Received: 1 August 2019 | Accepted: 1 August 2019

DOI: 10.1002/cbm.2128

INVITED SPECIAL ISSUE ARTICLE

WILEY

Mental health in the criminal justice system: A pathways approach to service and research design

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Abstract

Background: *Care pathway* approaches were introduced into health care in the 1980s and have become standard international practice. They are now being introduced more specifically for health care in the criminal justice system. Care pathway delivery has the theoretical advantage of encouraging a whole-systems approach for health and social care within the criminal justice system, but how well is it supported by empirical evidence?

Aims: The aim of this study is to review the nature and extent of evidence streams supporting health care delivery within interagency pathway developments since 2000.

Method: We used an exploratory narrative method to review the nature and extent of evidence streams supporting health care delivery within interagency pathway developments since 2000. The available literature was reviewed using a keyword search approach with three databases: PubMed, Medline, and Google Scholar.

Findings: Research in this field has covered police custody, courts, prisons, and the wider community, but there is little that follows the entire career through all these elements of offender placement. Main themes in the research to date, regardless of where the research was conducted, have been counting the disorder or the need, development and evaluation of screening tools, and evaluation of clinical intervention styles. Most evidence to date is simply observational, although the possibility of conducting randomised controlled trials of interventions within parts of the criminal justice system, especially prisons, is now well established.

Conclusions: Access to health care while passing through the criminal justice system is essential because of the disproportionately high rates of mental disorder among offenders, and the concept of structured pathways to ensure this theoretically satisfying, but as yet empirically unsupported. Further, substantial cuts in services, generally following government economies, are largely unresearched. Considerable investment in new possibilities, driven by both pressure groups and government, tend to be informed by good will and theory rather than hard evidence and are often not evaluated even after introduction. This must change.

1 | INTRODUCTION

In the health sector, the organisation of care delivery into *care pathways* has become a standard international process in the period since the concept was first introduced in the mid-1980s (Vanhaecht et al., 2006). The purpose of these care pathways is to describe how, in general, optimal care should proceed, including how, when, and by whom assessments and interventions should be delivered for any given condition or group of conditions. As such, they are meant to offer a mechanism by which clinical services can be both organised and measured. They therefore also offer the theoretical potential to set up a cycle of improvement in the quality of care (Cheah, 1998).

Although evidence supporting the use of these care pathways has been mixed, they can be effective within a number of limited circumstances and contexts. Successes include ensuring timely assessment and interventions, promoting adherence to guidelines, and supporting decision making (Allen, Gillen, & Rixson, 2009). In the years since they were first described, however, numerous different terms have also been used to document ways in which clinical care can be organised. Terms such as "care model," "care map," or "multi-disciplinary care" have been used to denote a similar meaning, causing some confusion within the developing literature (Kinsman, Rotter, James, Snow, & Willis, 2010). In recognising these terminological difficulties and to provide some clarity, the European Pathway Association (2019) has produced a consensus definition, which states that "care pathways are a methodology for the mutual decision making and organisation of care for well-defined groups of patients during a well-defined period."

Reflecting this literature, it has become fashionable to describe the journeys taken by people who enter the criminal justice system and who access health services within it, in terms of pathways (National Institute for Health and Care Excellence, 2019). In part, this reflects the theoretical progress that is made as people move from one part of the criminal justice system to another and the need to undertake assessments and make clinical decisions at a number of defined stages, such as upon entering prison. This apparent pathway starts in the community at the point of arrest and sometimes before in cases where people are already known to health or justice services. It continues following entry into police custody and attendance at lower (Magistrates') and upper (Crown) courts if required. It then extends into prison custody for those who are sent there on remand (pre-trial) or after they receive a sentence, before then returning to the community at the point of release from prison. In real life, of course, this theoretical pathway structure is often messy, with arrests and rearrests, multiple court attendances at different levels, bail and community orders providing additional stages and complexity to the pathways followed by many. Nonetheless, the idea of a progressive pathway running through the core of the criminal justice system—a *spine*, as it were—is a useful

conceptual model around which to consider the delivery and development of services and the organisation of research priorities.

This paper aims to use this underlying pathways model as a conceptual guide to explore the extent to which there is existing mental health research at each broad landmark on the criminal justice system pathway and consider what is now required.

2 | METHODS

We used an exploratory narrative method to review the nature and extent of evidence streams supporting health care delivery within interagency pathway developments since 2000.

The available literature was reviewed using three databases—PubMed, Medline, and Google Scholar—and we used a keyword approach to search for relevant material, with the following keywords:

- Pathways (or healthcare pathways or health in justice pathways),
- AND (police or police custody),
- AND (court),
- AND (prison).

We also accessed relevant government documents in England and Wales from 2009, given that a pathways approach became national government policy in these jurisdictions following the introduction of the Corston (2007) and Bradley (2009) reports.

As a main goal behind this paper was to identify key areas for new research in the United Kingdom, and there are jurisdictional differences in both criminal justice and health care delivery systems, there is a bias towards reporting U.K.-based studies.

We focused on reports and articles that considered a pathways approach to service design and delivery and excluded non-English language publications.

3 | FINDINGS

3.1 | Mental health in police custody

Police contact is the first step for any potential progress through the criminal justice system. Studies of any interaction between police and mental health services are confounded by the fact that the police are increasingly having to respond in the community to distressed people with mental disorders; indeed, police powers for removing a person from a public place to a place of safety are written into mental health legislation, at least in the United Kingdom. Since the publication of the Corston report in 2007, the literature on health care provision for people presenting with mental disorders in police custody has moved towards a greater focus on providing care for people likely to be charged with a criminal offence. Published data have been in three main areas—observational studies of need among the people who are detained, simple, but effective methods of identifying mental disorder among such people and evaluation of health care delivery models.

Observational studies have demonstrated high rates of mental disorder and substance misuse problems among police detainees (Forrester, Samele, Slade, Craig, & Valmaggia, 2017; McKinnon & Grubin, 2010; Payne-James et al., 2010). Large numbers of these detainees have histories of contact with psychiatric services or present with active psychiatric symptoms when they are clinically reviewed. These findings are broadly consistent with samples from other parts of the criminal justice system, in the United Kingdom, and overseas (Baksheev, Thomas, & Ogloff, 2010; Dorn et al., 2014; Ogloff, Warren, Tye, Blaher, & Thomas, 2011). There is also an overrepresentation of

neurodevelopmental problems, including intellectual disabilities and attention deficit hyperactivity disorder, among police detainees (Young, Goodwin, Sedgwick, & Gudjonsson, 2013).

There is evidence that detainees who exhibit mental health and substance misuse problems can be identified with acceptable reliability and validity in police custody by clinical staff using research-validated screening tools (McKinnon & Grubin, 2012; Noga, Walsh, Shaw, & Senior, 2015). The application of screening processes in operational reality has not, however, kept pace with these research findings, and in England and Wales, this area presently requires review and improvement (Forrester, Taylor, & Valmaggia, 2016). The Health Screening of People in Police Custody (HELP-PC) project, for example, has produced an evidence-based screen that can be simply applied; however, in most areas, appropriate screening is simply not being done (McKinnon & Grubin, 2012). Meanwhile, attempts to help police by flagging risk may be disadvantaging the people with mental disorder who come into contact with them (Kane, Evans, & Shokraneh, 2018).

Mental health intervention models designed for police custody suites have been evaluated, including consideration of crisis intervention teams, liaison and diversion services, and street triage schemes. There is some limited evidence in the literature for the effectiveness of both liaison and diversion and street triage interventions (Reveruzzi & Pilling, 2016; Scott, McGilloway, Dempster, Browne, & Donnelly, 2013). The developing literature favours an integrated multiagency approach to service delivery, but the literature remains sparse, includes no randomised controlled trials, and does not clearly favour a particular model (Kane et al., 2018), indicating that those who are involved in making policy and designing services should review the national approach that is currently being taken within England and Wales.

It is now 10 years since the publication of Lord Bradley's (2009) review of people with mental health problems or learning disabilities in the criminal justice system in England and Wales, and mental health services and multiagency approaches have developed substantially in this area since then. These services—known as *liaison and diversion services*—have been rolled out across the criminal justice system and explicitly include the possibility of diverting people into mental health services before formal criminal charges are made. They have continued to receive political support and treasury backing and, as a consequence, now cover almost three quarters of the population of England, representing considerable change since they were first started as single-site pilots in the late 1980s (NHS England, 2019; Srivastava, Forrester, Davies, & Nadkarni, 2013).

Despite this developing evidence base and successes in service provision in the early stages of the criminal justice system, there are several issues that require more focus. There is currently an increasing recognition that people from Black, Asian, and some minority ethnic groups have much higher arrest rates than White groups, leading to a national review and a series of recommendations (Lammy, 2017). The extent to which these are being followed is unclear, as is the impact this could have on the mental health of criminal justice-involved individuals from these groups. Meanwhile, although there is evidence of a reduction in recorded crime, demand upon the police has risen OR increased - not both in a number of areas, and at the same time, there has been a drop in overall police numbers. In particular, there appears to have been an increase in the number of incidents in which mental health is a factor (College of Policing, 2015). There has also been a renewed focus on deaths in police custody, of which there were 14 in 2015/2016, although 60 people died by suicide after being released from police custody during that same year. In the 10-year period between 2005 and 2015, 51% of people who died in police custody did so from natural causes, whereas drugs and/or alcohol were involved in 49% of cases (Angiolini, 2017). It is clear that much more needs to be done in each of these areas to ensure the delivery of appropriate services and prevent adverse and harmful outcomes.

3.2 | Mental health in courts

In 2017, the Magistrates' Courts managed 1.5 million cases in England and Wales, of which 114,000 (7.6%) were subsequently committed to Crown Courts (upper courts) for further action, including trial and sentencing (House of Commons, 2018). Magistrates' Courts (lower courts) in England and Wales are now mostly served by liaison and

diversion services that often work across several parts of the criminal justice system—mainly police custody and courts, although they also sometimes provide liaison input into prisons and probation services—offering a pathways-type service within geographical areas (NHS England, 2019). In the main, these teams are staffed by nurses, although other staff, including psychiatrists, social workers, and psychologists, can also be provided (Forrester et al., 2018). The aim of such services is to provide assessment of a range of mental disorders and clinical liaison across a number of agencies and to promote the diversion of people from the criminal justice system to safe alternatives, such as hospital or community pathways, where this is appropriate. Although there is a commitment to the provision of mental health services in the lower courts, they are not routinely provided in Crown Courts. Apart from a handful of small schemes offering a liaison function involving local secure psychiatric services, mental health input into these courts is mainly provided by expert witnesses.

Published literature indicates a high prevalence of mental disorder among court attendees (James, 2009; Shaw, Creed, Price, Huxley, & Tomenson, 1999), for whom a range of special measures can be made available. These measures are meant to provide protection to vulnerable witnesses and they can include the use of screens, live links, giving evidence in private, the removal of official clothing such as wigs and gowns, using video-recorded interviews, or the assistance of an intermediary (Crown Prosecution Service, 2019).

A range of diversion outcomes are available at various stages within the court process, and the available legislation can enable them to be tailored to the specific circumstances. For example, defendants can be diverted to hospital under civil sections of the Mental Health Act 1983 while they are unconvicted, or convicted but unsentenced, or following a conviction, to community orders or suspended prison sentences provided under the Criminal Justice Act 2003, or mental health disposals provided under the Mental Health Act 1983. In cases where either fitness to plead or insanity is an issue, there are three possible disposals: a hospital order, a supervision order, or absolute discharge.

One option that can be particularly effective for some offenders with mental disorder who do not require hospitalisation is the personal tailoring of the community order or suspended prison sentence. It is possible to add a number of specific requirements, with supervision by a probation officer, the most commonly used of the 13 possibilities. Of the three community health treatment requirements, which include alcohol and drug treatment requirements, the mental health treatment requirement has not only been underused, but its use was falling; the court, in essence, makes a form of contract between the probation officer, the clinician, and the prospective patient, who must agree to the order (Scott & Moffatt, 2017). It is reassuring that the offender patients involved appear to understand these orders (Manjunath, Gillham, Samele, & Taylor, 2018), but empirical research on their effectiveness is lacking. A similar kind of community order in New York, to which patients must also give consent, has proved highly effective in reducing rearrest and incarceration (Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011) as well as inpatient hospitalisation, among other benefits (Swartz, Swanson, Steadman, Robbins, & Monahan, 2009). A government-funded programme to improve availability of relevant services has proved effective in terms of both increasing overall numbers of people being given a mental health treatment requirement and in being given combined health requirements where the contribution of substance misuse has been recognised (Her Majesty's Prison and Probation Service, 2014). Now, there should be research evaluation of the health and criminal justice outcomes that follow from such orders. These must include reporting outcomes for the individual offenders and also test the impact on the ever growing prison population. As yet, notwithstanding government policy since the publication of the Bradley (2009) report to reduce the prison population in England and Wales, this has not happened in practice (National Audit Office, 2017).

3.3 | Mental health in prisons

To date, the main approaches to the management of mental disorders in prisons have also fallen onto three main categories: observations on the prevalence of mental disorders among prisoners, the development of screening tools, and evaluation of services and interventions delivered—considering both treatment offered within the prison environment and transfer to health service facility options.

A high prevalence of mental disorder among prisoners has been reported across the world and is well established in the international literature (Fazel & Baillargeon, 2011). Specific concerns have also been investigated, including alcohol and substance misuse (Kissell et al., 2014; Singleton, Farrell, & Meltzer, 2003), self-harm and self-inflicted death among prisoners (Hawton, Linsell, Adeniji, Sariaslan, & Fazel, 2014), traumatic brain injury (Williams, Cordan, Mewse, Tonks, & Burgess, 2010), attention deficit hyperactivity disorder (Young et al., 2018), and ultra-high psychosis risk (Evans et al., 2017). Meanwhile, the idea that health care screening must take place at prison reception has gained international approval (United Nations General Assembly, 2016). A number of tools are available to screen for mental disorders, six of which are supported by studies demonstrating replication—including the England Mental Health Screen, the Jail Screening Assessment Tool, the Brief Jail Mental Health Screen, the Referral Decision Scale, the Correctional Mental Health Screen for Men, and the Correctional Mental Health Screen for Women (Martin, Colman, Simpson, & McKenzie, 2013).

The management and treatment of people in prisons in situ has been considered broadly in terms of mental state change during imprisonment. A systematic review of longitudinal studies internationally confirmed, perhaps surprisingly, a tendency towards improvement in mental state, perhaps especially during the early weeks of stay (see Walker et al., 2014, for a systematic review). In England and Wales, it is estimated that over a third of prisoners have diagnosable mental health conditions and mental health in-reach teams have been developed to provide care and treatment using a model that is meant to be equivalent to the services prisoners would receive if they were resident in the community. Although these teams are now providing care to many people who would not otherwise have received it, variations in their coverage and content, and persisting issues with the identification of mentally ill prisoners, have remained problematic (Forrester et al., 2013; Senior et al., 2013).

If a prisoner has a disorder of health, including mental health, of sufficient severity to require inpatient treatment, then, in the United Kingdom, that individual must be transferred to a health service hospital (under mental health legislation in the case of mental disorder). In England and Wales, there were 1,081 such transfers during the year 2016/2017. Most of these people waited much longer for hospital admission than the recommended 14-day period (National Audit Office, 2017). Although this group only represents around 3.5% of the 31,328 in prison thought to have mental health problems (National Audit Office, 2017), they are acutely unwell, and delays to transfer generally prevent effective treatment delivery. Continued commitment to both management in situ and reduced delays to transfer is needed to ensure that transfer to hospital is completed promptly for the small number of acute cases and that high-quality mental health care is available in prison for the larger group of prisoners with mental health problems that can be managed by teams working within prisons.

Developments in prison models of care using specific screening, referral, and stratification processes have been implemented within large prison systems and described in the literature (O'Neill et al., 2016; Pillai et al., 2016). The organisation of these processes into a particular model—the *STAIR model*—is one easily understandable way of signifying what should happen within the prison health care pathway and when. It includes five key elements—screening, triage, assessment, intervention, and reintegration (STAIR) (Forrester et al., 2018; McKenna et al., 2018; Pillai et al., 2016). Although this model is broadly in keeping with guidelines for the management of adults who are in contact with the criminal justice system, which particularly emphasise screening processes, further research is needed to refine existing models to ensure they are sensitive to the wide range of mental disorders seen (National Institute for Health and Care Excellence, 2017). Service developments are also needed to ensure that resources provided on the ground are both adequate and appropriate (Patel, Harvey, & Forrester, 2018).

3.4 | Mental health following release

Literature on the postrelease period for prisoners with mental health problems is limited, but available evidence indicates that outcomes in this period are poor. Continuity of care between prison and community-based services is difficult to provide, and prisoners often lose contact with services after release, even where management in prison is in place (Lennox et al., 2012). Mortality after release from prison is high, with elevated risk of both drug-related

mortality (Farrell & Marsden, 2008) and suicide (Pratt, Piper, Appleby, Webb, & Shaw, 2006). It has also been suggested that prisoners with mental illness have higher rates of reoffending than those without mental disorder and are more likely to return to prison due to lack of support (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009).

Despite these outcomes, care targeted at the transition from prison to the community is seldom present. Services based in prison have limited ability to provide care after release, and due to the chaotic nature of release, community services have limited ability to respond to referrals. Targeted interventions are therefore needed to attempt to improve outcomes in this area. A number of evidence-based interventions are available, and studies suggest that interventions focused on the transition from prison to the community can improve outcomes with prisoners with mental health problems (Hopkin, Evans-Lacko, Forrester, Shaw, & Thornicroft, 2018). In the United Kingdom, community mental health care services are well established, and short-term bridging interventions may be sufficient to improve care by ensuring that continuity of care between existing services is achieved. Randomised controlled trials are, however, feasible in this area (Lennox et al., 2018); one such trial having shown that providing additional care in 4 weeks before and 6 weeks after release, and planning more proactively for transition to the community, can improve engagement with mental health services (Shaw et al., 2014).

Further research is now needed in this area to consider what initiatives work best to facilitate engagement with services and improve outcomes in the postrelease period. In addition, we need to understand how these services can best ensure that continuity of care is optimised. It will also be important to understand how these services can best work alongside probation services by testing appropriate models.

It is not possible to conclude without referring to the offender personality disorder pathway programme, a large-scale national initiative in England and Wales that provides a range of therapeutic services for people with severe personality disorders and associated risk to others, across the criminal justice system (National Offender Management Service and NHS England, 2015). Key components of this model include the use of case identification and pathways planning, psychologically informed planned environments, and case management in the community, both following release and through probation services (Benefield, Turner, Bolger, & Bainbridge, 2017). This model is presently being evaluated, and a review of its advantages and limitations will soon be possible.

4 | CONCLUSIONS AND IMPLICATIONS FOR FUTURE RESEARCH

It is clear that there have been many welcome research developments in this field and that these research developments have led to an improved understanding of service design and application. It is also apparent, however, that research has not always been done either preparatory to service development or after a service has been put in place. There has too often been a reliance on lower quality evidence, rather than introducing higher quality studies including quasi-experimental and randomised controlled trial work. The many service developments in the field tend to be driven centrally by political declarations and policy statements rather than being underpinned by robust research evidence. This would not be acceptable in most, if any, other areas of health care provision.

Moving forward, it will now be important for us to develop our understanding in a number of key areas. When, where, and how often should screening be applied, and what tools offer the best results? What qualities in liaison and diversion services improve the uptake of community alternatives to prison custody and have a beneficial effect on rates of recidivism? Can integrated service delivery work across sectors and achieve its theoretical potential by improving the accessibility to and overall quality of services? How do we best resolve serious and persisting problems in respect of clinical complexity and mortality, and what interventions should now be targeted through research to ensure better outcomes? How can environmental effects, such as the impact of overcrowding or segregation, best be understood, and what environmental improvements are required?

Such questions cannot be easily answered without a considered and strategic approach to research planning within this field, recognising the difficulties in ensuring research funding in an area where the acquisition of such funding has always been difficult. In order to take this forward, we recommend that a suitable expert group is

brought together to identify the most important research questions and develop responses. What are the research priorities for the next decade?

ACKNOWLEDGEMENTS

None.

CONFLICT OF INTERESTS

The authors declare no conflict of interests.

FUNDING INFORMATION

There are no funding sources to declare.

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How to cite this article: Forrester A, Hopkin G. Mental health in the criminal justice system: A pathways approach to service and research design. *Crim Behav Ment Health*. 2019;29:207–217. https://doi.org/10.1002/cbm.2128