Nacro response to The Women and Equalities Committee inquiry into the mental health of men and boys

About Nacro

We are a national social justice charity with more than 50 years' experience of changing lives, building stronger communities and reducing crime. We house, we educate, we support, we advise, and we speak out for and with disadvantaged young people and adults. We are passionate about changing lives. We never give up.

Our services include supported housing for vulnerable people; vocational training programmes; substance misuse services; offender management services; Resettlement Advice Service for offenders, families and employers. In 2016/17 we supported more than 38,000 disadvantaged young people and adults who face challenges with education, housing, health or who have a history of offending. We aspire for our work to be consistently high quality, innovative and based on evidence. We work in partnership with more than a hundred organisations: public, private and charities. We use our knowledge of what works to help inform policy and shape practice.

In responding to this inquiry we have limited our comment to men and boys in contact with the criminal justice system (CJS). This group is at particular risk of poor mental health, often experiencing multiple and complex needs with coexisting health and social problems, such as substance misuse, and housing problems together with mental health issues. These problems may be compounded by others, such as poor physical health and social factors such as unemployment, persistent poverty and debt. For many, their poor health arises from, or has been exacerbated by, early childhood experiences such as abuse and neglect, problems with housing and/or employment, and higher rates of smoking, alcohol and substance misuse.

Please contact Andrea Coady, Policy and Research Officer, for more information on our response: andrea.coady@nacro.org.uk.

Summary

Men and boys who come into contact with the criminal justice system are particularly at risk of poor mental health, and often face multiple disadvantage, including substance misuse, domestic abuse and homelessness. These problems may be compounded by poor physical health and social factors such as unemployment, persistent poverty and debt.

Almost half of the people in prison have been identified as suffering anxiety and/or depression compared with 15% of the general population. [1] The prevalence of mental health issues for men and

[1] MoJ Surveying Prisoner Crime Reduction (SPCR). SPCR interviewed 1,435 adult prisoners sentenced to between one month and four years in 2005 and 2006.

boys in contact with the criminal justice system is starkly illustrated by the fact that self-inflicted deaths are at least 5 to 6 times more likely in prison than in the general population.[2]

It is of concern that provision of mental health services for men and boys who come into contact with the criminal justice system remains patchy. Sufficient resource and funding is needed to ensure that appropriate services are available at all points in the criminal justice system: from the point of initial contact with the police, throughout the duration of a sentence, whether in the community or custody, and during any transitions from custody to community. In addition, we would emphasise that a wide range of tailored services need to be available meet the needs of men and boys from Black, Asian and minority ethnic (BAME) groups, who are disproportionately represented at all stages of the CJS and across mental health services.

Our approach

We know that too many people with mental health problems present at crisis point, whether this be in A&E, police custody or prison. Their problems are left undiagnosed and unsupported in the community resulting in costly consequences for individuals, their family and blue light services. People in crisis often present with multiple and complex needs such as drug or alcohol addiction, homelessness or time in prison.

We understand the vital role that supported housing plays for people with mental health problems. For many people living in Nacro housing, mental health problems are diagnosed during their time with us, or present as a 'secondary need'. We take a person-centred approach to the support we offer, making sure we address the needs of the whole person.

Our mental health work

We deliver specialist education in two Secure Forensic Mental Health Units – Bluebird House and The Wells Unit – for the NHS. Bluebird House is a specialist, secure mental health inpatient unit in Southampton which provides assessment, treatment and care for young people. The unit helps both males and females who have complex mental health problems and are aged 12-18 years. The Wells unit is a 10 bed male inpatient unit for adolescent young men aged 12-18 years. It provides a highly specialised, multi-disciplinary assessment and treatment service for young males with severe mental illness who are a danger to themselves or others, and who may have committed criminal offences. In addition, we deliver specialist education in Medway Secure Training Centre on behalf of the Ministry of Justice.

We work with people leaving custody to ensure that all of their mental and physical wellbeing needs are met, giving them the best possible chance of moving on to a positive future. In the Greenwich project Nacro provides support with transition from prison to the community for those men in the Greenwich prisons who have significant mental health concerns.

Our housing services support people to overcome or manage any mental health problems they may be experiencing, in addition to help with education, training and employment and maximising their general health and wellbeing. We work towards building an individual's independent living skills, as well as addressing social skills and social isolation, preparing them for more permanent accommodation in the community.

[2] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(17)30430-3/fulltext

Our response

Which groups of men and boys are particularly at risk of poor mental health and what is leading to this?

Men and boys in the CJS are particularly at risk of poor mental health, although it is difficult to know the extent of the problem.The National Audit Office (NAO) reported in June 2017[3] that the Government does not know how many people in prison have a mental illness, how much it is spending on mental health in prisons or whether it is achieving its objectives.

It is important to note that the population in contact with the CJS is far larger than the prison population. At any one time, the proportion of offenders supervised by probation services outnumbers those serving a custodial sentence by around 3 to 1[4]. The prevalence of social, physical and mental health problems among offenders in the community is thought to be similar in character to those issues amongst the prison population, but not necessarily extent. As there is limited comprehensive information about the health needs of offenders in the community, the prison population is used as a proxy.

Statistics

- **Suicide and self harm[5]**

Adult estate:

- There were 83 self-inflicted deaths of men in prison in the 12 months to September 2018 (an increase of 10 from the previous 12 months)
- Self-harm: in the 12 months to June 2018:
    - there were 40,265 recorded incidents of self-harm by men in prison, which amounts to 498 recorded incidents per 1,000 men (an increase of 20% from the previous year)
    - self-harm incidents requiring hospital attendance have increased in the male establishment by 10% to 2,959.[6]

Youth estate:

- Self-harm: in the 12 months to June 2018:
    - there were 539 recorded incidents of self-harm for boys in the youth estate, which amounts to 779 recorded incidents per 1,000 boys (an increase of 0.74% from the previous year).

[3] https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf
[4] http://www.revolving-doors.org.uk/file/2050/download?token=m-t2NRKC
[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750582/safety-in-custody-bulletin-2018-q2.pdf
[6] The need for hospitalisation is not a straightforward indicator of the severity of the self-harm incident because it is affected by the type of injury suffered and the availability of medical services at the prison

- 18 Self-harm incidents required hospital attendance, a significant decrease from the previous year's figure of 71 (which seemed to be an unusual spike, as the years 2014-16 averaged 28).

Self-inflicted deaths are 5 to 6 times more likely in prison than in the general population.[7]

- **Police intervention**

Mental health related incidents are estimated to take between 20 to 40% of police time.[8]

- **Mental health issues in prison**

- HM Inspectorate of Prisons surveys suggest that there are 31,328 people in prison who report having mental health or well-being issues at any one time (37% of the average monthly prison population).
- 7,917 people were recorded by NHS England as receiving treatment for mental health illnesses in prison in England in March 2017.[9]
- 7% of men in prison have experienced a psychotic disorder within the previous year, a figure substantially higher than the prevalence within the general population (0.7%).
- 33% of men in prison suffer from depression, while the prevalence in the general population is 9%. The proportion with a diagnosed personality disorder is 64%.[10]
- 16% of men have received treatment for a mental health problem in the year before entering custody. 42% of men entering prison reported that they had mental health issues.[11]
- Almost half of people in prison have been identified as suffering anxiety and/or depression compared with 15% of the general population.[12]
- 23% of the prison population have a severe and enduring mental illness with 19% suffering from major depression and 4% from psychosis.[13]

- **Community sentences**

It is estimated that 39% of people supervised by probation services have a current mental health condition.[14]

- **Transition from prison to the community**

The risk of suicide is highest in the 28 days following release from prison, and a study in 2006 found that the risk of suicide in people recently released from prison was approaching that seen in discharged psychiatric patients.[15]

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[7] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(17)30430-3/fulltext
[8] House of Commons Home Affairs Committee (2015) Mental Health and Policing
[9] Ibid.
[10] https://www.london.gov.uk/sites/default/files/omhfinal.pdf
[11] HM Chief Inspector of Prisons (2017) Annual Report 2016–17
[12] MoJ Surveying Prisoner Crime Reduction (SPCR). SPCR interviewed 1,435 adult prisoners sentenced to between one month and four years in 2005 and 2006.
[13] The Offender Health Research Network (2009) *A National Evaluation of Prison Mental Health In-Reach Services: a report to the national institute of health research* http://www.ohrn.nhs.uk/resource/Research/Inreach.pdf
[14] Brooker, C., Sirdifield, C., Blizard, R., Maxwell Harrison, D., Tetley, D., Moran, P., Pluck, G., Chafer, A., Denney, D. & Turner, M. (2011) An Investigation into the Prevalence of Mental Health Disorder and Patterns of Health Service Access in a Probation Population. Lincoln: University of Lincoln

Mental health issues across different areas of the criminal justice system

1. Liaison and Diversion

There is an increasing awareness of the overlap between mental health, policing and the CJS. Providing appropriate intervention and treatment at the right time and in the right place is vital to improving outcomes for people with mental health issues and other vulnerabilities. Liaison and Diversion (L&D) services provide an opportunity to identify mental health issues. L&D services are not treatment services, but an assessment and identification service that makes necessary referrals to treatment and informs criminal justice practitioners about the health issues identified, for use in their decision making. NHS England is leading a cross-government programme to expand these services to the whole of England by 2021.[16] Statistics from the Health and Justice Team at the NHS show that, in the Milton Keynes L&D programme between 2014 and 2018, 188,000 adults and 29,000 children and young people have engaged with L&D services. Of those, 69% of adults and 49% of children and young people were identified as having a mental health need.

The increased provision of L&D services is positive but a question remains about whether community mental health services are available and sufficiently resourced to be able to respond adequately to referrals from L & D.

2. Community sentences

An estimated 39% of people supervised by probation services have a current mental health condition. However, mental ill health in the probation caseload is, for the most part, unrecognised and untreated.[17]

Community sentences can be particularly effective for people who have committed a large number of previous offences (more than 50) and those with mental health problems, according to research by the Ministry of Justice.[18]

Issues often arise when a person has a 'dual diagnosis': having co-occurring issues of mental illness and substance abuse. The relationship between the two conditions is often complex: people may become mentally ill as a direct result of drug or alcohol abuse, or may become dependent on drugs and alcohol as a way of self-medicating for a mental health condition, or the two issues can exist independently. Evidence suggests that vulnerable people can be passed between services and consequently fall through the gaps. Substance abuse services may lack the expertise to deal with service users with severe mental health issues, while mental health services may refuse to work with an individual until their substance abuse issue has been addressed.[19]

The Mental Health Treatment Requirement (MHTR) is one of twelve options available to magistrates and judges when they make a Community Order. However, there has been a low uptake of the

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[15] Pratt, D., Piper, M., Appleby, L., Webb, R. and Shaw, J., 2006. Suicide in recently released prisoners: a population-based cohort study. The Lancet, 368(9530), pp.119-123

[16] Mental Health and Deaths in Prison: Interim Report: Government Response to the Committee's Seventh Report of Session 2016–17

[17] https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/briefing45_probation.pdf

[18] Hillier, J. and Mews, A. (2018) Do offender characteristics affect the impact of short custodial sentences and court orders on reoffending?, London: Ministry of Justice

[19] https://www.turning-point.co.uk/_cache_4d1c/content/dual_dilemma-5090910000020596.pdf

MHTR to date as it represents fewer than 1% of all requirements made as part of Community Orders.[20] The MHTR has unfulfilled potential to engagement with appropriate treatment and support. Wider use of the MHTR could result in improved health outcomes and reduced reoffending. There are currently 5 pilot sites looking to increase the number of vulnerable offenders with mental health, alcohol and substance abuse issues being given community service treatment requirements (CSTRs). The pilot sites went live at various points in late 2017 and early 2018 – in Birmingham, Plymouth, Sefton, Milton Keynes and Northampton. Figures from August 2018 suggest that over 400 CSTRs had been given.[21] The project hopes to increase use of services, ultimately helping to reduce reoffending and improve rehabilitation. The programme sets out a minimum standard of service, and there has been additional training and improved collaboration between agencies. This includes a steering group at each site to aid the smooth running of the diversion process. It is our understanding that the Northampton pilot has significantly increased the numbers given CSTRs, but the specific focus of this pilot has been women. Building on this work, we would suggest that consideration should be given to what elements of CSTRs and MHTRs should be in place specifically to address the needs of men.

Similarly, we would note that out of court disposals (OOCDs) that include a pathway from L&D tend to be rightly developed for women to avoid custodial sentences, such as the West Yorkshire L&D Service - Women's Specific Out of Court Disposal (OOCD) Pathway . We would therefore also suggest that there is an argument for considering how OOCDs could provide a pathway from L&D specifically for men.

3. In prison

Prisons were designed to accommodate physically fit and mentally stable individuals, with prison life addressing the needs of the many. Prison itself is an environment which can give rise to the development of physical and mental health issues. Most research suggests that people in prison are more likely to suffer from mental health problems than people in the community. Complex social and personal issues such as a history of unemployment, substance misuse or trauma are more common among the prison population, and being in prison can exacerbate poor mental health and well-being. People in prison are less able to manage their mental health because most aspects of their day-to-day life are controlled by the prison. Many move in and out of prison, or between prisons, which makes the provision of healthcare more difficult. People in prison whose mental health needs are not addressed may be more likely to reoffend.

In 2016, the Prisons and Probation Ombudsman (PPO) found that 70% of people in prison who had taken their own life between 2012 and 2014 had been identified as having mental health needs.[22] As mental health problems frequently go unrecognised and undiagnosed, the prevalence of mental health issues found in PPO investigations is likely to be an under-representation. Mental health difficulties, anxiety about being in prison, drug use, violence, debt, isolation and poor regimes are some of the factors causing men to harm themselves or take their own lives. In more than 90% of PPO reports on men's prisons in this period they were critical of one or more of the key indicators they use to assess the effectiveness of suicide and self-harm prevention measures. While mental health needs were noted in almost three-quarters of people who suffered a self-inflicted death, only half had their mental health needs identified at the point of reception into prison. Further, the PPO

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[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/391162/Mental_Health_Treatment_Requirement_-_A_Guide_to_Integrated_Delivery.pdf

[21] https://www.gov.uk/government/news/vulnerable-offenders-steered-towards-treatment

[22] https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf

concluded that a mental health referral should have been made (but was not) in 29% of self-inflicted deaths. Identification of mental health needs was often lacking, due to "poor information sharing, failure to make referrals, inappropriate mental health assessments, and inadequate staff training."

HM Chief Inspector of Prisons reports that many people in prison experienced delays in transfer to external mental health facilities. In 2016, half of the 111 patients who had been transferred or listed for transfer had waited longer than the target of two weeks, with up to 169 days in one case[23].

4. Transition from prison to the community

The transition from prison to the community is stressful for people, particularly those with mental health problems. Continuity of care between prison and community based health services is difficult to provide, and people in prison can lose contact with services after release. We know that there is often a window of opportunity for people on release when they are keen to make change and move on, but people can be released from prison without support or treatment arrangements being in place. It is important that the transition from receiving healthcare in prison to receiving healthcare in the community is as seamless as possible, as prison leavers often require access to immediate medical support and medication.

People in prison are not always registered with primary care services upon their release from prison, which represents a barrier to care and even for people in prison with severe mental illness, contact with community mental health care is rare in the months after release. This lack of continuity of treatment may lead to an increase in chaotic and unplanned interactions with blue light services after release.

In the Greenwich project Nacro and Centra provide an in custody and through the gate support service to those people in prison who have significant mental health concerns to ensure that they have clearly defined release plans and that that there is an immediate link with community based support services. The criteria for referrals is that the individual must have a mental health diagnosis or be engaging with the mental health team in custody. Support is provided 2 months prior to release and up to 4 to 6 weeks follow up resettlement work.

The NHS Long Term plan, published in January 2019, sets continuity of care as a priority for people in prison. We are pleased to note that the plan recognises the huge numbers of people that cycle in and out of prison every year and the need to support the transition to community-based services so that people can continue to get the support they need. Over the next five years, RECONNECT – the care after custody service – will engage and support more people after custody per year. This will be supported by the full roll-out of a digital patient record system for more effective transfer of patient records before, during and after custody.

Race, mental health and criminal justice

People from Black, Asian and minority ethnic (BAME) groups are disproportionately represented at all stages of the CJS; the Equality and Human Rights Commission has stated there is greater

[23] https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/07/6.4472_HMI-Prisons_AR-2017-18_Content_A4_Final_WEB.pdf

disproportionality in the number of Black people in prisons in the UK than in the United States.[24] Additionally, research studies and data monitoring have consistently shown that those from Black communities in particular are also overrepresented across mental health services.[25] This anomaly is compounded by the fact that both systems seriously disadvantage Black people.[26]

We would refer the Committee to the recommendations contained in the briefing *Race, mental health and criminal justice: moving forward*[27], from Nacro, Clinks, the Association of Mental Health Providers, Mental Health Foundation and the Race Equality Foundation. Appendix 1 to this response contains the recommendations from that briefing.

Mental health of boys in contact with the criminal justice system

Evidence suggests that young people in contact with the justice system are three times more likely than other young people to have an unmet mental health need and yet they are less likely to access the right support.[28] They are also more likely to have learning difficulties, communication problems, and other complex and multiple needs[29] yet less likely to have their needs met.[30]

Mental health problems in children do not manifest themselves as clearly as they do in adults and they can emerge in ways that are less easily defined – eg through behavioural problems and emotional difficulties, substance misuse and self-harm.[31] The most common conditions among children and young people in contact with the youth justice system are conduct disorders, followed by anxiety and depression. The prevalence rates for emerging personality disorder, psychosis, attention conditions, post-traumatic stress disorder and self-harm are notably higher than in the general population.[32]

The Beyond Youth Custody programme[33]

The Beyond Youth Custody programme (BYC) was a six-year England-wide learning and awareness programme funded by the Big Lottery Fund as part of the Youth in Focus (YIF) initiative. BYC brought together Nacro with three research and evaluation partners: ARCS (UK), and Salford and Bedfordshire universities. Since its inception in 2012, BYC built a robust evidence base about what works in terms of effective resettlement for young people. This evidence base – rooted in the views of children and young people – was used to challenge, advance and promote better thinking in

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[24] Equality and Human Rights Commission. (2011). How fair is Britain? Equality, Human Rights and Good Relations in 2010. The First Triennial Review, [online] p.172. Available at:
https://www.equalityhumanrights.com/sites/default/files/how_fair_is_britain_-_complete_
report.pdf [accessed 29.09.2014].

[25] Fernando, S. (1991). Mental Health, Race and Culture. London: Macmillan/MIND Publications.

[26] Ibid.

[27] https://3bx16p38bchl32s0e12di03h-wpengine.netdna-ssl.com/wp-content/uploads/2017/08/Race-mental-health-and-criminal-justice-moving-forward.pdf

[28] Hagel A (2002) *The mental health of young offenders: Bright futures – Working with vulnerable young people.* London: Mental Health Foundation

[29] Hughes K, Hardcastle K and Perkins C (2015) *The mental health needs of gang- affiliated young people*, *a briefing produced as part of the Ending Gang and Youth Violence programme* London: Public Health England

[30] Chitsabesan P et al (2006) *Mental Health needs of young offenders in custody and in the community.* British Journal of Psychiatry 188(6) pp 534-540

[31] Mental Health Foundation (1999) *Bright Futures: Promoting children and young people's mental health*; Young Minds (2003) *Mental Health Services for Adolescents and Young Adults*.

[32] Lader D, Singleton N and Meltzer H (2000) *Psychiatric Morbidity Among Young Offenders in England and Wales*. London: Office for National Statistics; Harrington R and Bailey S, with others (2005) *Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community*. London: YJB

[33] http://www.beyondyouthcustody.net/

policy and practice for the effective resettlement of young people leaving custody. The framework provides a new focus for resettlement services' aims and objectives, and is particularly useful as a common language for the inter-agency working that is essential when supporting children and young people in the youth justice system.

There is a great deal of evidence to suggest that people who come into contact with the CJS have a disproportionate amount of childhood and adolescent trauma in their backgrounds. In addition to abuse and neglect, these histories can involve a wide range of adverse childhood and adolescent experiences including assaults and bullying, domestic violence, abandonment or separation, bereavement and witnessing family, school or community violence. They are also more likely to have suffered brain injury during childhood and adolescence than non-offenders. A trauma-informed approach is therefore key, and such approaches can be thought of as incorporating three key elements: an understanding of the prevalence of trauma; recognition of the effects of trauma both on those affected and on those who work with them; and the design of services which are informed by this knowledge.

1. Boys in custody

The YIF evidence suggests that periods of time spent in custody itself has impacts that are detrimental to longer-term desistance, and that an understanding of these impacts can aid the effectiveness of resettlement services. Some of those impacts concern practical issues, such as barriers to securing suitable housing. YIF participants have also described the ways imprisonment has affected their emotional wellbeing. Following a year in custody, one participant said: "Prison just changes you altogether. You don't think the same, you don't act the same any more. I just think it sends you a bit crazy really. Always stays with you. I think it's the year missed." Such descriptions make it clear that resettlement work needs to include a focus on rebuilding or strengthening resilience.

2. Transition to the community for boys

Young people released from custody enter a period of disorientation following release, where the transition destabilises them. This requires the young person to undertake a process of reorientation in order to move towards successful resettlement and desistance. In the meantime, the period of the early days to weeks can be an overwhelmingly stressful experience. Boy's related experiences are consistent with symptoms of adjustment disorders which carry increased risks of long-term psychiatric illnesses and suicide.

This process is made more difficult because:

1. boys may not have developed strategies to cope with transitions,
2. this particular group have higher levels of need and vulnerabilities,
3. they are more likely to have to orient themselves around a chaotic home environment,
4. they are simultaneously trying to renegotiate a post-custody identity for themselves, and
5. research suggests that structural support such as stable accommodation, education, training, employment and financial stability on which to build their reorientation may well not be available by the time of release.

The BYC framework proposes a 'theory of change' for the sustainable re-entry of children and young people into the community. It highlights how service providers should support children and young people to develop a shift in identity – a new narrative for how they relate to others. It involves

guiding and enabling the child to create new roles in their life story that foster and reinforce this positive identity which promotes wellbeing and desistance.

In highlighting the phenomenon of disorientation after release, we raise questions for urgent policy and practice consideration, including the appropriateness of intensive early licence requirements, and of breach proceedings for failure to comply with such requirements.Beyond the obvious preference to avoid sentencing or remanding to custody, the Beyond Youth Custody research report *Custody to Community: How young people cope with release* makes specific recommendations for easing this orientation process. However, the first step is for policymakers and service providers to acknowledge the disorientation and anxieties arising after release and take this into account in resettlement planning and enforcement.

Meaningful engagement and work on shifting the young person towards a more constructive narrative cannot begin while they are struggling to cope with feeling lost and stressed on release from custody. Consequently, if incarceration is absolutely necessary, it is essential that policymakers and practitioners take steps to ease the transition for young people returning to the community. The young people (and the environment/supporters) need to be prepared well in advance for these post-release challenges, and appropriate support should be in place to guide them through a destabilising and stressful period in order to promote quicker and more successful longer-term resettlement. The specific recommendations to help ease the reorientation process set out in *Custody to Community: How young people cope with release* are in Appendix 2 to this inquiry response.

Appendix 1

The recommendations contained in the briefing *Race, mental health and criminal justice: moving forward* are:[34]

1. Commissioners and providers should ensure that a wide range of tailored services are available to meet the needs of different BAME groups. These should include both peer support and independent advocacy services at all points on the justice pathway. Peer support should be provided by people with experience of both the CJS and mental health or other vulnerability eg learning disability or substance misuse.

2. Assessments completed at all stages of the justice pathway including those by liaison and diversion teams, prison mental health teams and police custody healthcare should:

   - appropriately assess the impact of trauma

   - consider the spiritual and faith needs of individuals and integrate this understanding into each individual's care plan

3. Service providers should ensure that all printed materials use diverse images, have an easy read copy available, and are available in different languages for those for whom English is not their first language and for those with learning difficulties.

4. Commissioners, service providers and criminal justice agencies should engage with anti-stigma initiatives.

5. The prison environment needs to become psychologically informed to support and promote the mental wellbeing of people in prison, including those from BAME communities with mental health difficulties. It should also endeavour to improve behavioural outcomes of people in prison and those working within the prison setting.

6. The Ministry of Justice should develop its systems to report anonymised single case data for analysis. The Ministry of Justice, NHS England and other partners should work together to develop data analysis systems that can report triangulated data for race, mental health and criminal justice, and intersectionality to include protected characteristics, mental health and criminal justice.

7. Organisations providing services to people in the CJS should collect case studies that demonstrate the effectiveness of interventions to address disproportionality.

8. Commissioners and providers should liaise directly with service users and those with lived experience to understand how services should be designed to effectively engage people from BAME communities in mental health treatment.

9. NHS England should monitor how Health and Justice commissioners and providers co-produce service specifications, commissioning and procurement processes, and health and justice services with people with lived experience. This should include engagement with people from a wide range of BAME groups with lived experience of criminal justice and mental health or other vulnerability.

10. Agencies should include people with lived experience in the monitoring of the Public Sector Equality Duty (PSED) and in Equality Impact Assessments (EIA).

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[34] https://3bx16p38bchl32s0e12di03h-wpengine.netdna-ssl.com/wp-content/uploads/2017/08/Race-mental-health-and-criminal-justice-moving-forward.pdf

11. Commissioners and providers should ensure that their workforces are representative of the communities they serve and reflect the requirements set out in the NHS Workforce Race Equality Standard (WRES).
12. Criminal justice practitioners and providers delivering services in health and justice settings should have training in:
    - effective race equality that enables participants to challenge and address the discrimination and unequal outcomes people face
    - trauma-informed assessments
    - assessing faith and spirituality needs
13. Criminal justice agencies should establish mental health champions.
14. All providers delivering services across health and justice settings should be encouraged and supported to take a multi-agency approach. This should include all agencies and organisations – including the voluntary sector – working with the individual service user, family members and carers. Crucially, the approach needs to demonstrate effective service user engagement.
15. NHS England Health and Justice commissioners should ensure that commissioning processes don't disadvantage voluntary sector organisations in being able to able to bid for tenders.

Appendix 2

Custody research report *Custody to Community: How young people cope with release* makes specific recommendations for easing this orientation process.

Nacro's recommendations:

- The first step is for policymakers and service providers to acknowledge that release involves disorientation and can be stressful. Once aware, they can begin to anticipate and understand some of the likely reactions of young people, and take these into account in planning, carrying out, and enforcing a sentence.

For the custodial phase:

- Young people also need to be made aware in advance of how they may feel on release. Ideally, the young people should undergo a planned preparation for release that begins as early as possible during their custodial period, helping them to find and adopt coping mechanisms for the huge changes in their lives.
- Release on temporary licence (ROTL) or mobility, as it is known in some institutions, should be used much more widely. It is already known that if ROTL is used for visits and interviews relating to accommodation and education, training or employment it can be useful in helping offenders to prepare for resettlement. Taking the reorientation process into account would suggest that resettlement can also be aided by an increased use of ROTL to help re-familiarise (or familiarise if it is a new area) a child with their home environment. Extending the use of ROTL would also facilitate a more graduated process of readjustment; enabling young people to get used to the change of pace and the extent of change they will experience when they leave the confines of the institution

over a period of time, thereby minimising the extent of the shock associated with release: If just for an hour, just like walking around. *Barry, 14*

- Physical conditioning of the young person for life outside could help reduce tiredness and better equip them to cope with the pace of life and activities outside. Physical activities in the institution should consider the likely needs of young people on release and prepare them accordingly to combat the sudden shift from a largely sedentary regime.
- Renegotiating relationships and interactions with those closest to them could be aided by focusing more on family interactions while inside. Although made more difficult by custodial institutions increasingly being a considerable distance from home (Bateman, Hazel and Wright, 2013), regular communication with as many family and friends as possible should be encouraged. Such contact should not be restricted in any way as part of a behavioural management scheme or as a disciplinary sanction.
- Providers of resettlement services should ensure that they assist parents and other family and friends to visit the young person regularly when inside, if the young person wishes it. Institutions should consider how they can facilitate more alone time between young people and their families before release in order to help start the renegotiation process.

This report reaffirms the importance of early planning for release, beginning as soon as the custodial period starts and with early confirmation of the resettlement arrangements that will be in place when the young person leaves the institution. This is not only so that interventions are able to start promptly on release (see below), but also so that the young person has an opportunity to prepare themselves for where they are likely to be living and what they are likely to be doing when they leave.

For the release phase:

- All young people should be met at the institution at the time of release by someone that they are familiar with and trust. If family or friends are not available or suitable, then any service provider picking up the child must be well known to them and trusted. If this relationship has not been developed before custody, particular attention should be paid to ensuring that the rapport and trust is built up during the custodial phase – which will mean more regular contact than sentence planning meetings.
- Consideration should be given to what practical support can be put in place that might minimise the trauma of transition. On occasion this will require making available additional resources to allow young people to buy new clothes or other things that will make them feel less uncomfortable in what has become an unfamiliar environment.
- A structured timetable should be put in place for the initial period after release. This should bear in mind the stressful symptoms of disorientation, including withdrawal, so should be flexible and adaptable to the individual. Moreover, the timetable should not place unreasonable expectations on young people, recognising that intensive activity immediately on release from incarceration might simply increase the trauma associated with the transition to the community. Intervention should accordingly be planned in a graduated manner, increasing what is expected of young people according to how quickly and successfully they are able to readjust to life outside of prison.
- Service providers should consider activities during the initial period after release that specifically aid the reorientation process. These may help readjustment by, for instance, facilitating families and young people to have more structure to their timetable or lifestyle than they are used to. Service providers may help with re-familiarisation by perhaps mentoring them into their surrounding environment in a controlled and

supported way, with appropriate briefing and debriefing. They may help renegotiation of relationships by perhaps facilitating sessions and scenarios with family and friends, and guiding interaction in a positive way.