park Hospital (Doncaster) and St Andrews Hospital (Northampton). The NIPS told us that it had in the past sent two severely personality disordered offenders to Cheswold Park. Inspectors have visited these hospitals, and can confirm that the facilities they offer are of a high standard, and there is availability. But they are not cheap, costing around £250,000 a year for each resident and typically taking people for 18 months to two years.
- 3.40 The question has been raised whether we should not invite one of these private providers to build a new facility in Northern Ireland, which would have the benefit of easier access for officials and for visitors. There is a strong case to be made that local provision would be beneficial to the patients and improve their chances of recovery. The Youth Justice Agency (see Chapter 5) was sceptical of the benefit of sending young people outside Northern Ireland in this way, and emphasised the value of keeping young people close to their families and support networks. Inspectors understand that the providers would be willing to invest here if they were guaranteed a sufficient caseload. But the economic unit seems to be around 70 beds, and it is unlikely that Northern Ireland could justify a facility of its own – unless, just conceivably, in partnership with the Republic of Ireland.
- 3.41 Inspectors conclude that it is best for the Health Trusts (selectively, and when the need arises) to pay to use the high-quality facilities which are available in England for adults, despite the disadvantages of their distance from home; but in the case of children the balance of advantage is likely to favour treatment within Northern Ireland if at all possible.
- 3.42 Muckamore Abbey Hospital near Antrim is a treatment facility for people with learning disabilities, and includes a forensic treatment ward. Individuals can be placed in Muckamore by direct order of the Courts through a Hospital Order.



Knockbracken Mental Health Services (Belfast Trust) is a psychiatric facility comprising 12 wards providing short and long term care for people with mental illness. Some wards offer limited security and the establishment is a major resource for placing people detained under the Mental Health Order. Each of the five Health and Social Care Trusts have at least one local psychiatric facility which provides care and treatment for people with a mental illness, including those who require their care to be delivered in a low secure environment. Each Trust also has a facility where people detained under the Mental Health Order can be assessed and treated.

Hostel accommodation

3.43 There is a case for building a new, semi-secure hostel accommodation as a step-down from custody for those who do not pose a significant threat but, who find it extremely difficult to survive in the outside world. A consultant psychiatrist called for 'clusters of housing and hostels' with programmes for continuing treatment and resettlement. Without support, too many people who find it difficult to cope resort to excessive use of alcohol or other drugs, which makes their physical and mental condition worse and inevitably brings them back into the criminal justice system. Probation Officers drew attention to the close links between homelessness and problems of addiction and mental health, and emphasised the need for suitable accommodation for mentally disordered women. Judges told us

that it was a problem that hostels (Approved Premises) were not available to be used as a bail address for mentally disordered offenders.

3.44 Approved Premises are unpopular with local residents wherever they are sited, but if they are properly staffed to provide the necessary level of supervision and support they are not expensive (perhaps £20-30,000 per place per year). Nevertheless, CJI is very supportive of the work of the existing Approved Premises, and additional well-run hostels could represent good value in relation to the alternatives. **We recommend that the needs of mentally disordered offenders should be factored into the ongoing strategic review of hostel (Approved Premises) accommodation.**

Community Mental Health Orders

3.45 Probation Officers told us that there was a need for more Community Orders with mental health requirements and for offending behaviour programmes to be tailored for individuals with personality disorders. Judges said that they found community-based sentences difficult, as it was hard to design the right package for an individual. They said that sometimes a defendant would request, on his own initiative, to be linked to CPN services with which he was familiar, and that often led to a good outcome. They thought there was a need for continuing mental health supervision for many mentally disordered offenders, and that it was



frequently unsatisfactory to impose a six-month hospital order without an assurance that there would be continuing supervision for as long as necessary thereafter. Offenders may behave acceptably while taking medication in a secure environment, but there can often be a question about how to manage the risk once they return to the community.

CHAPTER 4:

Prison and parole

“Care in the community has now become care in custody”

– quoted by a number of interviewees

- 4.1 Northern Ireland’s prisons contain a large number of prisoners with mental health problems, and that proportion would appear to be increasing. A total of 700 out of 850 prisoners in Maghaberry Prison are on medication, mainly tranquillisers, and about seven per cent of the whole prison population – around 100 prisoners – are thought to be seriously mentally ill. While Inspectors have to be concerned for the welfare of all prisoners, it is that smaller number that is the prime focus of this inspection.
- 4.2 By and large prison does not make their condition better, and often makes it worse. The transition from prison back into the community is particularly problematic. In England and Wales, some 200 persons a year commit suicide within a few weeks of leaving prison. In addition, there are concentrations of addiction and of learning disability in the prison population.

Northern Ireland’s prisons

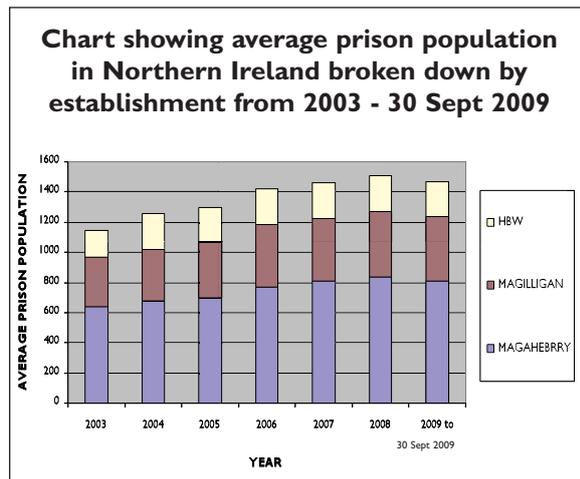
- 4.3 Northern Ireland has three prison establishments, one of which comprises a young offenders’ centre (YOC) and a women’s prison:

Establishment	Security Level	Complement
Maghaberry Prison	High	850
Magilligan Prison	Medium	500
Hydebank Wood YOC	Low	200
Ash House - Hydebank Wood Women’s Prison	Low	60

- 4.4 Maghaberry Prison houses a wide range of prisoners, from lifers to short-term and remand prisoners, in conditions of high security. Magilligan Prison takes the less dangerous prisoners and those coming towards the end of their sentence, including a high proportion of sex offenders. Hydebank Wood YOC houses young men between 18 and 23, as well as a small number of under-18s who for one reason or another cannot be taken into the Juvenile Justice Centre (Woodlands).



- 4.5 The prison population has been growing steadily in recent years, though it still represents one of the lowest imprisonment ratios in these islands:



* These numbers are not representative of the yearly average as per the previous years, as the population usually peaks in the summer.

Additional capacity has recently been created at Magilligan Prison, and there are further plans to develop the prison estate to cater for the increase in prisoner numbers which will be consequent on the introduction of extended and indeterminate sentences under the Criminal Justice Order 2008.

- 4.6 The increase in prisoner numbers as a result of the Order will not be spread evenly across all types of prisoners. The prisoners who will find themselves stacking up in prison on grounds of assessed dangerousness will tend to be those with severe personality disorders. The population of prisoners who have special needs and who are particularly hard to manage could therefore double even if the overall prison population rises by only 10%.

- 4.7 It could be argued that if someone is to be given a disproportionate term of imprisonment on account of mental problems which are not their fault, society owes it to them to offer them a better environment than that of Maghaberry Prison in which to spend their days. The problem is though, that whatever facility they are held in needs to be high secure. Transfer to a state hospital is not always appropriate, because their mental disorders are often intractable and would represent a poor use of scarce medical resources. The only conclusion is that these personality disordered offenders will have to remain in prison, and the best we can do for them is to promote a high standard of 'healthy prison' regime for them and for all prisoners, with excellent care and plenty of purposeful activity.

- 4.8 This accords with what a former Governor said to us. In his view, the improvement of mental health in prisons should not be seen in isolation. The best way to improve mental health was through a total *Healthy Prisons* agenda: safety, respect, purposeful activity and effective preparation for resettlement. Inspectors would endorse that view.

The transfer of responsibility for healthcare in prison

- 4.9 In 1996 HM Inspectorate of Prisons published an important report on the inadequacy of care for the mentally disordered in prisons, entitled *Patient or Prisoner?* The report said: "Prisoners are entitled to the same level of healthcare as that provided in society at large. Those who are sick, addicted,

mentally ill or disabled should be treated to the same standards demanded in the National Health Service.”

This led in due course to the transfer of responsibility for the commissioning of healthcare in Northern Ireland prisons from the Prison Service to the Health Service with effect from 1 April 2008. It was hoped that that transfer, which was accompanied by a re-allocation of financial resources, would lead to a significant improvement in healthcare.

- 4.10 The NIPS management told Inspectors that it was developing good collaboration with the Health Service but most of those interviewed who were involved with provision on the ground said that there had been little sign of change as yet. A consultant psychiatrist told us that the policies and procedures of the NHS needed to be brought in to the prisons: they did not have a proper psychiatric unit operating to Health Service standards, although Inspectors acknowledge the restrictions both environmental and legal that impact on this situation.
- 4.11 Another doctor said that he did not believe the Health Service could drive change in the prisons without operational control of staff. Healthcare in Northern Ireland prisons is still mainly delivered by NIPS staff, and it is sometimes argued that there is a problem in having staff within a prison who are not under the control of the Governor. However, Inspectors believe that it is essential that there should be clarity as to which agency has lead

responsibility for the delivery of healthcare in the prisons.

- 4.12 That is not to deny the importance of working in partnership. The NIPS/Health Service task force which planned the transfer in England and Wales emphasised the importance of the two services working together closely to identify the health needs of prisoners and plan services accordingly. Inspectors are not convinced that a positive and constructive partnership on these lines yet exists on the ground in Northern Ireland's prisons, though the parties are working towards it. Indeed, they are uncertain whether in the long term partnership is the correct relationship: this is further discussed in Chapter 7.
- 4.13 The transfer of responsibility for healthcare in prisons to Health Personal Social Services (HPSS) commenced in April 2008 with lead responsibility taken by the South Eastern Health & Social Care Trust (SEHSCT). The transfer is now complete with core services transferring in April 2008 and addiction services on 1 October 2008. The Trust has signalled its intent to provide an equivalent service to those in prisons to that afforded to those in the community. It has now delivered investment in mental health in the prisons in relation to:
- the appointment of a single provider of substance misuse services to the prisons;
 - mental health discharge co-ordinator nurses based in Maghaberry Prison and covering all three establishments; and
 - addiction nurses.



Further investment is required including:

- additional sessions from psychiatrists at consultant and staff grade;
- strengthening CBT services; and
- recruitment of a range of care and support staff to assist in the administration of medicines, observation of patients and the delivery of basic nursing care. This will allow better use of nurses' time for the provision of assessment, care planning and the implementation and evaluation of programmes of care.

Reception into prison

- 4.14 On committal every prisoner receives a health assessment, including mental health screening and onward referral, if required, to a mental health nurse. S/He can then make a further referral, after a more comprehensive mental health assessment, to another specialist such as a consultant psychiatrist, cognitive behavioural therapist or voluntary agency for drugs and alcohol abuse.
- 4.15 A review of the committal process recently took place and currently a two-stage committal process is underway as a pilot at Hydebank Wood YOC and at Maghaberry Prison, which involves a first night screening for key risks followed by a more in-depth screening 72-hours after committal. This second stage screening is a welcome development. Inspectors were told by experts that the initial assessment form was 'unsophisticated' and the process was not wholly reliable, so that problems often emerged afterwards. The new system should pick up more of these issues.

Continuity of healthcare

- 4.16 There is a problem over the exchange of information between the Health Service and the NIPS. Medical confidentiality is a constraint. It is often difficult for Governors and even for the medical staff in prison to obtain patient records from GPs, though Inspectors were told the position was getting better. The transfer of responsibility for prisoner health to the Health Service should help with this. Within the prison there can also be restrictions on the transmission of essential information. Probation Officers, too, complained about the difficulty of communicating either with GPs or with the psychiatrists attached to the NIPS. Judges told us that they considered it imperative that prisons should systematically receive all medical records requested at court. The Health Service is now focussing its attention on the sharing of information between GPs and the NIPS and it is confident that the difficulties experienced in the past can be resolved.
- 4.17 It is critical that the screening of prisoners in reception is NOT the first time when problems are identified. The HSCB supports the appropriate flow of medical information between the community GP and the prison GP and vice versa as happens with any patient in the Health Service. A confidential conversation between the GP and the prison GP about any prisoner should be facilitated at any stage should either party request it. However, medical records should not be accessed by anyone other than



healthcare staff. The Health and Social Care Board (HSCB) are currently preparing a template which can be used to share information between the community GP and the prison GP and vice versa.

- 4.18 Prisoners may remain on remand in Northern Ireland prisons for a year or more, but there are limitations on the treatment mentally disordered prisoners can receive during that time unless they agree to do so. They may be advised by their solicitor not to assent, in case it might in some way prejudice their trial. There is a particular problem of remand prisoners with personality disorders, and the current system is not working adequately to get them transferred in to the appropriate programmes in the prisons.
- 4.19 There is a particular problem at the point where remand prisoners go to court, are acquitted and therefore do not return. Mental healthcare staff told us that they are usually not notified when a patient has returned to the community, so there is no scope for them to liaise with community mental health services. The point of return into the community is a critical one, and for mentally disordered prisoners who have been 'inside' for a year or more it is no less critical because they have been acquitted. They should not be released into the community without any support arrangements in place. Inspectors were told of some graphic examples of personality disordered prisoners who had gone on to commit extremely serious crimes very shortly after release.

Psychiatric services

- 4.20 There are two consultant psychiatrists who assist the NIPS part-time. Both are highly valued, but the time they can devote to the prisons is not equal to the demands upon them. It is recognised by all concerned that there is a need for more sessions in the prisons. One of them pointed out, however, that this simply mirrors the position in the outside world. Even with the pressures on them in the prisons, a prisoner with acute problems is still likely to see a psychiatrist sooner than a similar patient in the community.
- 4.21 The same would be true in relation to the availability of mental health nurses. There was a need for more mental health nurses in the prisons, but there were currently vacancies in mental health nursing training in Northern Ireland. It was pointed out that nursing in prison used to command a pay premium over nursing in the community, but that was no longer the case. Recruitment into the NIPS was slow, with security checks taking a long time. It was emphasised that work in prison required experienced and clinically confident staff.
- 4.22 Each of the consultant psychiatrists divide their time between the prisons and the community. One provides five sessions per week in Maghaberry Prison; the other looks after remand prisoners and the REACH landing at Maghaberry, visits Hydebank Wood YOC for two sessions a week and provides one session a fortnight at Magilligan Prison. The total





psychiatric input is shown in the table below.

Psychiatry input per week

Prison	Consultant psychiatry sessions	Staff grade psychiatry sessions	Psychiatric Specialist Registrar (SpR) sessions
Maghaberry	5	10	2
Magilligan	0	0.5	0
Hydebank Wood	2	1	0

4.23 At Hydebank Wood YOC there is a healthcare manager, two mental health nurses and the visiting consultant psychiatrist. Six mental health beds are available. The mental health nurses often have to help out with general nursing. There is no routine provision for the treatment of mental illness among the juveniles (as opposed to the young men) at Hydebank Wood, but the consultant would see them in an emergency. Judges told us that they felt that the YOC was less well equipped to deal with mental health issues than the main prisons. There is a programme of CBT at Hydebank Wood YOC provided by visiting therapists, which

is popular and well regarded, but it does not seem to be linked to any other mental health services.

4.24 Magilligan Prison has a large population of sex offenders, who often have personality disorders, and yet mental health provision is very limited. There is no in-patient unit at Magilligan Prison, and any patient with acute mental health needs is transferred to Maghaberry Prison. Magilligan Prison has 14 nurses, of whom two are Registered Mental Health Nurses (RMNs), but they are often diverted to generic nursing duties.

Nursing staff in NI Prisons

complement (staff in post)

Prison	Healthcare Manager	Senior Officer	Nurse Officer	Healthcare Officer	Total
Maghaberry	1(1)	4(4)	39(32)	3(3)	47(40)
Magilligan	1(1)	1(1)	10(10)	4(4)	16(16)
Hydebank Wood	1(1)	1(1)	8(7)	4(4)	14(13)
Total	3(3)	6(6)	57(49)	11(11)	77(69)

**The compliment of staff changes over time. Indeed we were told by the Prison Service that there were vacancies of over 42% in Maghaberry Prison in November 2009.

4.25 Inspectors were told that there was a need for more hospital beds within Maghaberry Prison as a safe haven for those with mental health problems as a short term measure, since life on the landings was noisy and chaotic. An alternative facility is, however, provided by the REACH project.

The REACH project

4.26 The REACH project, based in Lagan House, assists prisoners with complex needs under the guidance of a Prison Service Safer Custody Steering Group. It is essentially designed for those exhibiting personality disorder, poor coping skills, self-harming or otherwise disturbed behaviours, and provides multi-disciplinary support where needed, in a slightly more sheltered environment. It is staffed by prison officers who have received special training and aims to improve the prisoners' social functioning and create better prisoner/staff relationships through a pattern of structured participative activities. There are 20 places for remand or sentenced prisoners.

4.27 A senior manager told us that the REACH project had done good work, but it had not quite reached its potential and seemed to have 'plateau-ed' since the departure of the governor who had instituted it. It perhaps also lacked sufficient corporate ownership by the NIPS. This was confirmed by our inspection on the treatment of vulnerable prisoners, published in December 2009. Despite the REACH landing having a high priority within the prison, it still had to fight for

resources on an on-going basis. It should, he thought, have been more occupational and therapeutic, but it did not have enough psychiatric support. A consultant agreed that the REACH landing should increase its capacity and the scope of its work, with additional support from the SEHSCT.

Suicide and self-harm

4.28 There have been four suicides in prison in Northern Ireland in recent years, two of them being women. It should be noted that the suicide rate for Northern Ireland prisons is no higher, however, than the rest of the United Kingdom. Attention has recently centred on the suicide of Colin Bell in Maghaberry in August 2008, which has been the subject of a report by the Prisoner Ombudsman for Northern Ireland and a clinical review by Professor Roy McClelland.

Colin Bell

Colin Bell, aged 34, was known to be in a poor mental condition. He was reported to be restless and anxious, and to show signs of paranoia. He repeatedly self-harmed and attempted suicide during the later stages of his time in prison. He had received attention from the mental health staff at Maghaberry Prison on several occasions, but it was not a lack of mental health care that resulted in his death (though there could have been improvements in that care, as the Prisoner Ombudsman noted). The main problem was the poor handling by the NIPS of a prisoner in his condition, and what would appear to have been negligence by prison staff on the night of his death.



The Prisoner Ombudsman noted in her report that she had discussed Professor McClelland's clinical report with the Health and Social Care Trust and had raised with them in particular:

- Gaps in the specialist psychological input into the deliberations of the multi-disciplinary team, particularly as Mr Bell's situation became more difficult, that might have produced alternative strategies for managing his situation;
- Lack of medical input into multi-disciplinary case conferences and into the decisions to extend the use of a Safer/Observation cell and anti-ligature clothing; and
- The fundamental problem of the absence of a secure hospital facility for prisoners with mental health problems in Northern Ireland and the acute difficulties this presents for the NIPS.

The Trust agreed that in six months [from January 2009], when a review of the implementation of the recommendations of the Ombudsman's report was carried out, it would make a statement about progress and plans on the health management issues the Ombudsman identified.

- 4.29 Joint inspections of Northern Ireland's prisons by CJI and Her Majesty's Inspectorate of Prisons (HMIP) have criticised several aspects of their provision for vulnerable prisoners. Most recently, in January 2009 Inspectors found that safer custody in Maghaberry Prison had largely been a neglected area. With an average of 29 prisoners being designated as vulnerable each month in Maghaberry, the numbers involved were significant. A more recent inspection on the treatment of vulnerable prisoners noted that the NIPS clearly understands the challenges of managing vulnerable prisoners and had developed appropriate policies and procedures. The difficulty lay in giving effect to these positive intentions at establishment level and particularly in Maghaberry Prison.
- 4.30 At establishment level, particularly in Maghaberry Prison, Inspectors have expressed concerns about the emotional and physical care of these prisoners. Some communal areas of the prison, such as association rooms, were not directly supervised by officers. Vulnerable men were often held in strip clothing in observation rooms which were cold, unsuitable, and were the antithesis of a therapeutic environment. The inspection on the treatment of vulnerable prisoners highlighted the on-going problems for these prisoners.
- 4.31 Despite the positive policy intent safer custody had largely been a neglected area at operational level and there had been no consistent leadership in recent years. Policies and procedures were often poor, both in content and in application. There had been no review of the anti-bullying policy for over seven years, case reviews (which prisoners were not routinely invited to attend) were not multi-disciplinary, the quality of care plans was poor, their content was non-specific, and charring was frequently delegated to lower level managers who received



no training for this important role.

4.32 Inspectors were told that Death in Custody Action Plans and outcomes from Coroner's inquests were discussed at the bi-monthly service-wide self-harm and suicide prevention forum that involved all three Northern Ireland establishments. Yet, the inspections of Maghaberry Prison in January 2009 (published in July 2009) and the Colin Bell Action Plan in September 2009 have shown that there is still considerable room for improvement in implementing previous recommendations. As with previous NIPS Action Plans, managers confuse actions with outcomes and fail to recognise that many recommendations require continuous managerial attention and cannot be signed-off by a specific date.

4.33 Maghaberry Prison had taken some positive steps by establishing the REACH landing to support those identified as poor copers or with challenging behaviours; and by setting up a listener scheme. Our recent inspection on the treatment of vulnerable prisoners has considered this issue in some detail and we do not propose to repeat the arguments again here. Suffice to say at this point is that the potential of the REACH landing has yet to be achieved. Both the NIPS and the SEHSCT have a clear idea as to what needs to happen and these requirements have been published in a joint memo in April 2009. Future inspections will determine the success of these efforts in changing the outcomes for vulnerable prisoners. Our overall conclusion is that there remains a significant job of work to be done in

delivering a therapeutic approach for vulnerable prisoners in Maghaberry Prison, and this needs to be supported by appropriate governance arrangements.

4.34 Some improvements have been made in the management of the risk of suicide and self-harm. A range of staff groups now attend Applied Suicide Intervention Skills Training (ASIST) training to ensure that they have a better awareness of prisoners with mental health needs, and there is a clear suicide prevention policy for the NIPS as a whole. A Principal Officer in each establishment now has suicide and self-harm as his or her primary responsibility. However an inspection by HMIP and CJI in January 2009 found that its earlier recommendation that: "*A local suicide prevention policy should be introduced that describes how the Northern Ireland Prison Service policy is implemented at Maghaberry Prison and sets out local procedures and responsibilities for introducing a more supportive and therapeutic response to those at risk of suicide and self-harm*" had not been achieved. There was no local policy to describe how the service-wide suicide prevention policy applied to the particular context of Maghaberry Prison. Our recent review of the treatment of vulnerable prisoners showed a number of important activities had taken place since the death of Colin Bell. In general, these tended to focus on the immediate system and negligence issues arising from his death. There remains more to do as the work of the Safer Custody Group and the Ministerial Forum on Safer Custody impacts on the delivery of services for prisoners.



Addiction services

- 4.35 Many offenders with mental health problems also suffer from drug and alcohol problems. Within the caseloads of the mental health teams in the prisons, a relatively small number of patients have severe mental illness, as defined, but a greater number have personality disorders exacerbated by drugs and alcohol.
- 4.36 Within the NIPS a range of teams are responsible for the assessment, treatment and care of individuals with substance misuse problems. They include prison healthcare, with specialist input from the consultant psychiatrist, but also substance misuse services provided by prison-based voluntary agencies. In 2000 three voluntary sector agencies were appointed to provide services to the three establishments:

<i>Establishment</i>	<i>Addiction service</i>
Magherry Prison	Dunlewey Substance Advice Centre
Magilligan Prison	Northlands Centre
Hydebank Wood YOC	Opportunity Youth

- 4.37 They offer counselling and supportive interventions to all prisoners and often work in tandem with resettlement staff to provide drug and alcohol related programmes. The services of these agencies are well regarded, but Inspectors heard comments that there were inconsistencies in their approaches, and that they did not liaise sufficiently with one another. Information was not always being passed on to follow the movement of a prisoner.

- 4.38 At Magilligan Prison Inspectors were told it was not always easy to get patients on to drug treatment programmes. It required referral by the GP. This is something that perhaps needs to be looked at. NIPS management confirmed that clinical interventions had been slower to develop as investment in specialist services had been constrained. The new sentencing framework of the Criminal Justice Order 2008 and the increasing complexity of substance misuse problems had influenced the need to review how alcohol and drug services were delivered. They told Inspectors:

- an Addiction Services Manager had been appointed and had been in post since June 2007;
- the transfer of the budget for Addiction Services was expected to transfer to the Health Trust very shortly;
- a service specification for re-tendering for specialist addictions services would be drawn up;
- two Addiction Nurses and an additional half-time Consultant Psychiatrist would be recruited; and
- lead responsibility for addiction services transferred to the SEHSCT at 1 October 2008.

Prison officers

- 4.39 Prison officers have the most contact with prisoners from day to day and as such can act as their primary carers. A HQ official told Inspectors that the NIPS should look for ways of enhancing the skills of prison officers to enable them to perform that role more effectively, observing prisoners



thoughtfully and recording their aberrant behaviour. However, in Northern Ireland the prison culture does not lend itself to that approach. For historical reasons, prison officers tend to maintain a psychological distance from their prisoners and not to engage too closely. Inspectors were told that prison officers would call healthcare as soon as there was a mental health issue with a prisoner, and simply hand over the problem. There is no 'personal officer' scheme in Northern Ireland's prisons. CJI understands, however, that modules for prison officers in pro-social modelling, and improved report writing have been introduced into the training regime.

- 4.40 There is certainly potential for prison officers to make a more positive contribution to the mental welfare of prisoners, and there are an increasing number of officers who are prepared to rise to the challenge, but there is still a need for a radical change in the culture within the prisons. For instance, we were told that the provision of healthcare is often interrupted and curtailed by the frequent lockdowns which are a feature of the way the prisons are run.

Listener schemes

- 4.41 Schemes have been tried out in the Northern Ireland prisons under which selected prisoners have been trained to act as 'Listeners' to other prisoners with mental health issues, particularly those at risk of self-harming. Sometimes such prisoners would be 'doubled up' with their Listeners. The schemes have had

some success in the adult male establishments, and were commended by HMIP and CJI in a recent report, though there is a problem with the turn-over of suitable prisoners. At Hydebank Wood YOC, there have been problems with both the women and, for different reasons, the young offenders. Listener schemes can be useful, but they need to be managed with care and in the view of Inspectors they should not be asked to bear more weight than they reasonably can.

Women prisoners

- 4.42 Women are held in Ash House within the Hydebank Wood site. There is accommodation for about 60 women, and in the year prior to the 2007 inspection it had been running close to capacity.
- 4.43 Women prisoners have special mental health needs, as discussed in Baroness Corston's widely respected 2007 report. Corston commented that "*many women in prison have been failed by the NHS long before they arrive at the prison gates, and many are simply too ill for prison to be an appropriate location for them*".
- 4.44 Fewer women than male prisoners are mentally ill, but they have more complex psychological needs and in particular, feel the separation involved in imprisonment more keenly than men do. Many women prisoners have a history of abuse, and they are at high risk of self-harming. They tend to be very demanding of mental health staff (and of healthcare staff in general).



4.45 There is a strong view, which Inspectors endorse, that women with personality disorders should not be in prison if it can possibly be avoided: even more than is the case with men, imprisonment has a negative impact on them. CJI has recommended elsewhere that there should, whenever it can be afforded, be a new type of facility to accommodate women in custody, which should have less emphasis on security and a greater emphasis on providing a therapeutic environment for women who are often very damaged and very vulnerable.

4.46 In the 2007 inspection report on Ash House, HMIP and CJI drew attention to the shortcomings of the mental health provision for the women. The report said: *“Until the week of the inspection, there had been only one mental health nurse for the whole establishment (i.e. Hydebank Wood, including the YOC) for some time and women complained about the quality of the service. The mental health in-reach teams provided only cognitive behavioural therapy, and there was only one session of a consultant psychiatrist to provide secondary care for women, which was insufficient.”*

4.47 The NIPS with the PBNi is developing a holistic strategy addressing the delivery of services to women offenders both within the community and in custody. The strategy for women prisoners published in the spring of 2009 includes the following as ‘key priorities’:

- the scope for increased diversion of women from court;
- strengthening community

sentences;

- creating appropriate community-based facilities to support women offenders; and
- the implementation of a gender-specific approach to policy and procedures in custody.

4.48 A conference was held in April 2008 and consultation events in summer 2009 to take this forward. Work is also progressing with the Health Service looking at options for dealing with mental health issues among women in prison, including:

- improvement of the committal screening process;
- development of a model of care to meet the mental health needs of women prisoners;
- exploration of other therapeutic interventions, including those that might address post-traumatic stress disorder;
- development of policies and procedures to inform clinical decisions; and
- development of health promotion among women in prison.

NIPS have recently published gender specific standards and a guide for staff working with women prisoners. Inspectors welcome these developments.

Psychologists

4.49 Psychologists play an important part in two aspects of the work of the NIPS. They help to plan and deliver courses of treatment for prisoners, such as cognitive skills, anger management and sexual offender treatment programmes; and they assess potentially dangerous



prisoners as they come to the point of release. However, they are in short supply, not only in the NIPS but in other parts of the justice system too. The NIPS has not succeeded in recruiting the posts it requires¹⁶, and will in all probability continue to struggle to do so.

4.50 When life sentence prisoners and those with extended or indeterminate sentences come toward the end of their tariff, a report has to be prepared for the consideration of the Parole Commissioners for Northern Ireland, and although there are other inputs to that process, the Commissioners are known to attach considerable weight to the judgment of the forensic psychologists. It is therefore crucially important that there should be a sufficient number of qualified and experienced psychologists performing this role. If the Parole Commissioners were not to have confidence in the assessments they were receiving, there would be a danger that prisoners would begin to stack up in the prisons, contrary to justice, and at great expense¹⁷.

4.51 The psychologists in the NIPS are forensic rather than clinical or occupational psychologists, and they are detached from the mental health services, the psychiatrists, mental health nurses and CBT therapists. It would be useful for the NIPS to have a clinical psychologist. At one time it used to have two; and the

recent internal review of psychology services suggested that there was scope for taking a wider range of non-specialist psychologists and inducting them into forensic work.

4.52 Inspectors agree that there is scope for, and there would be benefits from, a wider range of psychological input and from closer liaison between the forensic and therapeutic professional services. As the review stated, psychology services need to be better managed and it is important that they are used in the roles only they can fulfil. Prison officers need to be developed to do the work that does not require a full professional input. CJI's 2007 inspection of the *Northern Ireland Prisoner Resettlement Strategy* had also drawn attention to deficiencies in the management of psychology services in the prisons. The psychology service has been the subject of Review by the Prison Service (Daniell Review) and this provides a useful basis to make the necessary changes required to improve overall service delivery. Once again there needs to be meaningful changes to the current structures and model of service delivery to have an impact on the regime for prisoners. Inspectors welcome the fact that NIPS have recently issued an Invitation to Tender (ITT) for psychology services in an effort to meet the current shortfall in forensic psychology services.

16 In 2008 the Director of the Prison Service invited Mr J A Daniell to conduct a stocktaking of the NI Prison Service's psychology resources in the light of the new demands arising from the Criminal Justice Order and PPANI.

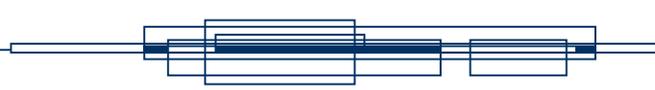
17 CJI's 2007 inspection of the NI Prisoner Resettlement Strategy reported that the Life Sentence review Commissioners "were recently shocked to discover that there was no quality assurance process in relation to lifer assessments, and there had been some recent cases where the assessments provided to them had been defective".





Preparation for discharge

- 4.53 No agency currently takes responsibility for mentally disordered ex-prisoners at the point of their release into the community. One prison governor accused the Health Service of 'dipping out of the problem'. But it is not always the fault of the health and social services as support services in the community are often not made aware of people being released from prison.
- 4.54 There is concern in the Health Service about the new Public Protection Arrangements for Northern Ireland (PPANI), which it is felt will place greater pressure on services which are already in short supply. It acknowledged that it would be unacceptable to say that someone could not be released simply because the services were not available, but said that that was the reality.
- 4.55 A repeated message was that mental healthcare in Northern Ireland was disjointed. There needed to be ways of following cases through. There should be better pathways and communication between agencies in and out of prison – which ought to be possible in Northern Ireland since it is such a small place. A consultant told us that 70% of his patients would benefit from a linked-up system with continuing programmes and longitudinal care. A former Governor said that he felt that there had been a greater focus on resettlement and addressing offending behaviour in recent years, but those efforts were in vain if the mental health needs of the prisoners were not tackled first.
- 4.56 The importance of the role of the PBNI was mentioned by several interviewees. For those on Probation Orders, probation officers coordinated the management of transfer to community probation. Resettlement, Inspectors were told, unquestionably worked better when probation were involved than when they were not. Probation Officers complained, however, about the slowness of action on assessing needs when prisoners were coming to the end of their sentences.
- 4.57 It is also important that, so far as possible, prisoners should be clean of drugs at the point of discharge, to give them the best possible chance of surviving in the outside world without returning to drug-taking and crime. It was specifically suggested that there should be a detox unit in Maghaberry Prison to get prisoners ready for release.
- 4.58 When prisoners are discharged a letter is sent to their GP, but sometimes the GP has by then removed the patient from their list, so the contact with community health services fails. Steps are now being taken to check so far as possible, whether a prisoner has a GP before s/he is released. A staff member from the Southern Health and Social Care Trust now comes in to the Maghaberry Prison health suite one morning a month to help with the discharges. A positive note is that the NIPS has appointed two discharge co-ordinators.



Prison in-reach in the Republic of Ireland

4.59 Inspectors visited the Prison Inreach and Court Liaison Service in the Republic of Ireland, which offers an interesting model for diversion out of the prison system. Brief notes on this are attached as an appendix to this report.



Children and young people



Mental disorder in young people

- 5.1 As with adult offenders, there is a high incidence of mental health needs in the young offender population. A survey in 2006 using a screening system developed by the Youth Justice Board in England and Wales indicated that 59% of the sample of young people who were clients of the Youth Justice Agency for Northern Ireland (YJA) showed signs of mental health issues of one sort or another.
- 5.2 Inspectors were impressed by what they were told (paragraph 1.22) about the importance of early intervention with children and the desirability, if possible, of picking up mental health needs at the primary school stage. Teachers told Inspectors that they could often identify children with PD at an early age, but they faced difficulty in getting attention for them. There was a shortage of educational psychologists, and the fact that children were 'statemented' did not secure treatment.
- 5.3 A teacher who specialised in providing support for pupils with behavioural difficulties commented that personality disorder on its own was not usually an insuperable problem. If children were reasonably bright and had supportive parents, they could often overcome PD and become successful pupils. It was the combination of PD with below-average intelligence and a disturbed home background that created the greatest problems. This accords with what can be observed in the prisoner population, where the combination of PD and below-average intelligence results in un-socialised lifestyles and predisposes an individual towards offending behaviour.
- 5.4 The Youth Justice Agency (YJA) agreed with this, and told Inspectors that when a young person who offends is found to have mental health needs that:
- the needs are typically diverse and complex;
 - they are almost always linked to other critical issues affecting the young person, such as housing, education, substance misuse, training and employment; and
 - family relationships and social care are also of central importance.
- 5.5 The diagnosis of personality disorder in children and adolescents is problematic, and a definite diagnosis is not usually made before the age of 18. Psychiatrists are often able to



detect if a child is developing a personality disorder, and Inspectors were told that with the right treatment and help, such children could be given a second chance to go through adolescence successfully. YJA staff told Inspectors that there was a need for more therapies that could address these problems.

- 5.6 As happens with adults in Northern Ireland, young people are occasionally sent to hospitals in England for treatment, but this is rare. The YJA believes that whenever possible, children should be kept in Northern Ireland and treated close to their families and social support networks. It emphasises the importance of liaising and working with parents to address underlying developmental and family relationship issues.
- 5.7 The YJA commented that the needs of young people can fluctuate markedly, and that special attention needs to be given to periods of heightened risk. These would include remand to custody, the period leading up to and during criminal trials, and the period before and immediately after release from custody. Evidence suggests that depressed mood or substance misuse will substantially increase the risk of suicide or self-harm in such periods.

The Youth Justice Agency

- 5.8 The YJA is involved with young offenders with mental health issues in each of the three arms of its work. They are:
- Community Services,
 - Youth Conferencing, and

- Woodlands Juvenile Justice Centre.

- 5.9 There are also around 18 juvenile males at any time accommodated in a separate wing of Hydebank Wood Young Offenders Centre. Young people are predominately in Hydebank Wood due to the legislation restrictions on the placement of 17-year-olds in Woodlands, a small number, however, are there because they are too difficult to handle. CJI has commented elsewhere¹⁸ on the very poor regime offered to juveniles at Hydebank Wood YOC, and has urged that the courts should not commit children there unless the reasons are compelling.

Mental health strategy

- 5.10 The YJA has produced a mental health strategy, the key elements of which are:
- needs assessment;
 - awareness raising and de-stigmatising of mental illness;
 - promotion and prevention;
 - specialist services; and
 - evaluation.
- 5.11 As part of the strategy, an audit was conducted of the mental health skills of the YJA staff, which showed a great degree of experience of working with young people with mental health difficulties, particularly in the areas of suicide, self-harm, learning and conduct disorders, trauma, addiction, adolescent depression, and in the delivery of intervention plans. Many YJA staff are trained in family therapy

18 Report of an Announced Inspection of Hydebank Wood YOC, CJI and HM Inspectorate of Prisons, November 2007.



techniques. However, half of all staff surveyed identified a need for improved access to psychological and psychiatric services, to be provided in-house if possible.

- 5.12 The YJA is piloting the drugs and alcohol Regional Initial Assessment Tool (RIAT), in which all Community Services staff are now trained. A number of staff members are also trained in the AIM2 assessment for inappropriate sexual behaviour. The YJA is aiming to train some staff in Mental Health First Aid developed by the Health Promotion Agency.

Community Services

- 5.13 In the community, mental healthcare for children is provided by Child and Adolescent Mental Health Services (CAMHS). The YJA's Community Services liaise closely with CAMHS, and would be pro-active in identifying young people with mental health needs. The principle is that the core CAMHS in any area should offer assessment and treatment of child mental health disorders and onward referral to specialists. Specialist CAMHS may provide for more than one district or region, and should be able to offer a range of services.
- 5.14 Where possible the YJA attempts to access mainstream child and adolescent services through local CAMHS services. At times, access can be difficult and there can be long waiting lists for less serious cases. Ideally the YJA would like to see CAMHS outreach workers going in to each of its projects once a month for three hours, but not all of the CAMHS teams would be able to

meet such a commitment.

- 5.15 The YJA has been participating in various initiatives designed to improve the commissioning and development of CAMHS services. They are working on a protocol or Service Level Agreement (SLA) covering Community Services and Youth Conferencing. This would standardise the procedures (which at present vary from team to team) and result in better access and fewer inappropriate referrals. At present, according to the YJA, CAHMS feel that the YJA is over-referring to CAMHS because staff are not confident and want to be on the safe side. This is especially a problem in North Belfast, because of the concern about the number of suicides among young people there have been recently.
- 5.16 The YJA said that there was a problem with CAMHS cutting off involvement with a young person at or around their 18th birthday. It would be helpful if there could be some service for the 18 to 21-year-olds, who were not yet fully 'adult' but fell outside the 'child' category.
- 5.17 We understand that the regional CAMHS teams will by summer 2010 have access to a total of 33 beds at a child and adolescent unit at the Forster Green site. They told Inspectors their priorities were:
- developing speedy in-house assessment arrangements, to avoid the current practice of referring young people to A&E in an emergency. They would like to put an alternative in place, but they may be limited in the coverage they can offer;



- helping the staff who are used to handling adult patients to learn how to deal with children and adolescents who come in to their care;
- creating integrated teams drawing on the resources of the Juvenile Justice Centre (JJC) and Looked-after Children to provide better handling of the significant number of children who are known to both services. (The JJC staff support the idea of a fully integrated model); and
- providing more support for teachers and residential staff.

Youth Conferencing

5.18 The criminal justice system in Northern Ireland aims to divert as many children as possible away from the courts and into restorative conferencing, organised by the Youth Conferencing Service (YCS) of the YJA. Young offenders with identified mental health needs would almost always be diverted to conferencing¹⁹ if they were not diverted earlier by the police to the Health Service following a caution or informed warning. The YCS provides the opportunity for a more holistic perspective to be taken which addresses the needs of victims, offenders and community safety and public protection concerns. Creative plans can be put in place which satisfy the public interest and, at the same time, address complex needs.

5.19 When the YCS becomes aware of mental health needs which may relate to an offence which is going through the conferencing process, part of a Youth Conference Order may require a young person to agree to psychiatric evaluation and to co-operate with any treatment advised. In most cases these young people are referred to their local CAMHS, but occasionally they may require more specialist forensic referral.

The Juvenile Justice Centre (Woodlands)

5.20 Woodlands JJC provides accommodation for up to 48 children in modern, well-designed premises. The new facility was designed to improve supervision and reduce the risk of self-harm. Management recognises that the young people are very vulnerable and takes the concerns of potential suicide and self-harm very seriously. CJI's inspection of Woodlands Juvenile Justice Centre in May 2008 found that many children in the JJC had poor mental health and other negative indicators. Of the 30 children in residence on 30 November 2007:

- 20 had a diagnosed mental health disorder;
- 17 had a history of self-harm;
- 8 had at least one suicide attempt on record;
- 8 were on the child protection register; and
- 14 had a statement of educational needs.

¹⁹ Referrals to the YCS may come from the PPS as a diversion from prosecution or from the courts as a court-ordered conference following a finding of guilt. Both require the consent of the offender to participate in a conference. Following conference a plan is agreed which may be affirmed by the PPS or the court. Once affirmed, it becomes a statutory order which may be enforced. CJI reported on Youth Conferencing in February 2008.

5.21 Young people are screened and assessed as soon as possible after admission, and a risk management plan is put into effect where there are concerns. The assessment includes:

- basic health;
- medications;
- mental health issues;
- any contact with CAMHS;
- any contact with Social Services; and
- family history.

5.22 Where risk is believed to be high, referral is made to the psychologist in the Centre and onwards to specialist services such as psychiatry when appropriate. The assessment will identify any issues with drug abuse and any mental health issues. Almost all the children going through it are found to have some such issues. There is very little evidence of addiction to drugs and when this is the case, a detox programme is offered. Staff said that it often took a few days before any underlying mental health issues could be identified.

Professional staff

5.23 Within the JJC there are four full-time Registered Mental Health Nurses (RMNs) and there is access to a forensic psychologist and a consultant psychiatrist who will sometimes conduct an assessment. The JJC therefore has a reasonably good coverage of experts in mental health, and the RMNs said that they regarded the ratio of staff to children as good. The YJA have a visiting forensic consultant psychiatrist based

in Manchester (who they say is excellent) because there is no specialist in this area available in Northern Ireland. We recommend that the SEHSCT should continue to try to recruit a locally-based forensic adolescent psychiatrist to serve the needs of Northern Ireland.

Inspectors recommend that a **specialist child and adolescent psychiatrist should be appointed, based in Northern Ireland, to advise the criminal justice agencies.**

5.24 The YJA has been exploring ways of improving the commissioning of mental health services, perhaps following the model that is being developed in the NIPS. They have been negotiating with two health trusts about the possibility of purchasing a full range of CAMHS services on a sessional basis. The trusts have expressed interest in providing the services, but there may still be a further need for additional forensic mental health services in the light of the new legislation relating to dangerous and sexual offenders.

5.25 The RMNs said that they worked as part of a multi-skilled team, and they would not want more people involved, as it made it more difficult for the children if they had to relate to too many people. They emphasised that young people were always involved in discussions about their mental health needs. They said that the house staff in Woodlands JJC were also very good at working with children who had mental health issues.



General practitioners

5.26 As with the NIPS, the JJC finds that it is often difficult to get the necessary information from GPs. Some GPs provide excellent information, and some were reported to go out of their way to visit their young patients in Woodlands. But by and large obtaining medical information is a problem. Medical records are not usually transferred to the JJC, because the children are not likely to be there long enough, and the JJC's GP is reluctant to prescribe some medications without sight of them. The RMNs emphasised the need for speedy information, and said that it could be very frustrating to have to manage without it.

Relationship with community healthcare

5.27 Many of the children are there for very short periods, which militates against effective treatment while inside and points to the need for a seamless transition between mental healthcare in the JJC and outside. While the discharge planning system aimed to ensure continuity of healthcare after release, staff identified a number of gaps. Many children were motivated to get help while in custody but this was not sustained when they returned to the community, due to lack of response from external professionals and/or poor compliance by children in keeping community appointments.

5.28 Inspectors were told that it was not the practice for CAMHS to come into the JJC to develop a relationship with a young person before they were released into the community. It would be very desirable if that could happen:

if no relationship had been forged before a young person leaves, there was a high probability that they would not attend meetings with CAMHS subsequently. It was crucially important that the justice system should bring the young person to engage with CAMHS upon release. There was a feeling in the YJA that CAMHS regarded Looked-after Children as their first priority, and that young offenders came second.

5.29 As with prison, some young people commit repeat offences in order to be re-admitted to the JJC because they feel safe there. Many vulnerable young people find it difficult to return to life in the outside world, which is often chaotic and abusive, or even dangerous, and it would be valuable if there were some step-down facility to help them to re-adjust to life on the outside. It is analogous to the problem of 'poor copers' in the adult prison population, but more acute among children because of their greater vulnerability.

Relationship with education

5.30 Research suggests that those at risk of becoming tomorrow's criminals can be identified in some cases by the age of five years because of the environment in which they are living with high risk factors being poor parenting, poverty and criminality in the family. At the same time, research with school principals on the establishment of the Education and Skills Authority in Northern Ireland has demonstrated that schools require a robust child and family support system to help address issues



around truancy and disruptive behaviour in schools. Support to enable school principals to deal with children who present with significant problems that impact upon their education.

- 5.31 The creation of the Education and Skills Authority in Northern Ireland provides an opportunity to re-consider the approaches to family and children support. Early intervention is a critical factor in diverting young people away from criminal behaviour. It is equally important in bringing to the attention of the care system those children who present with mental health difficulties that may ultimately contribute to the beginnings of a criminal career. We will return to this issue in a forthcoming joint inspection with the Education and Training Inspectorate in Northern Ireland. In the meantime, it reinforces the importance of a joined-up justice system with devolved Departments when considering policy development in this sphere.

Statistics

- 5.32 The YJA does not keep statistics relating to the mental health of the children and young people who are its clients, and we recommend that it - and all the agencies of the criminal justice system - should do so. Inspectors recommend that **all the criminal justice agencies should collect statistics on the incidence of mental health issues in the cases they handle and these should be shared with the Health Service.**





- 6.1 We have commented at several points in this report on work that is in progress to improve the handling of mentally disordered persons in the criminal justice system. However, there are two initiatives in particular that deserve to be described in more detail.

Mental health in the prisons

- 6.2 When the budget for prison health was transferred to the DHSSPS, a specific allocation was made in respect of mental health service development. The sum of £225,000 was transferred from the NIPS for this purpose and £225,000 was allocated by the DHSSPS. The SEHSCT has developed plans for the reform and modernisation of the services, which include the following, drawing on the additional £450,000 a year which has been allocated:

1. Additional psychiatric sessions

Additional sessions at consultant and staff grade level will enable the assessment and treatment of those most seriously ill, those with treatable personality disorders and those with alcohol and drug problems. At the time of the inspection, an extra half-time

consultant forensic psychiatrist was being added to increase the provision to a full-time consultant with effect from April 2009, and it was intended that a further full-time staff grade psychiatrist should be recruited subsequently.

2. Two discharge co-ordinators

These nursing staff will be responsible for ensuring that no prisoner with mental health needs leaves prison without the relevant community services having been brought in to the planning of the discharge. Their appointments have now been made.

3. Two addiction nurses

These staff will be responsible for the development of treatment programmes to alleviate withdrawal, provide counselling and motivational work to promote recovery and to link in with community services, to ensure continuity of care when released into the community. They will be responsible for co-ordinating individual and group programmes that provide education to the wider prison population and take a lead role in health development. Their appointments have now been made.



4. Cognitive behavioural services

The provision of additional sessions provided either by psychologists, counselling services or qualified CBT nurses will help treat anxiety, depression and other mental disorders. Discussions were underway with Belfast Health and Social Care Trust regarding a further full-time post for this purpose.

5. Nursing assistants

These support staff will assist the nursing staff, freeing up their time to carry out their professional duties. Their appointments have now been made.

Inspectors recommend the Health Service should be held accountable for the delivery of the programme of improvements to mental healthcare in prisons which is planned.

The Personality Disorder Strategy

- 6.3 The criminal justice agencies in Northern Ireland have recognised the shortcomings of the treatment of personality disordered offenders in the present system, and a strategy is being developed to improve matters. At present it is acknowledged that:
- the legislative framework is inadequate;
 - there is a lack of co-ordination in the services provided;
 - there is uncertainty about the responsibilities of agencies and which should take the lead; and

- health priorities are elsewhere, and clinical needs are not being balanced properly against the needs of public protection.

- 6.4 A number of factors have brought about the pressure for change, including certain high-profile serious case reviews and the new public protection arrangements (PPANI) for violent and sexual offenders.
- 6.5 The Northern Ireland Personality Disorder Strategy recommends the development of a dedicated community-based unit for the assessment and management of personality disordered offenders, together with a strengthened partnership with health and other statutory and voluntary agencies, and a programme of joint training, research and evaluation. The aim is to produce a pathway for offenders linking prison, a dedicated residential unit and other placements in the community.
- 6.6 The strategic vision involves the following elements:
- pre-sentence screening and assessment by the PBNI;
 - referral for specialist assessment;
 - formulation of timely and sequenced interventions;
 - treatment in the right place, and at the right time, through effective movement between and within services; and
 - review and lifelong management.
- 6.7 Inspectors endorse this approach in principle. As the authors of the strategy recognise, however, progressing the idea of a dedicated residential unit is dependent on the



availability of resources from elsewhere in the criminal justice system, and the prospects do not seem good in the near future. We recommend **the Northern Ireland Personality Disorder Strategy should be pursued as quickly as possible, and to the degree that resources allow.**

- 6.8 The ultimate test for success in relation to the delivery of initiatives is not activity but the successful delivery of changed outcomes. Unless we can divert prisoners away from the justice system as appropriate, provide meaningful treatment and care while in custody, and plan for their resettlement back into the community, then conditions will not improve.



CHAPTER 7:

Conclusions

Tensions in the system

- 7.1 Mental health and the criminal justice system is one of those subjects which the Cabinet Office calls 'wicked'. The wicked subjects - the ones that are the most difficult for the government to handle - are those that spread across different arms of the government that have different agendas and do not naturally talk to one another. In this case, the arms of the government in question are the criminal justice system and the Health Service, each of which is very large and comprises a number of separate, semi-autonomous agencies. There is the added complication in Northern Ireland that at the time of this inspection, health and social services were devolved to the Northern Ireland Assembly and Executive, while responsibility for policing and criminal justice remained with the Westminster Government.
- 7.2 Although its profile has certainly been raised in the Health Service following the Bamford Review, mental health is not (and perhaps will never be) at the top of health or policing priorities. In any case each of the services is highly devolved in practice, with front-line staff having to exercise their individual discretion in dealing with a constant stream of day-to-day events. Although the PSNI is a disciplined service, one cannot change the behaviour (i.e. the practical priorities) of over 7,000 officers by issuing a new directive from HQ, nor can one change the behaviour of however many clinicians in the health service. It is important to be realistic about the practicality of making changes.
- 7.3 There is another difficulty about this subject on the criminal justice side. It makes the agencies of the criminal justice system uncomfortable because it goes to the heart of the question of criminal responsibility. Is it 'either/or'? Are people mentally ill or criminal, mad or bad? In the theory of jurisprudence there has to be *mens rea* (a criminal intention or knowledge that an act is wrong) for most offences (there are a few absolute offences), but in practice the law is, as we have seen, very restrictive about exempting people from criminal responsibility. One can have a very low IQ (well below 70), one can be intoxicated, and one can be seriously mentally disordered, and still be convicted of a crime. How the offence is disposed is another matter, but criminal prosecutions and convictions proceed in the great majority of cases.



Offender C

A recent case provides an illustration of this. Offender C was a paranoid schizophrenic who, while not taking his medication, killed a police officer for no apparent reason in broad daylight in the middle of an English city. He entered a plea of guilty to manslaughter on grounds of diminished responsibility, but was convicted of murder and sentenced to prison for a minimum of 25 years. Inspectors do not question that the verdict and sentence were in accordance with law: it is the very fact that this was not an abnormal decision that gives force to the example.

- 7.4 This probably reflects the wishes of the public. It is a pragmatic approach, and it does not necessarily result in bad outcomes, despite the danger of not always being entirely fair to the mentally disordered, and those of low mental capacity. But proceeding in this way introduces a tension between the forensic and the clinical ways of viewing mentally disordered offenders. The judgments which different sets of professionals make may not infrequently be in conflict. The two services, health and justice, need to work in partnership on issues of mental health - as we have observed at many points in this report - but that is not always an easy thing to ask of either service.

The governance of prison healthcare

- 7.5 Indeed, although the new arrangements for healthcare in the prisons are being launched with a great deal of good intent, and although they are likely to bring

about improvements, Inspectors are uncertain whether they will offer the best solution in the long run. A partnership only works if the partners share common objectives, and in this context there is, as we have seen, a tension between clinical and forensic need. Moreover, bringing healthcare standards in prison up to the level prevailing in the community may not be good enough if there are endemic shortages of resources in mental health.

- 7.6 Parity between prison and the community may not be enough: there may need to be a criminal justice premium. The justice system has a double claim on mental health services, because the public safety benefit, flowing from appropriate treatment, needs to be added to the clinical benefit to the individual. That can only adequately be reflected by giving the NIPS (and possibly other parts of the justice system) an enhanced budget for the purchase of mental health services, and allowing them to purchase those services from the best available source.
- 7.7 There is the further point that CJI believes in principle, that it is best if one person or agency is clearly in overall charge of a function and can be held accountable for it. Inspectors would always be doubtful about a shared responsibility.
- 7.8 Inspectors therefore favour a robust commissioner – provider relationship rather than a partnership. It is right that full responsibility for the health care of prisoners rests with the Health Service, as this is the case in other parts of the United Kingdom.



This means that all aspects of the current service delivery architecture must deliver. The NIPS must be specific in relation to its needs, and this should feed into the commissioning arrangements of the Health and Social Care Board. They must hold to account the SEHSCT for delivery and manage performance against agreed standards.

- 7.9 Having said this, the risk is that the treatment of mental health offenders within the Health Service gets an unsympathetic ear and indeed suffers negative consequences when difficult decisions on resources within the health service have to be made. Ultimately, the achievement of success means the delivery of meaningful outcomes for prisoners against the internationally recognised 'healthy prison' tests. If the current arrangements are not working over time then they should be changed to reflect the needs of the prison population. The success or otherwise of the current arrangements should be the subject of a formal review when the current arrangements have had the opportunity to bed down and when management and service delivery arrangements become more stable. Inspectors would not suggest that the present arrangements should be disturbed for the next five years. They should be given another five years to run in and prove their potential, and should then be reviewed in 2014 to see whether there is a case for change. The health needs of prisoners needs to be owned by the Health Service and built into on-going service developments. Inspectors

recommend that **a formal review of the service provided by the Health Service to the Northern Ireland Prison Service should be undertaken in 2014. The review would consider the impact on prisoner outcomes of the services provided by the South Eastern Health and Social Care Trust against NIPS requirements and Her Majesty's Inspectorate of Prisons' 'healthy prison' test.**

The future of the prison system

- 7.10 Perhaps the most important conclusion to come out of this report is that even if adjustments and improvements are made to the system, mentally disordered persons are going to continue to end up in prison, and in increasing numbers, because those who are deemed to be dangerous are likely to remain there for considerably longer. If mental health is not a marginal issue for the justice system as a whole, for the NIPS it is going to become an absolute pre-occupation. Making sure that there are adequate mental health services, adequate treatment programmes and a 'healthy prison' environment which will not exacerbate the mental problems of prisoners, needs to be a top priority. NIPS management recognises this and are responding to the challenge, but it will need committed support from the Health Service and from Ministers. Prisons and the regimes within them will need to be designed not just to be penal establishments, but to provide secure care for an increasing part of the population suffering from serious mental disorders.



7.11 There also needs to be close attention to the problem of bringing mentally disordered offenders back into the community, making sure that there is continuity of care and that there is appropriate continued supervision where it is needed. Inspectors believe that there is a need for more sheltered or hostel accommodation, which will be critical if the Parole Commissioners for Northern Ireland are going to have the confidence to allow prisoners to be discharged.

Management arrangements for delivery across the system

7.12 Lord Bradley in his recent report on people with mental health problems or learning difficulties in the justice system in Great Britain highlighted that one of the main problems with policy development has been the piecemeal basis upon which it has been undertaken. As he notes: *“There is no one organisation that can be held responsible for making changes for this population... If we are not to repeat the mistakes of the past, as exemplified by the rather uncoordinated approach to the implementation of liaison and diversion services, it will be vital to ensure that there is a clear, visible national focus on this agenda that transcends all the traditional governmental and organisational boundaries”*. Bradley goes on to recommend national accountability for the service improvement agenda via a new Programme Board. His intention is to bring together all the relevant government departments covering health, social care and

criminal justice to develop and oversee the delivery of services to offenders with mental health and learning disability issues. This is to be supported by a National Advisory Group and a small cross departmental implementation team. He goes on to note *“ultimately the delivery of this agenda will be via partners at a regional and local level, building on existing structures and relationships”*.

7.13 In response to the Bradley Review the Government published in November 2009 *‘Improving Health Supporting Justice’*²⁰. The response highlighted a number of areas including the importance of cross Departmental working to implement changes at a time of finite resources, the need for innovation in service delivery and the contribution of improved commissioning based on identified needs. The message from the response is strong; *“our overarching aim at each stage of the offender journey is to develop the mechanisms that enable the provision of mental healthcare in the most appropriate environment, whether in the criminal justice system or in a health setting”* and the need to look for improvements in the system by *“appropriately diverting offenders with mental health problems away from short sentences in prison towards effective treatment in the community”*. The Government also intends to set up a Health and Criminal Justice Programme Board reporting to the Inter-Ministerial Group and the National Criminal Justice Board.

20 *‘Improving Health, Supporting Justice – The National Delivery Plan of the Health and Criminal Justice Board’* HM Government November 2009

7.14 Inspectors see merit in the development of such an approach for Northern Ireland. There are clear issues around fragmentation of service delivery across the justice organisations and between justice and health. It is our understanding that the Department of Health aims to create a Forensic Sub Group to the Bamford Taskforce. This is early days and certainly there was limited understanding of its role or potential within the justice system. This may, however, provide an operational basis for improved co-operation and collaboration in the delivery of local services at all stages of the patient pathway. Indeed the implementation of the 'Offender Mental Health Care Pathway' provides a basis for support and intervention for the end-to-end management of offender mental health needs.

7.15 At a more strategic level we see merit in the creation of a joint Health and Criminal Justice Programme Board to help provide greater collaboration and partnership in the design and the delivery of services to offenders with mental health problems. Inspectors recommend **a joint Health and Criminal Justice Programme Board should be created to bring together all relevant organisations to develop a clear approach to the needs of mentally disordered offenders.**

The need for realism

7.16 The Bamford Review produced an admirable report, and it would be hard to disagree with any of its 169 recommendations relating to criminal

justice services. However it is scarcely surprising that the Executive found it hard to commit to many of them: they are just too wide-ranging and too ambitious for immediate implementation.

7.17 We have identified six key areas that the criminal justice agencies, with help from the Health Service could focus on, which we believe would make the most difference. They are:

- Establish clear rules about where mentally disordered people are to be taken when they are arrested or detained by the police. The rules should distinguish between different sorts of cases and should be specific about the relevant place of safety for each category in each police district.
- Make sure that mentally disordered people are properly assessed when they arrive at the place of safety. In police stations, this means extending the Mentally Disordered Offender (MDO) scheme to cover all the custody suites in Northern Ireland.
- Make sure that the assessment (and any other available information) is properly recorded on NiCHE RMS IT system and is passed on as part of any file which goes to the PPS.
- Make sure that the PPS brings any mental health issues to the attention of the Court at the earliest opportunity, so that the judge can consider it (and call for further expert advice, if necessary) before the case is heard.
- Make sure the care of prisoners is based around the 'healthy prison' agenda which provides real and significant outcomes for prisoners. There is a need for on-going review



of the quality of care provided by the Health Service and corrective action taken where necessary.

In addition there is a need for a local high secure hospital to which the most dangerous mentally disordered prisoners can be transferred for treatment.

- Focus on the need for suitable accommodation to help mentally disordered offenders to make the transition back into the community with adequate supervision and aftercare.

Section



Appendices



Appendix 1

The Republic of Ireland: Prison Inreach and Court Liaison Service

The PICLS is based at the Central Mental Hospital, Dundrum, (CMH) and Cloverhill Remand Prison. The CMH is a Health Service Executive facility which has 95 patients, of whom 87 are male. It averages 100 admissions a year. Most patients have psychoses that can be treated. The Inreach Team does not deal with Personality Disorders. A total of 20% of patients arrive under the 2001 Mental Health Act as non-adjudicated offenders. They are reviewed by Mental Health Tribunals. A total of 80% arrive following criminal proceedings under the Criminal Law (Insanity) Act 2006. Decisions about their release are taken by the Mental Health Review Board, which makes recommendations to the Department of Justice, Equality and Law Reform. Diversion does not necessarily equate with discontinuation of prosecution.

The CMH risk assesses and offers a progressive regime for men, but is currently unable to do so for the small numbers of women. The progressive regime ranges from high security with high staff/patient ratios, through to on-site and off-site hostels which afford greater degrees of independence. Oversight is exercised by the Mental Health Commission who visit twice a year, once announced and once unannounced. The Royal College of Psychiatrists also undertakes peer assessment across the islands through its Quality Audit network; and the European Commission for the Prevention of Torture (ECPT) also visits.

The multi-disciplinary Inreach Team has been operational for 20-30 years, but it was formalised and strengthened in 2006, and fully staffed since 2007. It is based in Cloverhill Prison with CMH staff: a psychiatrist, Community Psychiatric Nurses (CPNs) and social Workers. It took a deliberate decision to work with the remand prison rather than via Garda stations or the courts as numbers outside could be too great and it would be too difficult to monitor patients' progress. It is recognised that this may mean opportunities for earlier diversion are lost. There are different local diversion arrangements for other prisons, for both sentenced and remanded prisoners, outside Dublin.

The Inreach Teams' main functions are psychiatric screening of new remands; provision of court reports; triage according to the level of treatment need (this includes a gatekeeping role in respect of the CMH); psychiatric care for existing prisoners; and arrangement for diversion to community psychiatric facilities. It aims to screen out minor offenders who have major mental illnesses. The service is provided free to the Irish Prison Service, as are drugs and STI (sexually transmitted infection) services. Although it is an informal relationship and the Inreach Team is not accountable to the Cloverhill governor, it is said to work well because those involved are committed and communicate well.



Some key achievements and data are as follows:

- 680 new assessments in 2008 – many were minor offenders, but were remanded in custody due to their psychiatric conditions;
- 80% seen within seven days of committal;
- 113 had an active psychosis; 189 had a lifetime psychosis;
- 91 diverted to general psychiatric hospitals or community psychiatric facilities, within an average of 14 days;
- 19 admissions to the CMH from Cloverhill in 2008;
- Four CMH admissions were subsequently diverted;
- Significant reduction of people with major mental illness/minor offences entering the CMH, from 74% of assessments in 2005 to only 10% of assessments in 2007;
- Time spent in custody for those deemed suitable for local psychiatric treatment reduced from average 57 days in 2005 to 21 days in 2007; and
- While 77% of all patients transferred from Cloverhill to the CMH in 2005 were not actually deemed to need high security, this had reduced to 28% by 2007.





Appendix 2

List of agencies and organisations consulted

1. Aware Defeat Depression
2. Department of Health, Social Services and Public Safety (DHSSPS)
3. Representatives from a variety of Health and Social Care Trusts (HSC)
4. Judiciary
5. Northern Ireland Court Service (NICtS)
6. Northern Ireland Office (NIO)
7. Northern Ireland Prison Service (NIPS)
8. Police Service of Northern Ireland (PSNI)
9. Probation Board for Northern Ireland (PBNI)
10. Public Prosecution Service (PPS)
11. Rethink
12. University of Lincoln Mental Health and Criminal Justice Department
13. Youth Justice Agency (YJA)
14. Inspectors also undertook site visits to secure hospital premises in England.



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